Counselling Psychologists’ Experiences of Working with Exercise in Therapy:

A qualitative study

A thesis submitted to the University of Manchester for the degree of Doctorate in Counselling Psychology (DCounsPsych)
in the Faculty of Humanities

2014

Ruth Gordon

School of Environment, Education and Development
# List of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of tables</td>
<td>5</td>
</tr>
<tr>
<td>Abstract</td>
<td>6</td>
</tr>
<tr>
<td>Declaration</td>
<td>7</td>
</tr>
<tr>
<td>Copyright statement</td>
<td>8</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>9</td>
</tr>
<tr>
<td>Chapter 1</td>
<td></td>
</tr>
<tr>
<td>1. Introduction</td>
<td>10-13</td>
</tr>
<tr>
<td>1.1. Introduction to the current study</td>
<td>10</td>
</tr>
<tr>
<td>1.2. What is counselling psychology?</td>
<td>10-12</td>
</tr>
<tr>
<td>1.3. Structure of the thesis</td>
<td>13</td>
</tr>
<tr>
<td>1.4. Chapter summary</td>
<td>13</td>
</tr>
<tr>
<td>Chapter 2</td>
<td></td>
</tr>
<tr>
<td>2. Literature Review</td>
<td>14-41</td>
</tr>
<tr>
<td>2.1. Introduction</td>
<td>14</td>
</tr>
<tr>
<td>2.2. Counselling psychology and the body</td>
<td>16-19</td>
</tr>
<tr>
<td>2.3. What is exercise?</td>
<td>19-21</td>
</tr>
<tr>
<td>2.4. The impact of exercise on wellbeing</td>
<td>21-26</td>
</tr>
<tr>
<td>2.5. The impact of exercise in clinical populations</td>
<td>26-32</td>
</tr>
</tbody>
</table>
2.6. The use of exercise within mental health 32-35
2.7. Exercise and counselling psychology 35-40
2.8. Chapter summary 40-41

Chapter 3

3. Methodology 42-68
3.1. Introduction 42
3.2. Epistemological positioning 42-44
3.3. Quality of the research 44-47
3.4. Method 47-64
3.5. Ethical considerations 64-67
3.6. Chapter summary 67-68

Chapter 4

4. Analysis 69-115
4.1. Introduction 69
4.2. How have counselling psychologists used exercise within their therapeutic work?: Key themes 69-82
4.3. What has been the experience of those counselling psychologists who have incorporated exercise into their work?: Key themes 82-107
4.4 Reflexive Analysis 108-114
4.5. Chapter summary 115

Chapter 5

5. Discussion 116-145
5.1. Introduction 116
5.2. How have counselling psychologists used exercise in their therapeutic work? 116-121
5.3. Counselling psychologists’ experiences of using exercise 121-134
5.3.1 Vehicle for change
5.3.2 Holism
5.3.3 Influence of self
5.3.4 A quiet voice
5.3.5 One of many tools
5.3.6 Collaboration

5.4. Implications for counselling psychology 134-137
5.5. Methodological discussion 138-141
5.6. Recommendations 141-143
5.7. Personal reflections 143
5.8. Chapter summary 143-145

References 146-165
Appendices 166-215

Word count = 47,911
### List of tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Search terms used in the literature review</td>
<td>15</td>
</tr>
<tr>
<td>2. Participants’ demographic data</td>
<td>52</td>
</tr>
<tr>
<td>3. How counselling psychologists have used exercise within therapeutic work</td>
<td>70</td>
</tr>
<tr>
<td>4. Counselling psychologists’ experiences of incorporating exercise into their work</td>
<td>83</td>
</tr>
</tbody>
</table>
Counselling Psychologists’ Experiences of Working with Exercise in Therapy:

A qualitative study

Ruth Gordon

July 2014

The University of Manchester

Doctorate in Counselling Psychology

Abstract

*Background and objectives:* Despite the benefits of exercise for both physical and psychological health and the focus of counselling psychology on a holistic approach to wellbeing, we know little about the role of exercise within the discipline. Furthermore, no research has examined UK-based counselling psychologists’ experiences of working with exercise. The objective of this study was therefore to explore UK-based counselling psychologists’ experiences of incorporating exercise into their therapeutic work. The research questions were as follows: 1. How have counselling psychologists used exercise within their therapeutic work? and 2. What has been the experience of those counselling psychologists who have incorporated exercise into their work?  *Method and analyses:* A qualitative design was used within this project. Semi-structured interviews were conducted with eight UK-based counselling psychologists who stated that exercise had formed part of their therapeutic work. The interview material was then analysed using thematic analysis.  *Analysis:* The themes developed from the first research question revealed a number of ways in which exercise had formed part of counselling psychologists’ work; including as an intervention that clients engaged in between sessions, within the sessions themselves, and through collaboration with other professionals. Six main themes were developed when exploring the participants’ experiences of working with exercise: ‘vehicle for change’, ‘holism’, ‘influence of self’, ‘a quiet voice’, ‘one of many tools’ and ‘collaboration’. These are introduced and outlined in depth in turn.  *Conclusions:* The research enabled, for the first time, an insight into the role of exercise within counselling psychologists’ therapeutic work. Some UK-based counselling psychologists are using exercise with their clients; in a variety of forms and from a variety of rationales. The participants described a host of ways in which they had witnessed exercise as beneficial to their clients, but ranged in their views regarding whether exercise should be introduced into the work by the therapist. Exploring exercise raised wider issues relating to the approach of counselling psychologists towards clients’ physical health as well as the role of pluralism in further developing the use of exercise within therapy.  *Suggestions for theory, further research and practice are proposed.*
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DocuInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on Presentation of Theses.
Acknowledgements

Firstly, thank you to my parents; without your help and support I would literally not have been able to complete this course. No more being a student after this I promise!

Thank you to Terry Hanley and Clare Lennie for giving me the chance to complete the doctorate at Manchester when I was close to giving up hope that it was possible. Terry – thanks for your continued support throughout the course, and the many opportunities you have given me. Thanks also to Erica Burman for your help and patience with me throughout this process.

Thank you to my fellow trainees, it really feels that this course has been a joint effort! I am glad that I have shared it with you. Thanks especially to Pariya Habibi, Andrew Greaves, Sabita Estrada, Emily Cudworth and Laura Cutts, for the support, laughs and of course hours and hours of moaning! I couldn’t have done it without you.

A huge thank you to all my other friends who have been there for me throughout my return to student life, with special thanks to Rhian Davitt-Jones. I’d also like to give particular thanks to Lucy Smith for being an amazing friend.

Finally, thank you to all the participants who took the time to take part in this study, and to those who helped me to find them.
1. Introduction

1.1. Introduction to the current study

The present thesis explores UK-based counselling psychologists’ use of exercise in their therapeutic work. As will be seen in later chapters, an extensive literature base exists detailing both the physical and psychological benefits of exercise. Yet there is a paucity of research exploring the use of exercise within psychology. This paucity also extends to counselling psychology, despite the field’s emphasis on holistic wellbeing. Specifically, no research has explored ways in which UK-based counselling psychologists may have incorporated exercise into their therapeutic work, nor their experiences of doing so. In order to address these areas, the present study takes the form of a qualitative research design; specifically a series of semi-structured interviews with UK-based counselling psychologists. I further outline the rationale behind the research and its methodology in later sections. In the present chapter, as the focus of the research specifically relates to the use of exercise within counselling psychology, in order to provide a context for the study I firstly introduce the field in more detail. Finally, I outline the structure of the thesis as a whole.

1.2. What is counselling psychology?

The research questions at the heart of the present study centre on the discipline of counselling psychology. I will therefore start by outlining the philosophical values underlying the branch of psychology. Such values are an important part of professional identity (Cooper, 2009) and as a consequence, set the scene for why exercise is potentially a relevant part of the field’s discourse.

Counselling psychology is characterised by its humanistic value base (Strawbridge & Woolfe, 2010). Broadly, we can consider this to mean that for a counselling psychologist, the goal of a therapeutic encounter is to assist the client in the fulfilment of their potential. Specifically, Orlans and van Scoyoc (2008) state that counselling psychology draws on “ideas of a holistic kind” (p. 22). This is further exemplified in the following quote by Manafi (2010):
Mainly due to the field’s adherence to humanistic psychology and existential/phenomenological philosophy, counselling psychology embraces a view that springs from a holistic conceptualisation of human beings (p. 22). These statements appear very grandiose but what do we actually mean by a holistic focus? One way of considering it is to examine what makes the discipline distinct from others. For example Woolfe (1990), identified “a developing focus in the work of helpers on facilitating wellbeing as opposed to responding to sickness and pathology” (p. 531), as one of three psychological trends that he considered particularly encouraging for the field of counselling psychology. For me, this focus opens up the field of counselling psychology to anything that may contribute to the individual’s wellbeing, or as simply summed up by Milton (2010); “what makes us tick, what hurts and what is helpful” (p. xxv). So what elements could contribute to wellbeing? Interestingly, the US definition of counselling psychology, as denoted by the American Psychological Association (APA), specifically includes health: “Counseling psychology as a psychological speciality facilitates personal and interpersonal functioning...with a focus on...health related...concerns” (Division of Counseling Psychology, 1994). Mrdjenovich and Moore (2004), in a piece in *Counselling Psychology Quarterly*, take the inclusion of health further, noting how it might translate to clinical practice. They argue that given the traditional emphases of counselling psychology, such as “perspective of wellness and lifespan development”, “primary prevention” and “strength (as opposed to disease or deficit)” (p. 72), practitioners have value to add in physical health settings. We can therefore begin to see the relevance of health, and therefore exercise to counselling psychology.

The discussion that I am touching on here is not new; since its conception there has been extended debate surrounding the principles that underlie counselling psychology (e.g. Cooper, 2009; Goldstein, 2009; Moller, 2011). Beyond a focus on wellbeing, Milton (2010) argues that key bases include pluralism, a relational framework and the therapeutic relationship. A further tension that the discipline holds is that of the balance between ‘scientist-practitioner’ and ‘reflexive-practitioner’, a requirement articulated in the Health and Care Professions Council (HCPC) Standards of Proficiency for counselling psychologists, the UK regulatory body for the field (HCPC, 2010). According to Belar and Perry (1992), the scientist-practitioner model states that counselling psychologists should have a “research-
orientation in their practice, and a practice relevance in their research” (p. 72). This principle seems particularly important when considering concepts that could be incorporated into clinical work, such as exercise.

The broad nature of the identity outlined above is perhaps reinforced by the particular diversity of the background of counselling psychologists (Mrdjenovich & Moore, 2004). In terms of those joining the profession in the UK, the discipline is not tailored to the National Health Service (NHS) in the same way as clinical psychologists. Arguably therefore, individuals pursuing the counselling route are drawn to the profession for the variety of potential avenues and sectors in which they may eventually work (Clarkson, 1998). Indeed, many counselling psychologists come into the profession following another career. Such diversity is contributed to by the relatively recent requirement for a doctoral level qualification. Furthermore, counselling psychologists work from a variety of therapeutic models, from cognitive-behavioural to psychoanalytic, to existential, with many more in-between (Orlans & van Scoyoc, 2008).

As is becoming clear, counselling psychology is complex and broad in its range. Given the focus of the current study on exercise, it seems important to also consider the identities of other pertinent disciplines to the area. According to the British Psychological Society (BPS, 2013a), health psychologists “are specially trained to help people deal with the psychological and emotional aspects of health and illness. They use their knowledge of psychology and health to promote general well-being and understand physical illness”. The BPS also holds a Division of Sports and Exercise Psychology. The BPS notes that the aim of sports psychology is “to help athletes prepare psychologically for the demands of competition and training”, whereas exercise psychologists are concerned with “the application of psychology to increase exercise participation and motivational levels in the general public” (2013b). It seems clear that work from these fields may influence the relationship between counselling psychology and exercise.

The present section has comprised but a brief reflection on the identity of counselling psychology, however its aim has been to provide at least something of an introduction to the discipline, as well as its potential relationship to exercise.
1.3. Structure of the thesis
The current work aims to explore two research questions; examining how counselling psychologists have incorporated exercise into their therapeutic practice, as well as their experiences of doing so. In order to present a structured guide of the journey I have undertaken to address these questions, the work is presented in five chapters. The aim of the present chapter is to provide a brief introduction to the study, as well as to the field of counselling psychology. Chapter Two summarises the existing literature relevant to the research. Initially the focus is on literature exploring the relationship between counselling psychology and the body. I then go on to examine the concept of exercise further; starting with its definition and relationship to overall wellbeing, both physical and psychological. Next I examine the literature relating to the use of exercise for those experiencing mental health difficulties. The next focus is the research on the use of exercise as a preventative measure in mental health, as well as its use within the field more generally. I then become more specific, exploring the use of exercise in counselling psychology, including research on psychologists’ attitudes towards exercise. The next chapter, Chapter Three, presents the methodology of the present study including my epistemological position, the research design and the rationale and steps by which I analysed the interview material. In Chapter Four I present the analysis itself, before moving onto detail my reflections on the research process in the reflexive analysis. Finally, Chapter Five comprises a wider consideration and discussion of the research analysis. As part of the discussion I examine the limitations of the research, as well as its implications for the field and its practice, and recommendations for future research.

1.4. Chapter summary
In this first chapter I have aimed to give a broad introduction to the present research. I have outlined the objective of the study; to examine an area previously unexplored in UK counselling psychology; that of the role of exercise within therapy. The rationale behind the study will be further made clear throughout the next chapter in my review of the existing literature. I have briefly outlined some of the principles underlying the profession of counselling psychology. Finally I have described the structure of the present thesis.
1. Literature review

2.1. Introduction

In this first chapter, I aim to present the existing literature which relates to the current thesis. By doing so, I hope to show how the research questions at the centre of the current study have developed from the existing discourse. As will become evident, there are two main bodies of literature that to me appear relevant. There are those works; mostly theoretical, which have explored the relationship between counselling psychology and the body. Then there are those studies focused on exercise, its benefits, and its role as an intervention in the field of mental health. As I weave my way through the existing research, my hope is that the rationale for the present study becomes further clear, as the gap in both subject matter and research design becomes apparent.

As for the structure of the present chapter, as you will see it is divided into seven core sections. As a starting point I explore the literatures relating to counselling psychology and the body (perhaps indicative of its current non entity in the field, is that I feel I need to clarify that when I refer to the body here, I mean our physical bodies as human beings). I then focus on the seemingly quite separate literatures relating more directly to exercise, starting with the definition of exercise before moving onto outline the research on the links between exercise and wellbeing, both physical and psychological. Next I move onto the studies focused on exercise as an intervention in clinical populations. After that I explore the wider use of exercise within mental health care. In the final section I examine the existing literature on attitudes towards exercise within psychology, and counselling psychology.

2.1.1. Search strategy

I will now outline the details of the search that I undertook in order to complete the literature review. The majority of the literature was retrieved by searching electronic databases. I searched the databases PsycInfo, Medline, ASSIA (Applied Social Sciences Index and Abstracts), as well the search engine Google Scholar. In both cases I used specific search terms to identify literature relevant to the present study. I used both the terms exercise and physical activity in the search due to the overlap between the two terms (see Section 2.3.), as well as the limited amount of literature
retrieved when using only the term exercise. The specific search terms used are detailed in Table 1 below:

Table 1 – Search terms used in the literature review

<table>
<thead>
<tr>
<th>Search terms used</th>
<th>Table terms used</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘exercise’ and ‘mental health’</td>
<td>‘exercise’ and ‘psychologists’ and ‘attitudes’</td>
</tr>
<tr>
<td>‘exercise’ and ‘therapy’</td>
<td>‘exercise’ and ‘psychologists’ and ‘experiences’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counselling psychology’</td>
<td>‘counselling psychology’ and ‘the body’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counselling psychologists’</td>
<td>‘counselling’ and ‘the body’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counselling’</td>
<td>‘therapy’ and ‘the body’</td>
</tr>
<tr>
<td>‘exercise’ and ‘psychology’</td>
<td>‘psychology’ and ‘the body’</td>
</tr>
<tr>
<td>‘exercise’ and ‘psychology’ and ‘attitudes’</td>
<td>‘exercise’ and ‘benefits’</td>
</tr>
<tr>
<td>‘exercise’ and ‘psychology’ and ‘experiences’</td>
<td>‘exercise’ and ‘therapy’ and ‘depression’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counselling’ and ‘attitudes’</td>
<td>‘exercise’ and ‘counselling’ and ‘depression’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counselling’ and ‘experiences’</td>
<td>‘exercise’ and ‘therpay’ and ‘anxiety’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counsellors’ and ‘attitudes’</td>
<td>‘exercise’ and ‘depression’</td>
</tr>
<tr>
<td>‘exercise’ and ‘counsellors’ and ‘experiences’</td>
<td>‘exercise’ and ‘anxiety’</td>
</tr>
</tbody>
</table>

Further to the databases, sources of literature were books and e-books related to the subject. I also searched within the reference lists of articles that I had already found.

---

1 For each search using the term ‘exercise’, the equivalent search was also conducted using the term ‘physical activity’. 
2.2. Counselling psychology and the body

As noted above, I will first explore the existing discourse surrounding the relationship between the field of counselling psychology and the body. Again, as mentioned above I feel the need to be clear here that I mean our physical bodies, and not, as feels more familiar, any sort of body of work, nor research body.

I will begin the discussion with a brief exploration as to why the body may be considered relevant to counselling psychology. As noted in the introductory chapter, one of the underpinning principles of the field is a belief in the importance in the overall wellbeing of the individual (Gillon, 2007; Cooper, 2009). On conducting the present literature search however, it became evident that beyond such broad statements, the discussion, on paper at least, is not taken beyond that. It is not overly clear what is meant by wellbeing, nor in what ways counselling psychologists may realise this focus, either theoretically or in practice. We know that the holistic focus in theory emphasises wellbeing both in terms of body and mind (Moodley, Sutherland, & Oulanova, 2008). However, the history of the relationship between body and mind in psychology is contentious, as is well known. But how about specifically in relation to therapy?

The body has been invisible, for years unaddressed and ignored, left in the waiting room of the therapist’s office (Conger, 1994, p. 211).

It is with the above quote that Wahl (2003) starts “Counselling psychology and the body”, the chapter on that topic in the second edition of the Handbook of Counselling Psychology (Strawbridge, Dryden & Woolfe, 2003). The chapter offers a succinct summary of the theory and practices of the use of the body in therapy. As highlighted above one might assume that the holistic focus of counselling psychology makes it ripe for ‘body work’. However we can gather from the above quote, together with the joy with which Wahl writes about the inclusion of such a chapter in the handbook, that this is not the case. There are always dozens of competing demands to balance with the editing of such texts, but Wahl’s passion does make it somewhat sadder that the chapter was removed for the third edition. Wahl (2003) actually explains his joy as partly due to the exclusion of the topic in most texts, a point that others have also noted in the broader field of counselling and psychotherapy (e.g. Feltham, 2008).
If we look into the origins of this status quo, we quickly move into well known territory. Since the renowned Cartesian separation of body and mind, the emphasis in psychology has been on addressing questions of the mind over the physique. If we open the debate wider, we open ourselves to the philosophical discourse surrounding the role of the body, something that has been contested for more than two thousand years (Wahl, 2003). Within the debate is the ‘mind-body problem’, sometimes called the ‘world knot’, with such early names as Aristotle and Plato initiating the idea of a duality of mind and body. More recently, we witness a focus on cognitive approaches to achieving wellbeing, rather than feeling, insight or indeed, the body (Corey, 2005; Feltham 2008). Feltham (2008) references this in notion to actual physical contact between therapist and client within psychoanalytic therapy, which is considered strictly off limits. This is perhaps an extreme example but arguably illustrative of what it says about therapy more generally; “it also sends out a mixed message: therapy is about conversation, reflection and silence, not about the body (Galton, 2005, p. 135). If we come back into more recent times, arguably such a standpoint has been manifest in the UK in the increasing emphasis on CBT as therapeutic model (McLeod, 2001). Such a trend highlights a belief in the efficacy of cognitive focus in therapy (Feltham, 2008).

Nonetheless, for certain disciplines the body has become part of the therapeutic encounter. In fact, some argue that the birth of the body as part of therapy coincides with the birth of therapy itself; that is to say in early Freudian practice (Wahl, 2003). Freud emphasised the role of the body in its centre of our identity, as well as in the importance of physical nurture in the development of the ego, and therefore, personality (Freud, 1960). The body was also central due to the focus on the psychosomatic, with the idea in the 19th century that very difficult emotions could only be expressed physically, through hysteria. Jungians too, have emphasised mind-body links as a means of achieving self-understanding and wellbeing. It is in the work of Reich (1949) however, that we first see the translation of such theoretical emphases into practice, by way of the first body-focused therapy. This was developed by his students from a somewhat controversial practice into the more accepted therapies of bioenergetic analysis and core energetics (Lowen, 1975; Pierrakos, 1987). It must be noted, these are not well heard of or researched practices, but nonetheless form the basis of more modern body therapies practised
today. As for the more well known therapies, within the humanistic approach both Gestalt therapy and person-centred models include the body in their theoretical framework. Wahl (2003), notes the much forgotten idea that organismic experiencing is central to Rogers’ person-centred model which incorporates both sensory and bodily experience (Rogers, 1959). Further examples of work which incorporates the relationship between mind and body include some therapies based in medical settings. The biopsychosocial model of medicine (Engel, 1997) is increasingly advocated in this context, specifically as a way to understand and work with the client from a place of both body and mind. Demonstrating the diversity with which the body has been at least a theoretical part of therapy, is its place within trauma. In some movements, it is argued that psychological trauma has a physical effect on the body that can last well beyond the moment (e.g. Whitfield, 1988).

Up to this point I have spoken very much of the theoretical bases for the role of the body in therapy. What of the evidence for its part? Body-based therapies have generally been the subject of little research. However mindfulness- based cognitive therapy (MBCT) (Segal et al., 2002) can be considered an exception. MBCT makes central both the body and the body. It involves episodes of mindfulness, through means including body scan, yoga and mindful walking and stretching. As noted by Williams et al. (2006), the learning derived from, for example mindful walking or yoga includes “being mindful of sensations arising in the body whether pleasant or unpleasant”, “noticing aversion to sensations as it arises”, and “learning acceptance” (p. 203). Empirical evidence for MBCT has demonstrated reduced relapse of depression for those who have already experienced several periods of depression (Ma & Teasdale, 2004; Teasdale et al., 2000). Furthermore, in one study where some students on a counselling course participated in a mindfulness-based stress reduction programme (MBSR), the clients of these students reported higher levels of functioning than those who did not undertake the course (Grepmair et al., 2007). Of course these studies alone can not tell us if it was aspects relating to the body which made the MBCT efficacious, however they give an indication of the potential power of so-called mind-body therapies. As I mentioned above, in general, body therapies have been limited by lack of empirical evidence (Wahl, 2003). Other obstacles for the role of the body in therapy include the fear of legal ramifications (Feltham,
2008), as well as the significant ethical issues it raises, particularly in relation to the use of touch (Wahl, 2003).

If we turn to counselling psychology specifically, as indicated by the diversity of approaches noted above there is not a sole approach to the body. We therefore cannot give a definitive account of the relationship between the two. We can however take a step back, and refer once again to the principles that counselling psychology is underpinned on, as introduced above. One such principle is that of pluralism, both for clients and practitioners (McAteer, 2010). With this idea comes diversity, as well as the integration of differing therapeutic approaches. Although the specifically labelled body-oriented therapies may represent an arguably extreme form of the integration of the body, it is clear that the principles from which these therapies are derived still match the ideals that many counselling psychologists work to. Bringing us back to the focus of the discipline on wellbeing, if we take a look at the following quote from Cadwell (1997), the role of the body seems even more prescient: “healthy functioning is a physical as well as emotional, cognitive and behavioural experience, and dysfunction in any part of the organismic continuum will affect the whole system” (1997, p. 9). I would argue that given such a focus, the body is key to the discipline. Currently, it appears that apart from a select number of specific therapies, the body is trailing behind its cognitive confrere. I argue that it should be brought out from the waiting room and into the therapy room. Already therefore, could it be argued that exercise could be one way of realising such an idea? Having clarified where exercise could be positioned philosophically in relation to the field of counselling psychology, I will now move the literature review onto exercise itself.

2.3. What is exercise?

In order to define what is meant by exercise it is first necessary to examine the broader term of physical activity. The World Health Organisation (WHO) defines physical activity as “any bodily movement produced by skeletal muscles that requires energy expenditure” (WHO, 2014). It can be measured in terms of intensity; “the rate of energy expenditure that an activity demands…how hard a person is working” (Department of Health, 2011, p.53). The rate of expenditure can be measured in kilocalories per unit or METS (metabolic equivalents) compared to
metabolic rate when at rest. At rest the rate of energy expenditure is 1 MET; the value increasing with intensity, varying from individual to individual according to factors such as weight and fitness. Intensity of physical activity is commonly split into three categories; light, moderate and vigorous. The UK Department of Health (2011) cites ironing or strolling as examples of light intensity physical activity (2.3 and 2.5 METS respectively), vacuuming or doubles tennis as moderate physical activity (3.5 and 5.0 METS) and singles tennis or running as vigorous physical activity (8.0 and 10.0-13.5 METS respectively).

The WHO (2014) notes that exercise is a subcategory of physical activity, differentiated by its planned nature and purposefulness. It can be defined as: “physical activity that is planned, structured, repetitive, and purposive in the sense that improvement or maintenance of one of more components of physical fitness is an objective” (Caspersen et al., 1985). Exercise includes activities such as running, swimming, brisk walking and weightlifting. Like physical activity, exercise can also be categorised by its intensity. A number of methods exist for measuring intensity, one of the most common forms is via heart rate. The measure is expressed as a percentage of maximum heart rate; %MHR. Again, categories of intensity are commonly light, moderate or vigorous. Light exercise is that which demands approximately 40-50% MHR, and does not demonstrate a change in breathing patterns (CDC, 2014). An example would be gentle walking. Due to its purposive definition however, most types of exercise are moderate or intense. Moderate intensity exercise is defined as requiring a moderate amount of effort, and noticeably raises the heart rate (50-70% MHR). At this level talking is still possible, but not singing (NHS, 2013). Examples include brisk walking, cycling on level ground or with few hills and volleyball. In contrast, vigorous exercise causes the heart rate to be raised significantly (70-85% MHR), and hard and fast breathing, to the extent that not more than a few words can be spoken without pausing (NHS, 2013). Examples include jogging or running, cycling rapidly or on hills, and aerobics. Again, it should be noted that the level of intensity is dictated to some extent by the fitness and previous exercise experience of the individual. In terms of the present study, the focus is on exercise rather than the broader category of physical activity, in order to capture the purposive nature of the former. However as
can be seen from the present section there is a considerable degree of overlap between the two.

Exercise has long been part of our human history. Famously, as early as the ancient Greeks, we know of evidence of ‘games’ such as wrestling and diskos-throwing (Ionananides, 1975), and this is mirrored in evidence of exercise from ancient Egypt and Iran, as well as in Native American and 18th century Chinese populations. But what do we know about the history of exercise and wellbeing?

2.4. The impact of exercise on wellbeing

Exercise also has a long history of being cited as beneficial for wellbeing. As Callaghan (2004) illustrates in his useful account of exercise, the relationship goes back to the age of the Romans. Claudius Galen, doctor to the Roman Emperor Marcus Aurelius produced many books - of which De Sanitate Tuenda (Hygiene) is the most well known, on the subject of health and illness. According to a translated version (Green, 1951), Galen wrote: “the habit of the mind is impaired by faulty customs in food, drink and exercise…and these constitute the beginnings of severe diseases” (p. 26). Here we see the beginnings of the links between physical activity and physical wellbeing. As early as these works, the question of the intensity of exercise required to receive such benefits has also been under contention (Callaghan, 2004), and this is a debate that has continued until today. The latest recommendations from the UK Department of Health (2011) specify that adults should aim for at least 150 minutes of moderate intensity activity per week, for example by doing 30 minutes five days a week.

In the following sections of the literature review I will examine the existing works on the physical benefits of exercise, before going onto a more detailed review of the literature on its psychological impact. For both areas, the research is discussed in two ways, the direct effects of exercise on wellbeing, as well as its preventative implications.

2.4.1. Exercise and physical wellbeing

Exercise is well established as an activity which has powerful physical health benefits:
The potential benefits of physical activity to health are huge. If a medication existed which had similar effect, it would be regarded as a ‘wonder drug’ or a ‘miracle cure’ (Chief Medical Officer, 2009, p. 21).

This is clearly a powerful statement. More specifically, the Chief Medical officer has noted that the benefits of exercise include decreasing the risk of major diseases such as heart disease (Wessel et al., 2004; Allen, 1996; Blair, 1994), cancers (Blanchard et al., 2004; Lee, 2003), type 2 diabetes (Helmrech, Ragland & Paffenbarger, 1994; Uusitupa et al., 2000; Burchfield et al., 1995) and in the prevention of obesity (He & Baker, 2004). Exercise also reduces blood pressure (Arroll and Beaglehole, 1992). The effects are not limited by demography. For example, in one study which examined populations across multiple ethnicities, 20 to 30 minutes of physical activity most days of the week improved overall physical function such as balance in older adults, independently of demographic and other health-related factors (Brach et al., 2004). Research also suggests physical benefits for those with chronic conditions such as osteoarthritis (Lin et al., 2004) or COPD (Common Obstructive Pulmonary Disease) (Panton et al., 2004), as well as slower declines in physical health for those with cancer, for example those undergoing chemotherapy for breast cancer (Headley et al., 2004).

Above I have summarised some of the key findings relating to the impact of exercising on physical health. There is another angle however; that is the effect of inactivity - a lifestyle that is sedentary and does not incorporate much physical activity or exercise. There is a similarly strong research base for the effect of exercise in this direction. For example there is evidence that inactivity shortens life-span (e.g. Paffenbarger et al., 1986), and increases the likelihood of disease in a similar way to smoking (Pate et al., 1995), obesity and high blood pressure (Paffenbarger et al., 1994).

2.4.2. Exercise and psychological wellbeing

Having explored the relationship between exercise and physical wellbeing, I will now move onto its relationship to psychological wellbeing. Study in this area is not new. As early as 1987, the US National Institute Mental Health (NIMH) commissioned a board to examine the relationship between exercise and mental health. As cited in Callaghan (2004, p. 477), it concluded that exercise is “(i)
positively linked with mental health and well-being, (ii) reduces stress and state anxiety, and (iii) has emotional benefits for all ages and in both genders (Morgan & O’Connor 1988).” I will firstly outline the research on the links between exercise and depression, before considering research centering on the relationship between exercise and self esteem, as well as stress.

So what do we know about the relationship between exercise and mood? Depression is now the most prevalent non fatal condition in the world (Shinohara et al., 2013). As discussed in the introduction, prevention is particularly valued within counselling psychology (Division of Counseling Psychology, 1994). It therefore seems particularly pertinent for the field to learn as much as possible about those individuals who do not experience depression, in order to establish if this information can be used to help others. In the US, research has shown that the average age of a first depressive episode is 14 (National Research Council and Institute of Medicine, 2009). It has therefore been argued that preventative efforts should be targeted at adolescents and young people in order for them to learn skills that would help to manage any future episodes (Kwan, Davis & Dunn, 2012).

There is evidence to suggest that exercise is a preventative factor in the experiencing of depression. The research takes two forms; studies which demonstrate that those who are physically active report fewer depressive symptoms and/or less severe symptoms, and those which centre on the effects of sedentary lifestyles. I will firstly discuss the research centred on those who are physically active. In terms of correlational evidence, studies include that of Strawbridge et al. (2002), who found that 50-94 year olds who were physically active were less likely to suffer from depression. Their study included adjustments for age, sex, ethnicity, disability and body mass index, amongst other factors. Other studies which have demonstrated the same correlation include those by Goodwin (2003), Paffenbarger, Lee and Leung (1994) and Teychenne, Ball and Salmon (2008). Other evidence includes that from exercise interventions with non-clinical populations. A study by Janisse et al. (2004) looked at women who had just started a walking programme. They found that even amongst this group, physical activity (outside of the walking programme) was a predictor of positive mood, together with social support. Similarly, McLafferty et al. (2004) investigated the effects of a 24-week resistance training programme on a group of healthy older adults. Here the participants reported significantly improved
mood scores, as well as reduced confusion, anger and tension (McLafferty et al., 2004). At the other end of the age demographic, a number of studies have centred on the impact of exercise on young people’s mood. In a large study involving 4500 adolescents, naturally occurring increases in physical activity were found to correlate with fewer depressive symptoms (Motl et al., 2004). However it is not possible to tell from this study whether without the physical activity the same trends would have taken place (Martinsen, 2008). Nonetheless the effects on mood do not seem to be limited by type of exercise. In a study conducted by West et al., (2004), students were assigned to an exercise condition; involving participation in either a Hatha yoga or an African drumming class, or a control condition; attending a biology lecture. Self report measures completed by the students indicated significant reductions in stress and negative affect from both Hatha yoga and African drumming, but not the lecture.

The second type of evidence is derived from those who are not physically active; i.e. those who have sedentary lifestyles. An association has been established between sedentary lifestyles and the development of depression in both men and women, the strongest relationship being in women and those over 40 (Buckworth & Dishman, 2002). There are also some longitudinal studies examining the trend over time (e.g. Farmer et al., 1988). Camacho et al. (1991) studied a Californian population, assessing their level of physical activity as low, medium or high. They found that the relative risk of developing depression was significantly higher for those in the low category when data was gathered at a follow up point. A similar trend has been demonstrated in studies of adolescents (e.g. Sund et al., 2004). Looking more broadly in terms of clinical populations, research has also demonstrated that those with mental health problems do less exercise than those who do not (e.g. Martinsen & Medhus, 1989). There are a number of different ways in which exercise could act as a preventative factor for depression (Kwan, Davis & Dunn, 2012). The mechanisms underlying the effects of exercise will be examined further in Section 2.4.3.

The psychological impact of exercise is manifest across a number of factors in addition to mood, including self esteem. Self-esteem is a complex construct; there has been much debate around its makeup (e.g. Rosenberg, Schooler, Schoenbach & Rosenberg, 1995). Fox (2003), argues that self-esteem is particularly relevant to
health for a number of reasons, including its positive relationship to subjective wellbeing (Diener, 1984), and healthy behaviours (Torres & Fernandez, 1995). For good or for bad, body image is an important contributor to self esteem. It has been demonstrated that participation in exercise is associated with positive self-perceptions (Fox and Corbin, 1989; Sonstroem et al., 1992). As for the effect of exercise interventions on self-esteem, in his review, Fox (2003) noted that 78% of studies demonstrated improvements in either physical self-esteem or self-concept. For global self-esteem, the results were more mixed, with about half of the studies showing improvement.

In addition to the effect on self-esteem, stress has been highlighted as another area with an important relationship to exercise. For example a number of studies have shown that active individuals are less reactive to stressors in their environment than those who are not active (e.g. Graham et al., 1996; Boutcher et al., 1995).

2.4.3. Mechanisms underlying exercise and wellbeing

Before I go onto review the research exploring the use of exercise within mental health, I will briefly outline the potential mechanisms underlying the relationship between exercise and psychological wellbeing. There is wide debate over these mechanisms, with a number of proposed theories (Dubbert, 2002). I will consider both biological and psychological models.

First I consider the biological explanations. Theories here include the hyperthemic model as well as the endorphin hypothesis. The former suggests that any change in affect is due to the increase in body temperature caused by exercise. However as noted by Daley (2002), the evidence for this hypothesis has been mixed (e.g. Horne & Staff, 1983). On the other hand, the endorphin hypothesis sets out that improvement in mood is caused by the release of endorphins - endogenous opioids, causing the so-called ‘high’ after intense exercise. Again despite its popularity, in reality the evidence is limited for this theory (e.g. DeMerlier et al., 1986).

If we turn to the proposed psychological models of exercise, the most dominant theory is that of self esteem and mastery; improvement in wellbeing achieved as exercise facilitates an improvement in self esteem, or feelings of mastery. Even
within this area there exist diverse hypotheses. For example, it has been suggested that the increase in physical ability which comes with participation in exercise increases individuals’ self-estimation and therefore self esteem. As self-estimation is higher, individuals are more likely to continue to exercise, therefore further improving physical ability, self esteem and attraction to exercise, and thus the cycle continues (Sonstroem, 1978). Although there is some correlational evidence for this model, its application has at times been questioned (Daley, 2002). Another psychological theory centres on the function of exercise as a distraction, as studied by Bahrke and Morgan (1978) specifically in relation to its effect on state anxiety. As this study revealed similar effects from exercising on anxiety levels as resting however, it is clear that further work is necessary to the specific value of exercise. Furthermore, additional research is required to examine conditions other than anxiety. Other psychological models proposed to underlie the relationship between exercise and wellbeing include learning theory (Baranowski, Anderson & Carmack, 1998), social-cognitive theory (Dubbert & Stetson, 1999), as well as relapse-prevention (Sallis & Owen, 1999). Further to these theories, more recent shifts have included a movement towards a transtheoretical approach (Marcus et al., 1992; Marcus, King, Bock, Borelli & Clark, 1998), and the incorporation of theories of reasoned and planned behaviour (Courneya, 1995; Rosen, 2000).

As indicated by the diversity in the literature in this area, there is little consensus over the mechanisms underpinning the psychological benefits of exercise. It certainly seems possible and indeed likely that more than one factor may be important. Equally it seems possible that the relationship between exercise and wellbeing may differ from individual to individual (Biddle & Fox, 1989).

2.5. The impact of exercise in clinical populations

I have already reviewed the research detailing the impact of exercise on psychological wellbeing. This has included the impact of exercise as a preventative factor for mental health conditions. But what do we know about the impact of exercise on wellbeing for those already experiencing problems of mental health? There is some evidence that exercise is more beneficial for clinical populations than the general population (Martinsen & Stevens, 1994). Multiple forms of study have
been undertaken within this area. Some have focused on how exercise compares to traditional talking therapies, whereas others have centred on their combined effect. There are also examples of projects using exercise in mental health outside of the traditional one to one therapeutic setting. Callaghan (2004) references a Community Gym project in Barrow-in-Furness which uses the provision of exercise programmes for those with mental and physical health issues. In the following sections I will initially focus on the effect of exercise on those with depression, before going onto consider its impact on other disorders.

2.5.1. Exercise and depression

The area that has been subject to the most research is the relationship between exercise and depression. Research here spans over 100 years (Craft, 2012), and has resulted in a huge body of individual studies as well as meta-analyses (e.g. Martinsen, 1993; 1994; Mutrie, 2000; North et al., 1990). To consider one example; in their meta-review Craft and Landers (1998), conducted a search of 30 studies examining the effect of exercise as a stand alone intervention on clinical depression or depression as a secondary condition. They concluded that those who participated in exercise were less depressed than those who did not, with an overall mean effect of -0.72. Overall those who were most depressed at the start of the intervention demonstrated the biggest improvement in mood. The latest Cochrane reviews of the effects of exercise on depression in adults have concluded that exercise can have a positive effect on depressive symptoms but that the current evidence is not clear enough to determine its exact effectiveness, nor which exercise is most effective (Rimer et al., 2012; Cooney et al., 2013). The reviews included only randomised controlled trials, but this time included studies where exercise was compared to other treatments, as well as where exercise was the sole intervention. Further conclusions included that exercise needs to be kept up long term in order for the benefits to be sustained. The equivalent Cochrane review for depression in children and young people found the research to be more limited (Larun et al., 2006). Although there appeared to be a small effect in terms of exercise reducing depression, the strength of the link was not as powerful as in adult populations.

As indicated by these studies the existing research centres on both the effect of exercise in comparison to other types of intervention, and as an adjunct. Hays
(1999) - author of *Working it out: Using exercise in psychotherapy*, defines an adjunct in this context as “a multimodal approach, in which exercise is encouraged in conjunction with psychotherapy (p. 14). Craft and Landers (1998) and North et al. (1990) in their meta-analyses argued that exercise could be as effective as psychotherapy (and more effective than some behavioural interventions). Notably, amongst the findings was that the greatest impact on depression was when exercise was combined with therapy (North et al., 1990). This is not a consistent finding however. For example, Freemont and Wilcoxon Craighead (1987), split participants who were mildly to moderately depressed into three intervention groups; supervised running, cognitive therapy or both over 10 weeks. The results indicated a significant improvement in mood across all three groups, with no significant difference between the three. McGale et al. (2011), published in the Journal of Health Psychology, examined the use of a psychosocial intervention of football or aerobic and resistance training combined with CBT for men between 18 and 40. Both types of intervention significantly reduced symptoms of depression, as measured using the Beck Depression Inventory (BDI), compared to a control condition both following the intervention and at 8 weeks post intervention. More recently, the Cochrane Depression, Anxiety and Neurosis Group updated their systematic review to examine how exercise compares to other treatments such as psychotherapy for depression (Cooney et al., 2013). This suggested again that exercise may have a moderate effect on depression. However it still did not shed any light on the types of exercise that may be most effective. Furthermore when only the studies considered high quality were included, exercise had a small effect on depression, and was not statistically significant.

Some researchers have questioned the efficacy of exercise as an intervention for depression. The results of the TREAD randomised controlled trial published in 2012 (Chalder et al., 2012), made particular news in the UK, with headlines as 'exercise no help for depression’ (BBC, 2012). The study itself described an intervention where depressed individuals received a physical activity intervention in addition to their usual care package, which did not lead to significantly more improvement in depressive symptoms. However it has been argued that the headlines generated around this study were very misleading (e.g. Tomlin, 2012). Tomlin (2012) argues that although the intervention did not lead to more improvement than the usual care
group, the study measured just one particular type of exercise intervention, therefore it is impossible to say if the results would be the same with other types of intervention. In addition, the participants in the test condition did maintain increased levels of physical activity, the benefits of which are difficult to argue with, and furthermore the study did not test for the preventative effects of exercise on depression.

Overall we can conclude from this study and many other works, that further research is needed to clarify the effects of exercise on depression, and in particular the forms of exercise that may be helpful. Nevertheless it seems that exercise is increasingly perceived as an effective intervention. This is illustrated by its inclusion in the National Institute of Clinical Excellence (NICE) guidelines for depression. NICE has three sets of guidelines for depression; for adults, children and those with a co-morbid physical health condition. According to the guidelines for adults:

Physical activity programmes for people with persistent sub threshold depressive symptoms or mild to moderate depression should be delivered in groups with support from a competent practitioner and consist typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks) (NICE, 2009, p. 21).

The guidelines also do not specify what is meant by or who would be qualified to be a ‘competent practitioner’.

The guidelines for children and young people are similar:

A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks (NICE, 2005, p. 18).

And finally those with a physical health condition are as follows:

Physical activity programmes for patients with persistent sub threshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with sub threshold depressive symptoms that
complicate the care of the chronic physical health problem, should be modified (in terms of the duration of the programme and frequency and length of the sessions) for different levels of physical activity as a result of the particular chronic physical health problem, in liaison with the team providing care for the physical health problem to be delivered in groups with support from a competent practitioner consist typically of two to three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks) be coordinated or integrated with any rehabilitation programme for the chronic physical health problem (NICE, 2009, p. 22).

2.5.2. Exercise and other mental health conditions

Although exercise has been most often studied in relation to its impact on depression, a considerable body of work focuses on its efficacy for other disorders. Again, there are different forms of research; those which focus on exercise in itself as a treatment, and those where exercise supplements another type of intervention such as therapy. In this section I will briefly review the research that has been conducted in these diverse areas.

Let us first turn to the research centred on the effects of exercise on those experiencing anxiety. Petruzzello et al. (1991) report the results of three meta-analyses on the links between exercise and anxiety. They concluded that aerobic exercise was associated with reduced anxiety, on the proviso that the exercise lasted at least 20 minutes. Exercise has also been found to reduce anxiety sensitivity - fear of anxiety-related symptoms (Broman-Fulks et al., 2004). Some studies have incorporated exercise into CBT treatment for panic disorder and agoraphobia (e.g. Cromarty et al. 2004). This study demonstrated that CBT combined with an exercise programme led to improvements in wellbeing including reduced anxiety, agoraphobic conditions and improved self esteem. However it should be noted that there was no mention of whether these improvements were significant, nor was there a control group. A Cochrane review on the effect of exercise on anxiety disorders concluded that exercise can be helpful as an adjunctive treatment (Jayakody et al., 2013). However as the study included only 8 trials it is clear that further research is required in this area.
There is some evidence to suggest that exercise also affects body image. In their meta-analysis Campbell and Hausenblaus (2009) found that overall exercise had a positive effect. Along similar lines, exercise as an adjunct to therapy has been found to enhance the effects of CBT on binge eating disorder in obese women; participants who exercised as well as took part in CBT reduced the frequency of binges and experienced increased weight loss (Pendleton et al., 2002). A positive link has also been demonstrated between mental health and exercise in those experiencing problems with alcohol misuse (Donaghy et al., 1991), with a further review concluding that exercise has the potential to be beneficial in the treatment of problem drinkers (Donaghy & Mutrie, 1999).

Fibromyalgia is another condition which has been the focus of research regarding the treatment potential of exercise. Here, both singular studies of exercise (e.g. Wigers et al., 1996; Schachter et al., 2003), as well as combinations of exercise and CBT have been conducted (Gowans et al., 1999; Mannerkorpi et al., 2000). Van Koulil et al. (2007) describe the overall effects of both as limited. However they do note that specific extra analyses revealed better results in certain subgroups and within certain conditions. For example amongst those engaging in a combination of CBT and exercise, those who experienced the most benefit had a more recent diagnosis (Keel et al., 1998) and were experiencing a high level of distress (Williams et al., 2002), thereby illustrating the importance of targeted research. Van Koulil et al. (2007) also note a number of other methodological limitations of the studies conducted up to this point.

There is evidence to suggest that exercise can be beneficial to those who experience psychosis. Pelham and Campagna (1991), found that out-patient clients who participated in an exercise programme involving sessions on an ergometer four days a week for 30 minutes reported reduced depression and improved overall wellbeing, as well as better aerobic fitness. In another study, Faulkner and Sparkes (1999) investigated those who took part in a twice weekly exercise programme. In this case, the participants reported improved sleep and self-esteem, as well as reduced perceptions of auditory hallucinations.

Up to this point I have reviewed quantitative studies, which focus on the effectiveness of exercise-based interventions. However thanks to a number of
qualitative works, we can also gain an insight into the experiences of those who have participated in these interventions. For example Mills and Daniluk (2002), interviewed women victims of child sexual abuse who took part in a group dance therapy programme. Themes generated from the study included “reconnection to their bodies”, “permission to play”, “sense of spontaneity” and “sense of freedom” (pp. 80-82). The clients also emphasised the pleasure they had obtained from the therapy in comparison to traditional talking therapies. Reynolds (1996) offers a rare piece of qualitative research into a piece of Gestalt-based therapy for depression which incorporated exercise. Reynolds elegantly discusses the pathway of therapy beginning from the point that the client suggested that they would restart cycling. The therapist then used a number of Gestalt techniques, firstly asking the client to focus on “present awareness” (p. 387) during the cycling, then contemplating self-images, then encouraging the client to use “I” language to articulate the experience of cycling. Here the client cited physical benefits of exercise, as well as improvements in “cognitive and affective expression” (p. 383). Client views of exercise as part of mental health care will be explored in more detail in Section 2.6 below.

What can we conclude from the research examining exercise as an intervention in clinical populations? It is clear that evidence has demonstrated psychological benefits of exercise for a wide range of individuals, including those with depression, anxiety and psychosis. This has been manifest through a range of type of interventions. Certainly there is also a need for further research. But of what we know so far it seems evident that exercise has the potential to elicit psychological benefits for a wide range of conditions. But how does this evidence translate into the reality of mental health care? This is what I will explore in the following section.

2.6 The use of exercise within mental health

Above I reviewed the evidence for the effects of exercise on those with depression, as well as a range of other mental health conditions. It seems clear that the evidence shows exercise has the potential to be of benefit to many different populations. I also noted that the current NICE guidelines for depression included exercise (2005, 2009). But what is the actual position on the ground regarding the use of exercise in mental health care? The focus of the present thesis is on the use of exercise by UK-
Based counselling psychologists, so it is here that I will focus the majority of my attention.

Certainly the literature tells us that the idea of exercise forming part of therapeutic work is not new. As discussed in Section 2.2., we know that Freud placed a high value on the body in his theories of both personality and therapy; this for example translated into therapy sessions conducted whilst walking (Hays, 1999). In more recent times we have seen the relationship between exercise and counselling play out in the opposite direction; i.e. the prescription of exercise by GPs, supplemented by counselling. According to the American College of Sports Medicine, exercise prescription is the “process by whereby a person’s recommended regimen of physical activity is designed in a systematic and individualised manner” (2014, p. 157). The objective is to increase the success of such a regimen. The intervention – also sometimes called exercise counselling, became increasingly popular throughout the 1990s, including in the UK (Glenister, 1996; Biddle, Fox & Edmunds, 1994). Research has demonstrated that it leads to increased participation in physical activity, for example in those with Type 2 diabetes (Loreto et al., 2003).

In the UK the use of exercise more broadly has been explored principally in two review papers; Daley (2002) and Callaghan (2004). The overriding conclusion of the two reviews is that despite the evidence for the contribution of exercise to psychological wellbeing, it has not been widely adopted within the field. Specifically Daley (2002), states that the goal of her paper is to examine the value of exercise as an adjunct for mental health conditions. Daley does not specify what she means by adjunctive treatment. Earlier, I made reference to the definition of an adjunct by Hays (1999); we have to assume that this is also what is meant here. Such lack of clarity again demonstrates the need for specific research in this area. Nevertheless Daley argues that clinical psychologists and psychiatrists have not adopted exercise as a “viable adjunctive intervention strategy for improving the mental health of patients” (p. 262). Daley (2002) justifies this statement by citing the work of both Hale (1997) - who does not mention exercise as part of the treatment of depression, and Faulkner and Biddle (2001), whose research I will review in more detail later.
Let us turn now to the work of Callaghan (2004). This is largely comprised of a literature review exploring the impact of exercise on mental health. However, as indicated by the title of the paper; *Exercise: A Neglected Intervention in Mental Health Care?*, we also benefit from a review of the extent to which exercise is present as an intervention in the field. Whilst acknowledging the work of some who have offered ways in which exercise could contribute to mental health treatments (e.g. Hays, 1999; Chung & Baird, 1999), Callaghan answers the title of his piece in the affirmative. He notes the paucity of exercise as a treatment option in core texts and reports. It seems clear from these papers that despite the evidence for the contribution of exercise to wellbeing, it is not something that plays a big role within mental health. At the same time, the works of both Callaghan (2004) and Daley (2002) demonstrate the need for an up to date review. One could wonder whether the same conclusion would be reached today, given for example the inclusion of exercise in the NICE guidelines for depression (NICE, 2009), and the growth of studies evaluating exercise as an intervention as outlined in Section 2.5. above. It should also be noted that, importantly, these reviews are general to mental health care; they do not contribute specifically to our understanding of whether exercise has formed part of therapeutic work.

As we are seeing therefore, much of the existing literature focuses on exercise as an adjunct to therapy or an alternative to other treatments, rather than its incorporation within therapy itself. More specific to therapy is the work of Hays (1999), in her book *Working it Out: Using Exercise in Psychotherapy*. Hays (1999) corroborates the view of Daley (2002) and Callaghan (2004) on the paucity of exercise within the field, arguing: “mental health practitioners often focus solely on the mind, viewing people in separate, competing entities: mind and body” (p. 6). Yet Hays also offers the most detailed work regarding how exercise may be used with individuals therapeutically, across a range of mental health difficulties. She also proposes different roles that the therapist may embody in such encounters; from consultant, to role model, to participant. The presence of a book dedicated to the present topic in such an underdeveloped area represents a big contribution to the field. However, and likely because of this paucity, much of the guidance is not evidence-based.

We know that client views of therapeutic interventions can be quite different from those of practitioners (e.g. Bachelor, 1991). Let us therefore review in more detail
what we know of clients’ views of exercise in mental health care. Certainly the
evidence suggests that some clients have perceived such interventions as helpful. In
one study, psychiatric out-patients who completed a 12 week exercise-therapy
programme reported benefits such as mood-elevation and reduced anxiety (Pelham
& Campagna, 1991). Similarly, in a study of alcohol-dependent patients who
completed an exercise routine over 4 weeks, 29% described exercise as of
considerable value, and 60% of great value (Anstiss, 1988). It is not clear what
scores they gave to other elements of the intervention however. In a study conducted
by Martinsen and Medhus (1989), we are able to gain an idea of client perceptions of
exercise compared to other elements of treatment. Here clients were split into two
groups; the intervention group engaged in physical training whereas the control
group did not. Clients in the intervention group rated physical fitness training as the
most helpful element of the programme (other parts included psychotherapy, contact
with nurses and medication). In the control group clients rated psychotherapy the
most useful element. Interestingly, in studies of the general public ‘non-standard’
treatments such as physical activity and relaxation were rated as more effective for
depression and schizophrenia than ‘standard’ treatments such as medication and
admission to hospital (Jorm et al., 1997).

In the present section I have reviewed the use of exercise within mental health care.
We have seen that overall the impression is that it is not something that plays a large
role in the field, despite the evidence explored in Sections 2.4. and 2.5. in relation to
its contribution to wellbeing. There are limits to the research in this area however,
and we know even less about the use of exercise specifically within therapy. There
is also a paucity of research examining client views of exercise in a consistent way
and in recent years, however the glimpses that we have seen here imply that exercise
is generally perceived as a useful element of treatment.

2.7. Exercise and counselling psychology

We have examined the position of exercise in the field of mental health as a whole,
but what do we know about the attitudes of psychologists to exercise, and in
particular counselling psychologists? Firstly though, I will introduce the relationship
between exercise and counselling psychology more generally. It is clear that there is
a paucity of both journal articles and texts on the subject. One of the few significant contributions to the topic is Jill Owen’s (2010) chapter in *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues*, edited by Martin Milton. Here we have a useful discussion on the contribution that counselling psychology can make to the fields of sports and exercise psychology, such as through the differing therapeutic models. This does mean that the focus of the chapter is sports and exercise psychology rather than how sports or exercise may be incorporated into clinical work. Yet Owen argues that “counselling psychology’s recognition of the importance of the individual’s wider context means sports or exercise behaviour will be regarded in the context of other activities in clients’ lives” (2010, p. 215). Elsewhere, as discussed earlier the chapter on counselling psychology and the body in the *Handbook of Counselling Psychology* - where one might most likely expect a discussion of exercise and therapy, has now been taken out. A look through the index of the latest edition (Woolfe et al., 2011) finds no mention of ‘exercise’, nor perhaps more tellingly ‘body’, nor even ‘health’. One of the few articles on exercise in the British journal, *Counselling Psychology Quarterly*, is by Spencer (1990). A theoretical paper, Spencer argues that exercise should be used as an adjunct alongside other interventions. At the same time Spencer (1990) joins those who emphasise that exercise “should not be taken as a panacea for all psychological ills” (p. 293).

As for counselling psychology in the US, as noted by Wilfley and Kunce (1986), a rising interest in the health element of counselling psychology was marked by the dedication of a whole edition of the *Counseling Psychologist* to the topic. In that edition Thoreson and Eagleston (1985) argued that the inclusion of elements such as exercise into therapy sessions represents a way of widening the work of counselling psychologists into something that is more holistic, and that potentially also incorporates expertise and professionals from other disciplines. This seems especially poignant given its general lack of emphasis within the counselling psychology literature, or even the wider clinical psychology and counselling and psychotherapy discourses. Aside from the specific body therapies discussed earlier, one exception in the counselling field can be seen in the ‘Wheel of Wellness’. Developed by Myers, Sweeney & Witmer (2000), the model incorporates exercise as a specific element under one of their proposed five core life tasks of “self-direction”
Thinking about health more generally, it is not just exercise where we see little discussion, the introduction of arguably equivalent concepts such as diet or sleep have also received little attention.

2.7.1. Psychologists’ attitudes towards exercise and therapy

So far we have seen that at least theoretically, counselling psychology emphasises the wellbeing of the individual, often described as the opposite pole to a focus on psychopathology. We have looked at the potential role of the body in terms of providing this focus on wellbeing. We have examined the evidence for the role of exercise as a contributor to wellbeing, not just physically but psychologically. The research to date has sometimes been mixed, but where it has been more prolific, for example in relation to depression, we start to build a picture of its positive implications. On the other hand, we have also learnt that that there is a paucity of literature regarding the way in which wellbeing or indeed exercise, may form part of counselling psychologists’ work. This leads us to wonder what we can learn from the psychologists themselves, in terms of both their attitudes towards the concept, as well as the extent to which they have used exercise as part of their work. This is what I will now review.

Some of the existing studies include a discussion of the proportion of psychologists who use exercise with their clients. These were predominantly carried out in the US, and in the 1980s. One such study consisted of a quantitative inquiry into both psychologists’ own exercise behaviours and its subsequent incorporation into their practise, using a questionnaire as the research instrument (Barrow et al., 1987). 71.4% of the participants reported engaging in regular exercise. Most of those surveyed reported that they would also recommend exercise to their clients, as well as other therapists. This varied from 10% of psychologists who recommended exercise ‘all the time’, to the more frequent response of approximately 50% of recommending it ‘occasionally’. Furthermore, the participants hazarded guesses at what proportion of psychologists they believed incorporated exercise into therapy; these ranged from 0 to 25%. Barrow et al. (1987) also incorporated therapeutic model into the research, finding that those from a cognitive-behavioural or humanistic background were more likely to suggest exercise as part of the therapy
compared to those of psychodynamic or psychoanalytic traditions. There are a couple of methodological points that should be noted. The participants were practising psychologists based in the US, and in a specific area; the east coast. In addition, the research design consisted of self-review questionnaires; it is therefore possible that those who returned the questionnaires were more positive about incorporating these type of health practices into their work, than those who would not have returned them. The survey therefore tells the story of a very particular group of psychologists.

A further questionnaire-based study of 86 US psychologists – this time from the Psychotherapy division of the American Psychological Association (APA), revealed that the majority believed interventions relating to health education were an appropriate task for therapy (Royak-Schaler & Feldman, 1984). More specifically, 51% of the psychologists reviewed the health practices of their clients and furthermore made suggestions regarding their physical health. The health practices comprised a range of elements including eating patterns, sleep, smoking, weight, as well as exercise. The study focused on health practices as a whole, so we do not know the specific figures for exercise-based interventions. Interestingly though, there was a significant correlation between the therapists who practised health-promoting behaviours themselves and those who recommended them to their clients; of which the factor with the highest correlation was for physical exercise.

Burks and Keeley (1989) also used questionnaires in another study of Division 29 (Psychotherapy) members of the American Psychological Association. The research examined the psychotherapists’ own exercise habits, as well as their attitudes towards the use of both exercise and nutrition within therapy. The study revealed that 44.2% of the psychotherapists participated in regular exercise three times a week. The questionnaires also asked the psychotherapists how helpful they considered exercise for depression, anxiety, psychological factors affecting physical conditions and adjustment disorders. Furthermore, they examined how frequently the psychotherapists made recommendations on diet and exercise, with 83.3% stating that they had prescribed exercise to at least one of their clients. We also learn which specific type of exercise was recommended, with walking being suggested by 25% of participants, and running or jogging by 19%. Compared to other health behaviours, exercise and nutrition were assessed and recommended less frequently;
on the Likert scale used the mean response was ‘sometimes’, compared to ‘very often’ for alcohol consumption, drug use, sleeping habits and family history of physical problems. Unlike the study by Royak-Schaler and Feldman (1984), the survey was not limited to psychotherapists on the east coast of the US. However again it is likely that those with an interest in physical health were more likely to return the surveys, and it will have encountered the issues that come with any self-report based study.

Turning now to UK-based practitioners, in their paper, intriguingly entitled “Exercise and mental health, it’s just not psychology!”, Faulkner and Biddle (2001) examined clinical psychology doctoral leaders and lecturers’ perceptions of exercise as an adjunctive intervention to therapy. Again Faulkner and Biddle (2001) do not define exactly what they mean by adjunct. Importantly however, the study is the only one in the literature which focuses on the views of UK-based psychologists. The semi-structured interviews revealed that approximately half of the 21 participants were “very positive” (p. 437) about the potential contribution of exercise to mental health issues. The other half emphasised the role of exercise as a “normalising strategy” (p. 437); exercise may form part of their work for example in increasing client activity, but its use was not something that they supported in its own right. Participants’ reasons behind this included the perception that exercise was too simple an intervention, incompatibility with theoretical orientation and a lack of awareness of evidence supporting it as an adjunct. The research also incorporated the participants’ views on to what extent they believed exercise was promoted by psychologists, interestingly citing the same figures as Barrow et al. (1987); of 0 to 25%. Faulkner and Biddle concluded from the study that “exercise is extremely marginal in the treatment of mental health conditions” (2001, p. 438).

As I have already implied, Faulkner and Biddle (2001) make a significant contribution to the literature on exercise and psychology. Their study was the first to examine the attitudes of practitioners towards exercise since the 1980s. It was also the first research which comprised an interview-based research design. This contrasts with the previous self report questionnaires, providing more room for understanding the participants’ attitudes in depth. We can see the impact of such an approach even in the title of the paper, which is derived from a direct participant quote. At the same time, we need to bear in mind that the participants were part of a
clinical psychology teaching team. We do not know if the participants were engaging in therapeutic work at the time of the research, and if not, how long ago it may have been since they did. Even if they did undertake some therapeutic work we can assume that this would not be to the same extent as those who are full time practitioners. I have nevertheless explored this study in some detail as it represents the nearest of the existing literature to the present research.

In terms of counselling psychologists specifically, there is no research examining their attitudes towards exercise within therapy; no studies have centred on whether counselling psychologists ever use exercise, and if so their experiences of doing so. What can we conclude from the literature on therapist attitudes that does exist? Clearly there is a spectrum of views; from those who regularly recommend to their clients that they participate in exercise, to those who do not see the use of exercise as appropriate for their work. As outlined above, the most detailed perceptions have been elicited from the first qualitative study in the field by Faulkner and Biddle (2001). However, this does not tell us about the attitudes towards exercise of UK-based psychologists based in clinical settings, nor those of counselling psychologists. Given the philosophical basis of counselling psychology, as explored earlier, with its emphasis on a holistic approach to the individual and focus on prevention rather than psychopathology, as well as the value it places on an evidence-based approach, one may assume that there may be more openness to exercise. Yet this has never been explored, and therefore brings me to the aim of the current study.

This ultimately leads to the research questions of:

1. How have counselling psychologists used exercise within their therapeutic work?
2. What has been the experience of those counselling psychologists who have incorporated exercise into their work?

2.8. Chapter summary

In the present chapter I have presented the existing works which relate to the research objectives of the current study. I first reviewed the literatures centring on the relationship between counselling psychology and the body, highlighting the particular holistic focus of the discipline as well as the lack of focus of the body,
with the exception of some selective models of therapy. I moved onto discuss exercise as a specific manifestation of body related work, providing a definition, before moving onto explore what we know about the relationship between exercise and both physical and psychological wellbeing. I detailed the evidence highlighting the benefits of exercise for physical health. Next I focused on the relationship between exercise and psychological wellbeing, first exploring the research relating to the preventative effects of exercise, including what we have learnt from both active and non active individuals, including the effect on mood and self-esteem. I then briefly examined the theories underpinning the relationship between exercise and wellbeing, before moving onto explore what we know about the use of exercise for clinical populations. I first considered the evidence for the use of exercise as an intervention for depression, before considering a host of other conditions including anxiety and psychosis. I next moved onto to explore attitudes towards the use of exercise in mental health care, before turning specifically to what we know about counselling psychology and exercise, and finally reviewing the literature relating to practitioners’ attitudes towards exercise and therapy. I then detailed how this leads to the research questions at the centre of the present study.
3. Methodology

3.1. Introduction

As explored in the previous chapter, very little is known about the role of exercise in counselling psychology. The literature review established that there is a clear gap regarding both the way in which counselling psychologists may have used exercise in their therapeutic practice, and their experiences of doing so. In order to begin to explore this unknown area, a qualitative approach was chosen for the present study. More specifically, I chose to conduct a series of semi-structured interviews with counselling psychologists who had incorporated exercise into their work. In the following chapter I outline in detail the methodology that I undertook to conduct the present research study, which aims to address the research questions outlined below:

1. How have counselling psychologists used exercise within their therapeutic work?
2. What has been the experience of those counselling psychologists who have incorporated exercise into their work?

I will begin the chapter by detailing my epistemological stance, before going onto outline the criteria for quality against which I feel are important for the present study. I then detail the method, or research process itself; including the recruitment of the participants, the details of the participants, as well as myself as the researcher, the interviews, transcription and finally the process of analysis. Finally I go onto discuss the ethical considerations important to the study, as well as the relevance of power to the process.

3.2. Epistemological Positioning

When conducting research we cannot extricate ourselves from our epistemological approach (Walsh, 1995). Transparency about the epistemological position one holds is therefore vital. It is an important part of ensuring that the reader is aware of the kind of knowledge that one is aiming to produce, as well as the principles that are guiding its production. In this section I will firstly discuss my ontological standpoint before moving onto describe the epistemological principles from which I am working.
The ontology we hold is one’s view of what we believe about reality; that is to say our assumptions about the nature of reality (Morrow, 2007). It addresses the question: “what is there to know?” (Willig, 2008, p.13). One’s ontological view can come from a huge array of perspectives (Lather, 2006). This is reflected in the vast literature on the subject (e.g. Guba & Lincoln, 1994; Morrow, 2007). Even within qualitative research perspectives vary from realism to constructionism. As for me, the present study has been approached from a constructionist standpoint (Ponterotto, 2005). Ultimately the constructionist view holds that there is not one sole reality, but rather that reality is constructed in the mind of the individual (Hansen, 2004). Reality is shaped by the individual, which can be formed in multiple ways by their unique beliefs, experiences and environment. A key implication of such a standpoint is that there are as many potential realities as there are individuals (Morrow, 2007). This sits in opposition to the positivist paradigm which holds that there exists a single objective reality.

The relationship between ontological position and epistemological position – the position of the researcher on how that reality is known, or can be known - has been subject to some debate (e.g. Crotty, 1998; Onwuegbuzie & Leech, 2005). Arguably, holding a constructionist ontological position means that I come from a particular stance regarding how this multitude of realities can be understood. In the present case I believe that the process of data collection between the research and participant leads to a unique understanding of the subject of the research; that the particular reality is contingent on the dynamics of the relationship between the two individuals, the nature of the interview, and the interview type, amongst many other potential variables. Qualitative methodologies do not have a basis in set ontological or epistemological stances (Onwuegbuzie & Leech, 2005). Nonetheless, in the present study as a researcher undertaking a doctorate in counselling psychology, there is often a leaning towards a phenomenological understanding of the world. The discipline places a high value on the subjective experience of the individual. Morrow (2007) argues that these values make the constructionist paradigm particularly relevant to counselling psychology.

Following the ontological and epistemological positioning comes the question of methodological standpoint (Guba & Lincoln, 1994). Considering these positionings, how do I go about finding out what I believe can be known? In the present case, this
reflects my constructionist standpoint that reality is constructed by the individual; there are consequently multiple realities and my further understanding that this can be ‘known’, as much as one unique version of events can be understood. Such a stance has led me to choose a naturalistic approach to inquiry, in the form of semi-structured interviews.

The epistemological position also encapsulates the view of the researcher and their role; its axiology. As noted above, due to my constructionist stance I believe that the data; in this case resulting from interviews, are influenced by both participant and researcher. I therefore acknowledge the importance of my own beliefs and assumptions throughout the research process, from the interviews themselves, to the data analysis to the writing up. My position is that my influence should be acknowledged but not attempted to be eliminated, as it contributes to the particular truth that has been created in this series of interactions. In order to explicitly acknowledge my personal beliefs, I maintained a reflexive journal throughout the research process, in which I noted my views on the research, as well as the impact that the research had on me. The journal helped form the reflexive analysis that I include in the analysis chapter, as further acknowledgement of the influence of my own processes (Section 4.4.). My own assumptions were also identified and challenged in regular group and individual research supervision meetings.

### 3.3. Quality of the Research

In conducting a project of such length, it is naturally a concern that it is of sufficient quality. The term ‘quality’ in the field of qualitative research has been the subject of immense debate. In the following section I will examine some of the writings on the topic and also put forward the criteria that I believe the present research should be reviewed against. Part of the reason why the debate has been so extensive is due to attempts to develop criteria against which to measure qualitative research. There has been much criticism of the idea that a set of fixed criteria can meet the needs of qualitative researchers in this way (Parker, 2004; Mishler, 1990; Kvale, 1996). The differences between qualitative research and quantitative research are historical and far reaching, yet often the types of criteria against which qualitative research has been judged evoke the positivist traditions of their quantitative peers (Parker, 2004).
The applicability of traditional ideas of validity and reliability to qualitative research is questionable. Validity clashes with the constructionist stance that the subject of the research is something that could be represented as the same thing, negating the influence of the researcher. Even taking away this point, a definitive account would not typically be seen as a goal of qualitative research. Furthermore, the idea of reliability simplifies the structures that we might be examining in assuming that these would remain stable over time (Parker, 2004). Textbook style criteria for research do not address the underlying principles behind such inquiry (Mishler, 1990). Indeed it has been argued that binary notion of such divisions both between qualitative and quantitative research, as well within wider measures of quality have exhausted their utility (Lather, 2006).

But what does this mean in terms of evaluating the present research? Lather (2006) in particular, has highlighted the multiplicity of research approaches that exist even within qualitative works, as well as their stridence for legitimacy. Parker (2004) goes as far as to say:

> There is no overall set of criteria that would work to justify a specific study, for a new research question calls for a new rationale and combination of methodological resources to explore it, and the terms in which a research question is framed will entail particular methods (pp. 96-97).

I would argue that this facilitates a consideration of how an individual inquiry can be of use. Such a stance follows naturally from the value my epistemological view places on the individuality of multiple truths. That is not to say that anything goes however. We need something against which to judge this particular truth, hence the need to be explicit in outlining what an individual project should be judged by. According to Parker (2004), criteria for good research are “guidelines that are closed enough to guide evaluation and open enough to enable transformations of assumptions” (p. 96). I will next discuss the guidelines I believe to be important in the evaluation of the present research.

The first criterion is the acknowledgement of subjectivity. For example, qualitative researchers have been criticised for cherry-picking material in order to support their own arguments (Hollway & Jefferson, 2000). However what has been considered a problem of subjectivity can be couched as a strength, or at least an area for
exploration and elaboration furthering the discipline (Burman & Whelan, 2011). Indeed to make the subjectivity explicit makes for more transparent and therefore ‘good’ research (Parker, 2004; Burman & Whelan, 2011). This can come from stating the researcher’s position as well as being clear about methodological processes and rationale, such as the process of analysis and consequent creation of themes. As explored in the epistemological discussion above, my constructionist stance means that I believe that any data are constructed from the unique interaction between interviewer and participant. Both myself as a researcher and the unique features of each interview will have contributed to the stories created. It is therefore important to be explicit about my own positioning in relation to the research, as well as elements unique to each interview. I have done this in the form of a statement on my own beliefs towards exercise (Section 4.4.), as well as by including a reflexive analysis which makes explicit some of the more process-based elements of the research, from my perspective at least. This acknowledgement of such elements pays heed to the importance of you, the reader in being witness to the wider context of the research.

Parker (2004) further recommends three broad and flexible criteria, or guidelines for good research. The first of these is highlighting the context of existing research, as well as any gaps in the literature. Parker terms this the ‘grounding’ of the research. I have demonstrated this throughout the literature review (see Chapter 2.). The next principle is coherence; a clear narrative that makes sense from beginning to end of the study. I hope to have demonstrated this through the use of carefully planned sections telling the story of the research. The third guideline that Parker notes is accessibility. This comprises making the different sections of the research process clear, including the “conceptual background, research process and new perspectives” (2004, p.101). It can be argued that the realities of these points are not always so dissimilar from the steps that are taken to ensure for example the ‘validity’ and ‘reliability’ of the study, but rather are approached from different positions. For example I see the sending of transcripts and themes to the participants in the present study as something that contributes to the coherence and accessibility of the study, but in a more positivist framework, this may be classed as making the research ‘valid’ or ‘confirmed’. Other elements which ensure the transparency of the current research include making my epistemological stance explicit, as well as using the
present methodology chapter to outline in detail the rationale and procedures behind each step of the research.

3.3.1. Reflexivity

As noted above, the epistemological position with which I approach the present research recognises the contribution that I personally make to the work. In fact I would argue that it is impossible for the researcher not to exert their influence, and that this is something to be embraced rather than eliminated. Such an influence is something that I acknowledge as taking place throughout the research process. Clearly therefore, reflexivity is important, as it involves examining “the ways in which a researcher’s involvement with a particular study influences, acts upon and informs such research” (Nightingale & Cromby, 1999, p.228). This involvement can be formed from the researcher’s epistemological stance, themselves as a person, as well as their experiences and values (Willig, 2008). I have already detailed my epistemological standpoint above. However because I acknowledge the different facets that make up my own influence on the research, I outline some detail about me as the researcher below (see Section 3.4.4.). The aim here is to further add to the transparency of the research. This is in addition to the reflexive analysis (Section 4.4.), which details my thoughts on the research process, including my personal processes.

3.4. Method

3.4.1. Research Design

Above I outlined my epistemological position. In the present section I detail how this translates to the research design. Broadly, the research takes the form of a qualitative work. As elegantly stated by McLeod (2011), “at its heart, qualitative research involves doing one’s utmost to map and explore the meaning of an area of human experience” (p. iv). This is precisely the aim of the current study; to, for the first time, explore counselling psychologists’ experiences in relation to using exercise in their therapeutic work. As noted by Camic, Rhodes and Yardley (2003), qualitative research is particularly useful where an area has not been previously explored. This is the case here; as identified in the review of the existing literature,
that there has been no research examining counselling psychologists’ use of exercise within therapy.

A qualitative research design also fits with the philosophical stance behind counselling psychology as a whole. The field places a strong emphasis on the subjective experiences of individuals (Strawbridge & Woolfe, 2010; Moller, 2011). That is not to say that counselling psychologists can never produce quantitative approach, in fact it could be argued that the discipline would benefit from generating more (Kasket & Gil-Rodriguez, 2011). However in the current study the research question focuses on the experiences of counselling psychologists, and therefore a qualitative design is most appropriate. At the same time, it is clear that the present research questions may be of relevance to disciplines outside of counselling psychology; other branches of psychology such as clinical psychology, as well as the wider field of counselling and psychotherapy.

3.4.2. Participant recruitment

In the present section I will outline who I set out to recruit in terms of participants for the current research, as well as the procedure by which I recruited them. As stated previously, the aim of the research was to examine counselling psychologists’ experiences of using exercise as part of their therapy. I therefore aimed to recruit a specific participant group; UK-based counselling psychologists who had used exercise in some way in their client work. In order to do this I used convenience sampling. That is to say “locating any convenient cases who meet the required criteria and then selecting those who respond on a first-come-first-served basis until the sample size quotient is full” (Robinson, 2014, p. 32). This was largely for pragmatic reasons. There are relatively few counselling psychologists in the UK, compared to other types of applied psychologist. I also held the assumption that given the lack of existing literature focused on exercise, there would be few counselling psychologists who would describe themselves as having incorporated exercise into their therapeutic work. I therefore had to make use of the means that I had available in order to locate potential participants.

I aimed to recruit between 8 and 12 participants for the study; a typical size for studies using this type of analysis (McLeod, 2001). This number provided sufficient material to address the research question through the drawing out of themes across
the interview set. As noted by Morrow (2007), the objective of qualitative research is not to achieve a representative sample of individuals, but rather is focused on the depth of those undertaken. More than 8 to 12 would also have not been appropriate for pragmatic reasons due to the time required to transcribe and analyse the level of data that this would produce in professional doctorate study. Furthermore it is consistent with my epistemological position that it is not possible (nor would be desirable), to produce an ‘ultimate’ truth. Consequently there would be no benefit to conducting more interviews than is enough to produce a comprehensive analysis.

In order to target counselling psychologists who had used exercise as part of their therapeutic work, the research was promoted in a number of ways. A research advert (Appendix A) was posted on the research studies webpage of the BPS Division of Counselling Psychology for a period of 3 months. This did not elicit any responses. We know that participant recruitment is often influenced by the person of the researcher, for example through their location and personal connections (Robinson, 2014). This certainly seemed to be the case in the present study. The first participant was recruited because of a discussion I had with a fellow trainee counselling psychologist about the research. She told me about a counselling psychologist she knew who frequently used exercise as part of his work and advised she would notify him of the research. She then informed me via email that the psychologist had said that they would like to participate. Following this I contacted the psychologist directly by email, introducing myself and the project and attaching a copy of the study information sheet (Appendix B). The potential participant then had two weeks with the information sheet before I contacted them again via email to check if they were still sure about participating. We then arranged a location, date and time for the interview.

The most successful promotion method was contacting those counselling psychologists that I knew directly myself; four of the participants were recruited this way. The recruitment process with these participants was as follows: I first had a face to face conversation with them where I outlined the study, and the fact that I was looking for participants. Where they indicated that they may be interested in participating I emailed a copy of the information sheet to enable them to consider in their own time whether they did want to participate. As detailed above I then waited two weeks before confirming consent and proceeding to organise the interview.
details. Again with the objective of transparency, I outline the more reflexive process elements relating to this method in the reflexive analysis (see Section 4.4.).

Alongside this process, I requested that an email with the details of the study be sent to members of the BPS North West Branch of the Division of Counselling Psychology. This happened on 12th June 2013; a copy of the study information sheet was also attached to the email (Appendix C). The same information was posted on the Facebook group pages of the North West Branch, Counselling Psychology UK and Counselling Psychology and Psychotherapy Training, on 13th June 2013. The email to North West branch members resulted in one participant responding to me, Interestingly also somebody that I already knew. I also requested that the study be mentioned in the Division of Counselling Psychology e-letter which is sent out fortnightly to members across the UK (Appendix D). The present study was included in the e-letter that was emailed out on 24th June 2013. This did not elicit any responses.

Snowball sampling also became a feature of the recruitment (Browne, 2005). During the interviews I had already organised I asked the participants whether they knew of any other psychologists that may be interested in taking part. Two of the participants said they knew of others, and gave me their contact details. As a result I emailed and phoned four other potential participants. One of the final participants was recruited this way. In this case I phoned them, where we talked through the details of the study. As she indicated that she was interested in participating I emailed her the information sheet. When she indicated that she was happy with the details we then arranged the details of the interview by another telephone call. Further snowball sampling produced another participant. In this case I emailed other counselling psychologists that I had had email contact with over my time on the doctorate. I asked if they would be interested in participating in the study or if they knew anybody who would. One person responded advising that they knew somebody who they thought might be interested. She gave me their contact details, and I then emailed the potential participant, again introducing myself and the study and attaching the information sheet for additional information. This person replied confirming that they would be happy to take part in the study, after which point we corresponded further by email in order to arrange the details of the interview.
Another promotion route that I attempted was via a meeting of the North West Branch of the Division of Counselling Psychology. I attended the September 2013 meeting and presented an outline of the study to the group, taking information sheets with me to give out. One person approached me following this talk and asked for my contact details, advising that they felt they would be able to contribute something to the study. I gave them the information sheet but subsequently did not hear back from this person. Finally, I emailed the course leaders of all the UK counselling psychology doctoral courses with the details of the study and asking if they would be interested in participating (Appendix E). Although some of the course leaders responded to say that they felt the research was a good idea it did not result in any participants, as they felt that they had not done enough therapeutic work using exercise to be sufficient for an interview.

3.4.3. Participants

Eight participants took part in the present study; of which six were qualified counselling psychologists, one was a final year trainee counselling psychologist, and one was on the independent route to qualification. Originally I intended to interview only qualified counselling psychologists due to the greater experience I felt they would be able to bring to the study. However due to the difficulties with recruitment of participants as outlined above, I widened this to include those who not yet qualified. I discuss the potential impact of this in the reflective analysis (Section 4.4). The demographic details of the participants are outlined below (Table 2). For those participants who were not qualified counselling psychologists, the information relating to length of professional experience indicates years engaging therapeutically with clients, in order to honour the work which they drew upon as part of their interviews. The final column indicates whether the participants had a systematic way of assessing clients’ level of exercise or physical activity.
<table>
<thead>
<tr>
<th>Participant code</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Training Orientation</th>
<th>Qualified status</th>
<th>Length of professional experience</th>
<th>Asses exercise (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>51-60</td>
<td>Male</td>
<td>White British</td>
<td>CBT, Narrative, Systemic</td>
<td>Qualified</td>
<td>30+ years</td>
<td>Yes</td>
</tr>
<tr>
<td>P2</td>
<td>41-50</td>
<td>Male</td>
<td>White British</td>
<td>CBT, EMDR</td>
<td>Qualified</td>
<td>10-20 years</td>
<td>No</td>
</tr>
<tr>
<td>P3</td>
<td>31-40</td>
<td>Female</td>
<td>White British</td>
<td>Integrative - CBT</td>
<td>Qualified</td>
<td>6-10 years</td>
<td>No</td>
</tr>
<tr>
<td>P4</td>
<td>51-60</td>
<td>Male</td>
<td>White British</td>
<td>Integrative - CBT, Person-centred</td>
<td>Qualified</td>
<td>30+ years</td>
<td>No</td>
</tr>
<tr>
<td>P5</td>
<td>41-50</td>
<td>Female</td>
<td>White British</td>
<td>Integrative - CBT, Narrative</td>
<td>Independen t route</td>
<td>20-30 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P6</td>
<td>31-40</td>
<td>Female</td>
<td>White British</td>
<td>Integrative – Psychodynamic, Person-Centred</td>
<td>Trainee</td>
<td>10-20 years</td>
<td>No</td>
</tr>
<tr>
<td>P7</td>
<td>31-40</td>
<td>Female</td>
<td>White American</td>
<td>CBT</td>
<td>Qualified</td>
<td>10-20 years</td>
<td>No</td>
</tr>
<tr>
<td>P8</td>
<td>41-50</td>
<td>Female</td>
<td>White American</td>
<td>Integrative – CBT, Cognitive Analytic Therapy</td>
<td>Qualified</td>
<td>0-5 years</td>
<td>Yes</td>
</tr>
</tbody>
</table>
3.4.4. Researcher

As noted above, the constructionist stance acknowledges the influence of the researcher themselves on the research process. It is therefore important to present some detail on the researcher, in this case; me, as well as my attitudes towards exercise and therapy. This is what I will outline in the current section.

I am a white British female, who is a student on the Professional Doctorate in Counselling Psychology at the University of Manchester; a trainee counselling psychologist. I was 29 years old when I began the research process and conducted the interviews. The doctoral programme includes a requirement to engage in 450 therapy hours with clients. Prior to starting the course I did not have a significant amount of therapeutic experience. This means that the client time that I have gained has come in the form of completing these hours, via both placements and part time work. In terms of my personal view on exercise, it is something that I have enjoyed since I was a child. I have noticed that I experience what is sometimes called the ‘runner’s high’ after going for a jog, or even a walk. This feeling is partly what prompted me to think about exercise in the context of wellbeing, and specifically therapy. It seemed to me that, on the surface at least, exercise appeared to be a relatively simple mechanism via which to improve mood. This contrasted with my experience at university where it seemed like my peers and I were thinking so very hard about how to help people feel better. That is not to say that I believe that exercise is a quick fix or form of panacea. However the lack of literature in the area only added to my feeling that exercise was somewhat of an untapped resource, especially given the holistic basis of counselling psychology.

In terms of my experience of exercise within my own therapeutic practice, it is something has formed part of my work, but I would say not a large part. I have not for example, done any exercise in session with clients. Part of the therapeutic work that I do is specialist weight management therapy. In this work, often the subject of the body is something that is central to the work, but I find this unusual compared to my experience so of the more general adult work. Although this may be expected from someone doing a research study on the question I do not hold the view that exercise should necessarily form part of therapy.
Recognising the influence that I will have exerted over the present research process, in this section I have very briefly outlined some introductory details about myself as the researcher. I have explained my decisions behind conducting this particular study, and my own feelings and experiences of exercise within therapy.

3.4.5. Interviews

I conducted semi-structured interviews with the participants. Potter and Hepburn (2005) in particular have highlighted the frequency with which interviews are used in qualitative psychology. They also note the danger of using interviews without explicit explanation. This mirrors the discussion I outlined above in regards to transparency as a key criteria of research quality. I will therefore hereby outline the rationale behind using interviews in the present study, as well as detail the way in which I conducted them.

Interviews have been criticised for being seen as necessarily transparent and problem free (Potter & Hepburn, 2005). Similarly to the argument made below regarding transcription, interviews are not a generic being and can serve a breadth of research purposes (Smith, Hollway & Mishler, 2005). Interviews were the only option for data collection that I considered could facilitate the depth of response that was required to give an insight into the participants’ experiences of incorporating exercise into their work. In this instance I felt that questionnaires would not allow the depth of response required in order to address the research question. Due to the limited number of UK-based counselling psychologists, I felt that a focus group - one other method of engaging in qualitative research, would not be practical due to the potential geographical spread of the participants, as well as the difficulties in coordinating availability. I also chose to use interviews because of the flexibility that they allow in terms of the content shared. If there is something unexpected this path can be trodden (McLeod, 2003; Knox & Burkard, 2009). Again I felt this contrasted with what questionnaires would be able to facilitate. Interviews also allowed me to develop a relationship with the participant. Hopefully this led to a more transparent and in depth experience, than for example if the participants had completed a self-report questionnaire; clearly particularly important when the focus is on the experiences of the participants. This is nicely articulated by Grafanaki (1996), who states that “a trusting relationship facilitates the gathering of data that
are automatically grounded in participants’ experience and are thus more complete and rich” (p. 335). By recognising that the relationship between the participant and I contributes to the material generated, I am also acknowledging the impact that I will have an impact on the research in this way. The ability of the researcher to create a relationship with the participant is therefore important to the process. Specific skills cited as important to relationship building with participants include active listening, warmth and genuineness (Kvale, 2008); skills which are also critical to the client-therapist relationship in a therapeutic setting. I therefore hope that I brought the skills that I have learnt as part of my doctoral training into the research environment.

Potter and Hepburn (2005) developed a set of problems that they considered a necessary part of interviews. Amongst these they argue is a dearth of interviews considered interactions. Although I agree that this seems likely to be the case, similarly to Smith et al. (2005) in a commentary on Potter and Hepburn in the same edition of Quantitative Research in Psychology, I believe that their suggestions for how this should be managed are overly prescriptive. As for the current study, in my view Potter and Hepburn (2005) focus on discourse to an extent which goes beyond its requirements, as well as clashes with its overall approach. On the other hand, part of considering the interview as an interaction is a focus on its wider contextual features (Potter & Hepburn, 2005; Willig, 2008). These include elements such as the physical setting of the interview, something I do agree is important in order to ensure the comfort of the participant, and therefore aid rapport with the researcher. The creation of rapport between researcher and participant is particularly important when using semi-structured interviews, as their open-ended nature allows for greater potential variation in factors such as flow and ease between interviews (Willig, 2008).

In order to make the current participants as comfortable as possible, where the interview was face to face I liaised with each to negotiate an interview location that would be convenient for them. This was either one of their workplace or study settings or their home. In this way I was able to acknowledge their ‘cultural milieu’ (Willig, 2008, p. 24). Regarding the telephone interviews, I called the participants from a course tutor’s office at the University of Manchester. I ensured that no one else was present at that time. As discussed further in the reflexive analysis (Section 4.4.), in terms of power relations the interviews could be considered insider-insider
due to my own position as a fellow (albeit trainee) counselling psychologist. Such a
dynamic, and therefore relatively little difference between the background of myself
as the interviewer and the participants hopefully also contributed to the ease with
which the participants were able to discuss their experiences. Regarding linguistic
variability, it is also likely that the insider-insider relationship aided our mutual
understanding in the interviews, due to the common therapeutic language both
parties were familiar with. At the same time, it must be acknowledged that this does
guarantee understanding. In order to combat this I asked participants to clarify
where I was not sure of their meaning, or to expand on their answer.

3.4.6. Interview schedule

Prior to conducting the interviews I created an interview schedule (Appendix F).
This consisted of a number of guiding questions that I asked the participants. The
design of the schedule was influenced by the constructionist value given to in depth
answers, as well as the semi-structured nature of the interviews. According to Kvale
(2008), the number of interview questions should be limited in order to allow for
richness and spontaneity in the participants’ responses. Furthermore, given the
paucity of existing research related to the present research question, there were not
many existing studies available from which to inform the interview schedule. Nor
was there a specific area within the overall research questions on exercise that I was
aiming to focus on.

The steps that I undertook to devise the interview schedule were as follows. Firstly,
I familiarised myself with the interview questions used in existing related studies.
However as noted previously, as most of the existing research consisted of
quantitative works, there were therefore not many that could inform the present
interviews. I did refer to that of Faulkner and Biddle (2001), as a fellow qualitiati
study exploring exercise, in particularly drawing on their finding that clinical
psychology course leaders had perceived several obstacles to working with exercise
in therapy, as inspiration for the question focused on barriers. This inspired the
question in the schedule. The first question that I asked of the participants; to tell me
about their current therapeutic setting was designed to ease them into the interview
and allow for some rapport to develop before moving on the questions specifically
about exercise. An additional objective of the first question was to provide some context to their forthcoming answers. Following this period I drew up a first draft of interview questions, paying close attention to my overall research questions in order to ensure that I stayed true to the overarching goals of the study. I then discussed the list of questions with my supervisor. I then revised the list slightly, adding in the question about the client example. Finally I conducted my first interview as a pilot, in order to test out the interview schedule with a participant, both in terms of the questions, and the duration of the interview. I was happy with how the interview schedule worked, so kept the questions in their form as of that point.

As well as asking the questions detailed on the interview schedule, I used additional prompts to clarify what the participant had said. At other times to encourage the participants to expand on their answers I asked for examples. I also made statements summarising what the participants had said, again to further assist with my understanding of the meaning of what they were saying, but also as part of showing them that I was listening and engaging with what they were saying. Generally I did not explicitly share my own view on the use of exercise. However the fifth participant, when I asked at then end of the interview if they had any other questions or comments asked what had got me interested in the area of exercise. I explained this, which led onto more of an informal discussion in which I did share some of my views on the topic, as these had informed my decision to choose the research topic.

3.4.7. Procedure

Of the eight total interviews, six were conducted face to face and two over the phone. I conducted the first interview as a pilot. I explained to the participant that I would use it to test my interview schedule, and that on the basis of how the interview went I may change it. In the end I was happy with how the schedule worked out and therefore kept the schedule the same for the rest of the interviews. All the interviews lasted between 45 and 60 minutes.

I commenced all the interviews by explaining that the purpose of the study was to explore counselling psychologists’ experiences of using exercise in therapy. In the face to face interviews I brought another copy of the information sheet that they had
been emailed and invited them to read it if they wished. I clarified if they had any questions. I then asked if they felt comfortable to go ahead with the interview. If they confirmed that this was the case I asked the participants to confirm this in writing by signing the consent form (Appendix G). For the telephone interviews I emailed the consent form to the participant in advance of the interview. All the interviews were conducted between May and October 2013 and were audio recorded. The face to face interviews were recorded using a Sony NWZ-B153 digital music player, and those on the phone using an Olympus WS110 digital voice recorder. Following the interview I gave the participants the study debriefing sheet which included details of support that they could access after the interview if they wished to (Appendix H). I emailed the sheet in the case of the telephone interviews. Once each individual interview was complete I transferred the recording to my laptop. The interviews were then transcribed. I had advised the participants that the interview would be transcribed and emailed to them to check if they wished to, and that I would also email them the themes that were developed. None of the participants made any changes to the transcripts. Once I had finalised the themes for each research question, I emailed them to the participants for them to see. Again they did not suggest any changes.

3.4.8. Interview Transcription

As discussed in the epistemological section above (Section 3.2.), it is clear that holding a constructionist stance has many implications for the research and its methodology. Of particular importance is the position on what the generated material represents (Willig, 2008). In the present study I see the material as the participants’ accounts of their experiences of using exercise, whilst also acknowledging that the interviews represent a unique context between me as the researcher and the participant, therefore combining to ‘construct’ one particular story of the participants’ experiences. The focus in the present study is on the particular meaning of what the participants say about their experiences of using exercise, as generated in the present context. This view on what the material represents goes onto influence my decisions around the transcription of the interviews, which I outline below.
There exist a multitude of transcription formats (e.g. Edwards and Lampert, 1993; Jefferson, 2004). In the present study I used a standard orthographic notation (see Appendix I for a sample interview transcript). This felt appropriate for the method of analysis; thematic analysis, which does not focus on the language used in interviews, but rather the meaning drawn from the overall content (Willig, 2008). In their critique of the use of interviews in qualitative research, Potter and Hepburn (2005) argue that the reporting of interviews often does not translate their interactional nature and that a very detailed level of transcription should be adhered to, even if interactional features are not the main focus of the research. I am in agreement that it is important to reflect the interactional nature of interviews. To this end, as discussed above I included the interview schedule in the final work (Appendix F). I also notated the interview transcripts in a form that included my contributions to the interviews, including the smaller interjections such as “mm”. This stays true to my constructionist stance which emphasises the acknowledgement of the influence of the interviewer as well as the participant in the creation of the research material.

On the other hand I believe that prescriptive guidelines such as those of Potter and Hepburn (2005) do not take into account the individuality and therefore the diversity of the range of research methodologies that exist. Emphasising interactional features in this way also implies that other methods are somehow inferior (Smith et al., 2005). This clashes with my view of the value that pertains exactly from the multiplicity of research methodologies; a point that mirrors the discussion I made above relating to the need for broad criteria against which to judge qualitative research. It can also be argued that all transcription styles involve a level of selection and therefore researcher influence (Smith et al., 2005). The aim of the current research is not to deny any such influence. To me these points negate the rationale behind creating a transcription which goes beyond requirements of the research question, in the current case, the content of the interviews. Furthermore, transcribing to a level of detail that adheres to Jeffersonian conventions implies that there is a point at which transcription could become ‘perfect’ by means by being more rigorous, and by default more true to the meaning of the participants’ responses (Hollway, 2005). Again this contradicts my view that such an ‘ultimate’ account
does not exist, and fights with the value seen in the uniqueness constructed by the individual reading of each interaction.

3.4.9. Analysis

In the following section I describe and explain how I made sense of the interview material through a process of analysis. I firstly introduce the concept of thematic analysis, before going onto describe the rationale behind choosing this particular method for the current study. Finally I detail the process by which I carried out the analysis itself.

As noted above, I chose thematic analysis as the method of analysis for the present study. But what exactly do I mean by this? Braun and Clarke (2006) define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data” (p. 79). Thematic analysis has often been at the core of qualitative research methods, as hinted at in the broadness of its definition. Some have argued specifically that it is not a method of analysis in its own right but rather a technique that is used within other models (e.g. Boyatzis, 1998; Ryan & Bernard, 2000). This is manifest by its lack of citation in research studies. However Braun and Clarke (2006) argue that rather it has not been explicitly named as the method of analysis and that it does represent a unique model.

Thematic analysis was chosen as the method of analysis for the present study for a number of reasons. Before I go onto outline these reasons in more detail, I will briefly outline other forms of analysis that were considered, but ultimately dismissed. Grounded theory (Glaser & Strauss, 1967; Corbin & Strauss, 2008) shares many of the features of thematic analysis. However grounded theory is primarily designed to inform the generation of a theory. Theory generation was not the aim of the current study, due to both its exploratory nature and its focus on the experiences of the participants. Another method of analysis considered was Interpretative Phenomenological Analysis (IPA). IPA seemed potentially suitable for the present study due to its utility for exploring the lived experience of participants. It is also concerned with the meaning that individuals place on their experiences - how they make sense of them (Smith, 2004). The present study focuses on the experiences of
psychologists of working with exercise therapeutically and not a personal experience of their own. It was therefore deemed that thematic analysis was more appropriate, as unlike IPA it does not necessitate such a focus on personal lived experience and meaning making.

I will now discuss the reasons unique to thematic analysis which made it the choice of model for the present study. Firstly, of importance was its flexibility. A key factor behind this flexibility is that thematic analysis is “only a method of data analysis, rather than being an approach to conducting qualitative research” (Braun & Clarke, 2012, p. 58). It is not tied to a particular philosophical approach. It could be argued that this is a disadvantage, for example in that it is not as developed theoretically. However, in my view, such separation facilitates an openness as to what may develop from the data. It also pays homage to the unique dynamic between the individual researcher and participant, allowing for freedom in what flows from the interaction and hopefully staying closer to the actual experience created.

Braun and Clarke (2012) argue that thematic analysis allows for flexibility along three main dimensions across which qualitative research is conducted; “inductive versus deductive or theory-driven data coding and analysis, an experiential versus critical orientation to data, and an essentialist versus constructionist theoretical perspective” (p. 58). As I have made clear throughout this chapter, I am approaching the present research from a constructionist standpoint. I have therefore been able to use thematic analysis according to this position. The flexibility innate within the model does mean that there are lots of decision points as to how to apply the analysis. My constructionist stance has been a major influence on the decisions that I have made within the analysis, as I go onto describe below.

As noted above thematic analysis can be applied from either a deductive or inductive perspective. The model has therefore allowed me to work from an inductive approach in the present study; that is to say developing themes from the data that are focused on the data itself rather than ideas that I as the researcher place on the data. Such a perspective reflects constructionist values, as well as the lack of existing literature on counselling psychology and exercise from which any theoretical framework would be formed. The inductive approach is also more relevant for the
present study because of my objective to gain insight from the interview material as a whole, rather than exploring one aspect in detail. Although I used an inductive approach, I had already developed the research questions for the study; I was not anticipating that I would develop these as a result of the analysis. The analysis was therefore carried out with the objective of answering these specific questions. Although the questions are fairly broad, undoubtedly their pre-development will have influenced how I interpreted the interview material. This point highlights my view that even where I have for example made the ‘decision’ to use an inductive approach and therefore not explicitly introduced specific theories to the interview material, undoubtedly I will have brought my own ideas and influences to the analysis. This will therefore to some extent have influenced its form and ultimate themes. As noted by Brinkmann (2014) in his exploration of what is meant by data itself; “what we call data are always produced, constructed, mediated by human activities” (p. 2).

Thematic analysis can be used in a way that facilitates value in patterns, and therefore meaning, across the data set (Braun & Clarke, 2012). We know that the method is not tied to any particular theoretical framework. However it is important that it matches the needs of the research question. In the current study I wanted to conduct the analysis across all the interviews, with the goal of providing an account of the story across the data. Thematic analysis provides a way of managing the huge amount of data that is generated from interviews and organising it in a coherent way, as well as developing patterns across the data. This focus on the data set as a whole allows me to gain an overall picture of what it is like for the participants to incorporate exercise into their work. When researching an unknown area as in the present case it can be useful to have a broad focus (Braun & Clarke, 2006). This is opposed to a more in depth focus on a sole interview, as may be the case in more phenomenological methods of analysis.

Finally, thematic analysis does not demand that a theory be developed, as may be the case in methods such as grounded analysis. In the present study, the aim was not to create a theory around the use of exercise in counselling psychology. This seems particularly appropriate for the present research, due to the aim to explore such unchartered territory as counselling psychology and exercise. If the aim was to
explore a very specific area of this particular topic because it was an area that had been subject to much research, arguably this approach would not be as appropriate.

I have detailed my rationale behind choosing thematic analysis as the method of analysis for the current study. I will now outline the steps that I undertook in order to develop the analysis. The first stage involved familiarising myself with the data corpus. Firstly I read through the entire body of transcripts. I already felt very familiar with the material from the process of transcription, which had taken a number of readings in order to achieve the level of detail I desired. I then read through the transcripts a second time, but this time made notes on the interviews in a new document. Next I read through the transcripts again, this time systematically making notes of potential codes for each research question on summary sheets (see Appendix J for sample sheet). There is not one set way of undertaking coding in thematic analysis (Braun & Clarke, 2012). In terms of segmenting the data in the current study, I did not undergo line by line coding whereby priority is placed on finding a code for every line, but rather focused on what I considered ‘meaning units’ (Rennie, Phillips & Quartaro, 1988). This decision reflects the arguments made by some who note that line by line coding can take away from the meaning of the data itself (Rennie & Fergus, 2006; Lowndes & Hanley, 2010); the focus of the current research questions.

After I had completed a summary sheet for each interview, I examined all the summary sheets for patterns across the data set. In a separate document I then made a list of the codes from all the summary sheets (Appendix K). For each research question I grouped the codes according to those which were similar, and removed that were repeats of each other. I then examined the groups of codes and spent some time thinking about the underlying meaning of each one. Throughout this process I refined the groups of codes and then developed an initial idea of a theme title for each group. In a separate document I then noted the initial ideas for themes I was considering (Appendix L). Following this I went back through all the codes I had listed to check that I had accounted for all of them. I then spent some time considering and refining the themes, before developing an initial definition for each one. Next I went back to the interview transcripts and collated all the data extracts which related to the themes I had developed (see Appendix M for sample). This helped me to refine the definition of the themes, as well as develop ideas for sub-
themes. Once I had done this I drew a thematic map of all the themes and sub-themes developed up to that point (Appendix N). Again this helped me to ensure that the themes were distinct enough from each other, as well as to establish the definition and placement of the sub-themes. I reworked the map several times, referring back to the previous list of themes, as well as the table of data extracts. At the same time I defined and redefined the definitions of the themes, aiming to compile something that I felt happy with as a representation of the data corpus.

In terms of writing up the analysis, I again aimed to be as transparent as possible. The transparency of the process therefore did not just extend to the transcription and analysis, but also to the final write up. To this end I used direct quotes from the interviews to illustrate themes. Furthermore, I aimed to include enough of the context to ensure that you as the reader had a full as possible a picture surrounding what the participant was saying in that particular moment. Finally, I deliberately kept separate lines for the interviewee and interviewer, as well as provided individual line numbers. The aim here was to ensure the clarity of each ‘turn’, again so that the joint construction of the interview was clear, as well as to demonstrate how the themes represented such a level of detail, rather than broader, sweeping patterns (Potter & Hepburn, 2005).

3.5. Ethical considerations

As with any piece of research, ethical considerations were of great importance in the present study. Ethical questions in qualitative research should not be seen as any less pertinent than in quantitative work, despite the apparent humanist slant to qualitative inquiries (Burman, 1997). Arguably, in a qualitative work the need for explicit discussion of ethical questions is even more pertinent due to the relational nature of the process (Stacey, 1988). This is in addition to the risk that ethical questions become disguised because of the relational nature and the belief that for example, existing relationships with research participants can be ignored for the duration of the research (Burman, 1997). Such issues are addressed in the current study partly through the explicit discussion in the section on power below (Section 3.5.1.), as well as in the later more detailed reflexive analysis (Section 4.4.). Firstly, however I will outline the specific ethical guidelines adhered to. The mechanisms
within such guidelines do not guarantee ethical procedures (Burman, 1997). Indeed it can be argued that ethical practice should go beyond ‘rule-following’ as ethics cannot be resolved in a procedural way (Brinkmann & Kvale, 2008). Nor can ethical questions be resolved simply at the beginning of the research process. Following this argument ethical practice can be considered a way of being rather than doing. Here I hope that the similarity between therapeutic practice and the research interview enabled me to use some of the skills in ‘being’ that I apply in my client work, such as being accepting and empathetic, resulting in an ethically sensitive and considerate practice.

Nonetheless such a way of ‘being’ does not mean that ethical guidelines should be pushed aside. I hope that I managed to achieve ethically sound practice throughout the present process by a combination of both guidelines and way of being. In terms of the guidelines specific to a piece of research undertaken by a trainee psychologist; as well as those of the university, these include those of the British Psychological Society and the Health and Care Professions Council. In the case of the present study, the study was given ethical approval by the School of Education at the University of Manchester. The research was conducted according to the British Psychological Society Code of Human Research Ethics (BPS, 2011), as well as guided by the Health and Care Professions Council’s Standards of Conduct, Performance and Ethics (HCPC, 2008).

I will now outline the ways in which adherence to these guidelines was manifest in the current study. Firstly, as detailed above all the participants were given a study information sheet and two weeks to read it before deciding if they wished to take part (Appendix B). Participants were able to clarify any information they were not sure of and ask any questions. If they were happy to proceed with the study they signed a consent form (Appendix G). As also outlined in the information sheet participants were advised that there were under no obligation to take part in the interview and that they had the option to withdraw at any time. However it should be noted that the duty around ethics is not one that ends at such a point of explicit consent, but rather is an ongoing process (Burman & Whelan, 2011). I monitored participants’ consent beyond this point by keeping aware of any signs of doubts throughout the process. Following the interview the participants were provided with a debrief sheet (Appendix H). This gave the participants the details of potential
avenues for support, as well as the contact details of the researcher. Although due to
the nature of the topic it seemed unlikely that the participants would experience any
emotional distress as a result of the interview, I also felt prepared to manage any
distress due to my counselling training and experience.

Another vital element to the ethical considerations was confidentiality. Steps were
taken to maintain the anonymity of the participants at a number of stages throughout
the research process. The audio and transcription data were kept in encrypted files.
Files were also password protected. I also conducted the process of transcription in a
private area of my home. The quotes used in the final report were not identifiable. I
checked with the participants how they wished to be described in the study, and they
were referred to by numbers. Participants’ numbers were used in the storage of their
data and their contact details were kept separately from the interview material.

3.5.1. Power

“To prevent drowning in methodological nuances, we have to leave breathing space
for crucial epistemological questions around power, values, truth and politics”
(Burman & Whelan, 2011, p. 3). To this end I will now explore power as it is
manifest in the present research, in my view a natural follow on from a discussion on
ethics. Indeed it could be argued that the consideration of power relations forms part
of a researcher’s ethical responsibilities, or even more broadly; their ‘authorial
responsibilities’ (Burman & Whelan, 2011, p. 11). It should not be assumed that
qualitative research is any less likely to involve misuse of power than quantitative
projects (Burman, 1997; Haverkamp, 2005). As is perhaps already implied by my
constructionist stance, power is seen as one of the unique dynamics that exists within
the setting of an individual interview between researcher and participant. Burman
and Whelan (2011) argue that power is a “set of multiple, complex (and contested)
relationships that modulate and shift during the research process” (p. 11). As the
researcher in the present study, it is clear that such a position naturally holds some
power (West & Byrne, 2009). For example I was the person who knew, at least
roughly, the format of the interview. Yet at the same time my position as the person
responsible for the research process means that I was undoubtedly somewhat
beholden to the participants for their engagement. In the present interviews it could
be argued that there was relatively little contrast in power between researcher and participant due to the closeness that I held as a fellow counselling psychologist, albeit a trainee. In two of the interviews, the other participants were also in training, so arguably we were even closer, at least in terms of professional background. However as implied by Burman and Whelan’s (2011) definition of power, a dynamic concept such as power ebbs and flows throughout the smallest of segments within the research process, even moments. As a constructionist, this is not something that I subscribe to being ‘managed’ out of the process. Yet that does not mean that I did nothing to create as democratic an environment as possible. Part of such efforts can be witnessed in the ethical procedures that I followed, as described above. I was transparent about the research process with the participants, something that was made further explicit by the inclusion of documents such as the information sheet and consent form. A further discussion of power relations throughout the interview process forms part of my reflexive analysis (Section 4.4).

3.6. Chapter summary

In the present chapter I aimed to detail and explain the methodology that I followed in order to address research questions exploring counselling psychologists’ experiences of incorporating exercise into their therapeutic work. Firstly I outlined the epistemological stance with which I approached the research. This made clear the constructionist views that I held. I explored the standpoint from which I viewed the present study, as well as detailing further implications of this stance throughout the chapter. This was particularly pertinent to the way in which I approached producing a ‘good’ quality study, which was the next topic that I addressed. After this I went onto detail the method that I employed to address the research questions. I briefly explored the aims of using a qualitative approach, before going onto outline the way in which I recruited participants, the details of the participants, as well as those of myself as the researcher. I also explained and detailed my use of interviews, before going onto describe the process of transcribing the interviews. I then outlined how I analysed the interview material using thematic analysis. Finally I discussed my approach towards the ethical aspects of the study, citing the view that although I adhered to the particular guidelines relevant to undertaking a psychological study, I
also view it as a way of ‘being’, which I attempted to embody. As part of such ethical considerations I also considered the power relations that exist in interactions such as interviews.
4. Analysis

4.1. Introduction
In the preceding chapter I outlined the methodology that I undertook in order to address the goal of the research: to explore the use of exercise in therapy by UK-based counselling psychologists. Specifically the present study aimed to address the following research questions:

1. How have counselling psychologists used exercise within their therapeutic work?
2. What has been the experience of those counselling psychologists who have incorporated exercise into their work?

I explained that I conducted a series of semi-structured interviews with counselling psychologists, and chose to analyse the consequent interview material using thematic analysis. But what came of the process? In the present chapter I will detail the outcome of this analysis. I will address each research question in turn, with the chapter divided into two main sections accordingly. First I will focus on the ways in which counselling psychologists have used exercise within their therapeutic work; I will then turn to their experiences of doing so. In each chapter I will present the series of themes that I generated from the interview material. I illustrate these with direct quotes from the participants, with the aim of capturing the direct voice from that particular interview encounter. Where the quotes encompass interjections from both the participant and I, participant comments are highlighted in bold for clarification.

4.2. How have counselling psychologists used exercise within their therapeutic work?: Key Themes
In the present section I will outline the themes that I developed in response to the first research question; exploring how counselling psychologists may have used exercise within therapy. It became clear from the analysis that there were a number of ways in which the participants talked about using exercise as part of their sessions
with clients. For clarity, I have outlined the list of themes in the table below (Table 3). I will then outline each theme in turn in more detail.

Table 3 – How counselling psychologists have used exercise within therapeutic work

<table>
<thead>
<tr>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise between therapy sessions</td>
</tr>
<tr>
<td>Reducing exercise as part of therapy</td>
</tr>
<tr>
<td>Engaging in exercise within the session</td>
</tr>
<tr>
<td>External referrals for exercise</td>
</tr>
<tr>
<td>Contributing to other disciplines</td>
</tr>
<tr>
<td>Influence outside of role as counselling psychologist</td>
</tr>
</tbody>
</table>

4.2.1. Exercise between therapy sessions

The first theme that I will outline is that of exercise being an intervention that was engaged in by the client in between therapy sessions. The rationale and form of such an intervention varied greatly between participants. There was also difference in terms of who initiated the use of exercise in this way. Some of the participants were quite clear in terms of the intervention being something that they suggested or even prescribed to the client. In contrast, other participants explicitly explained that it was something that developed as a result of mutual discussion, or purely on the suggestion of the client. Below are some examples where the participants took the lead in suggesting exercise between sessions:

I know that you've sort of said that exercise has been a part of your therapeutic work..

Sure.

Could you tell me what this has involved?
Yeah. Mainly in terms of prescribing exercise to patients erm in relation to behavioural activation.

Ok.

Most patients who I see will … Erm If they have a mood related issue, or erm they erm perhaps have anxiety and so on. I might suggest that exercise, or increasing the exercise that they’re doing or indeed doing any at all, could help in their overall psychological recovery. (P1, lines 22-32)

Another participant described this input explicitly in terms of their psychoeducational role. The client group to which the participant refers in this case is that of a student counselling service:

I think a lot of the client group are at that age where they’ve never.. if they’re been ok, they’ve never had to do very much to maintain that. Yeah, yeah. I see what you mean

And it’s just one of those awful things that I think we get that at different life stages where we have to do a bit more just to tick over well.

Yeah

And you know that’s one of those very disappointing…life lessons sometimes for them is that..you know that they just cant be spontaneous all the time, it’s just like brushing their teeth or washing their face, that they might benefit from mindfulness meditation.

Yep

They really do need to think about going to the gym, not to get into a bathing suit or this or that,

Yeah

or walking, swimming, whatever but just to keep them mentally feeling ok, as well as physically,

Yeah

and explaining about the effect that is has on them. (P8, lines 99-113)

As illustrated in the first quote above, some of the participants named the use of exercise between sessions specifically as part of behavioural activation. Behavioural activation is a technique commonly used in Cognitive Behavioural Therapy (CBT)
for depression; its underlying principle is that changing what the client does – their
behaviour – can in itself lead to an improvement in mood. The participant in the
following quote outlines how he may introduce exercise as part of behavioural
activation. As can be seen he describes it being a form of negotiation. This alludes
to a two-way dimension between therapist and client.

Individually, I would, having been trained in cognitive therapy I would use.. erm if
people were fairly sedentary in their depression one of the first things I would do
would be to try and get them to negotiate some way of getting them active even if it
was walking to the shops and back, or something like that. (P4, lines 76-79)

Other participants specifically mentioned exercise being part of what the client does
between sessions in the context of activity scheduling, another technique commonly
used within CBT whereby the client first notes down what they do over the course of
the week, rating the activities for pleasure and the sense of achievement gained. The
idea is that the therapist then works with the client to gradually increase the activities
in their week from which they do derive either pleasure or accomplishment.

When we look at for example activity scheduling. And we talk about the kind of
things that you’re not doing now..

Right

and actually what does the research suggest would be helpful for how you’re
feeling. So I think within that dialogue I would probably say “you know activity is
really important, getting out of the house, maybe doing some exercise”. So I might
offer that.

Ok

That then might facilitate them to take that up. (P3 lines 202-209).

Aside from the specific techniques exercise might form a part of; the participants
also gave further insight into the breadth of rationale from which exercise might be
used. The following participant describes how running acted as a distraction
technique for a client who with bulimia:
She described using running as a way of *erm* clearing her mind, changing her mood. You know from being in a bad mood to being in a good mood and also stopping her from binging because if she went out for a run if she was feeling like really het up *erm* she would come back feeling a lot better. (P5, lines 69-72).

As well as the varying rationales underpinning the use of exercise between sessions, as I mentioned above there was also a range of ways in which it was introduced. This varied particularly in terms of how much the psychologists led the introduction of exercise into the therapy. In the quote from participant 3 above on activity scheduling, we saw that they were much less directive than participants 1 and 8 that we heard from first in this section. One of the other participants also emphasised that the intervention would not involve suggesting what kind of exercise the client did, but that they asked broad questions about how the client could be more active or healthy:

*I wouldn’t try and impose on them what kind of exercise I would want them to do but just asking them how could you be more active, how could you be more healthy and seeing what they come up with. And for some people it’s just you know take a walk to the shop instead of take the car or something like that. To be honest that’s enough for most people.* (P7, lines 130-133)

In the following quote again the participant emphasises that the idea to introduce exercise into the therapy came from the client and not her as the therapist, this time within the context of therapy for an eating disorder:

*And as part of our therapy she actually was thinking about ways that she thought she might get kind of back on track, and be her best self. And it came to her mind that she might like to start running again. And *erm* of course I thought that was a brilliant idea (both laugh). So I didn’t introduce the idea. She was...I kind of...We were looking at before she felt bad about her body how did she feel good about her body. It had to do with her feeling physically fit and really strong and capable.* (P5, lines 52-57)
What can we gather from this first theme of exercise used as an intervention between therapy sessions? Aside from the notion itself of exercise being part of the therapy in this way, there appeared to be two main points. Firstly, there was a broad range of rationales behind its use, including as part of behavioural activation, activity scheduling and improving body image. Secondly, the way in which exercise was introduced also varied, with some participants describing specifically suggesting to the client that they engage in some exercise, whereas others who were more led by the client and explicitly stated that they would not suggest exercise themselves.

So far I have discussed ways in which the participants incorporated exercise into therapy between sessions. Interestingly most of the participants also talked about what their work with exercise would not involve. This was mostly in the form of prescribing an exercise routine or schedule, as illustrated in the below quote:

*And then look at how, by engaging with those things again they can start to kind of feel differently. And not try and introduce an exercise regime (laughs)*

*No, no or anything like that,*

*yep*

*nothing as formalised as that really. But really it’s just about reintroducing or reengaging with the life they had before the incident. (P2, lines 113-119)*

Some of the participants linked what they would not incorporate into the therapy to their feelings about their own competence, and therefore what they felt able to introduce into the therapy. This is illustrated in the interesting exchange below:

*Would you say that exercise forms part of your work with the clients that you see?*

*Yeah I mean I don’t..and I assumed that you didn’t mean that I would physically do the exercise with them.*

*Not necessarily, no no! (laughs)*

*Cos I thought about that later, I thought gosh she couldn’t have meant that! Well..some people have..*

*I don’t have that expertise.*

*But no, even talking about it*
Oh talking about it, yes. (P8, lines 68-76)

The evident surprise with which this participant considers the idea of doing exercise as part of the in session activity is very clear in this example, providing a huge contrast to some of the other participants who do include exercise as part of their in session work. In this case, as well as not considering this as something that would be done within therapy, the participant also links her view to her ability to do so.

Most of the participants articulated that they would not suggest a specific exercise routine for a client. However we have also seen that for some participants they considered exercise in the session as something that they would not consider. This clearly contrasts with one of the other participants (P8) who we have seen describing many different forms of exercise within the session. It is possible these contrasting perspectives are linked to how the participants defined exercise.

4.2.1.1. Timings of using exercise

Some participants discussed the timings of their use of exercise throughout the therapy. For example, as seen in the quote below some participants introduced it at the start of the work:

Individually, I would, having been trained in cognitive therapy I would use.. erm if people were fairly sedentary in their depression one of the first things I would do would be to try and get them to negotiate some way of getting them active even if it was walking to the shops and back, or something like that. (P4, lines 76-79)

In contrast, others noted that exercise began to form part of the work further into the therapy as the clients’ self esteem began to increase. In this way it became part of their clients wanting to take more care of themselves as the therapy progressed:

Sometimes it does end up coming up as something they..they would name as a sign that they’re doing better because (laughs) they’re taking better care of their health generally but that’s not the same for everybody.
Are they the clients in the more general part, not the obesity service then that would generally be the case you might start on the depression work, and as they feel a bit better they would start exercising or..?

Yeah, even if it's not an exercise programme but just starting to become more active,
Yeah
Taking walks, things like that, just finding a way to be more healthy. (P7, lines 90-98)

The participant who talked most about using exercise within the sessions themselves also discussed its timing in relation to the structure of the session. She described using exercise in the first part of the session, particularly for children:

And I do some activity at the start of the session to help bring them down..
Right
and then get them to a quieter place where we can do some other stuff. (P6, lines 308-310)

In this section we have seen again the diversity of ways in which exercise can become part of the therapeutic encounter, with some therapists introducing it at the very start of the work together and others noticing that it comes into the therapy later as the therapy progresses. As well as the timing of the intervention, such discussion again highlights the way exercise is introduced into the therapy, with some counselling psychologists actively making it part of the work, whilst for others it is more organic to the process, and led by the client.

4.2.2. Reducing exercise as part of therapy
Although I have not explicitly noted this up to now, in one way or another the exercise interventions have focused on increasing the clients’ engagement in exercise. On the other end of the spectrum, two of the participants talked about the client’s exercise between sessions being part of the therapeutic work, but with the objective of reducing the amount of exercise engaged in as it formed part of their eating disorder presentation:
It comes up in conversation erm..really from the outset because when I do an initial consultation part of what we need to find out about from all of our clients is what they're..Do they have a current exercise routine, erm.. what’s its role in their life, and what if any role does it play in their eating disorder. Because we may need to do some work around their relationship with exercise if it’s not a healthy relationship.

Oh right
So I do all that asking about it. And it may play a greater or less role in our therapy depending on what it means to the client. (P5, lines 14-21)

I think the only time when I have done [mention exercise first] is working with some eating disorder presentations.

Mm
Where erm.. their maintenance cycle already has quite a high component of exercise.

Ok
So it’s already there..

Yeah..yeah
in the difficulty that they’re presenting with. Erm so immediately there needs to be an assessment of how that maintains or feeds into the eating disorder,

Mm
what’s pathological and what’s healthy.

Ok
And kind of revisiting that. (P3 lines 209-221)

This type of intervention is clearly in contrast to the prior section where participants’ emphasis was on increasing engagement in exercise. The difference highlights the importance of the meaning of exercise to the client; their subsequent use of it determining the role that exercise plays within the therapy.

4.2.3. Exercise within the therapy session
Up to this point I have outlined ways in exercise has formed part of therapeutic work in between sessions. I now move onto a different way exercise formed part of the therapeutic work for some participants; exercising within the session itself. Two of
the eight participants spoke of using exercise in this way. One participant in particular – Participant 6 - described a number of different types of exercise that this might involve. Interestingly in every example the participant emphasised their participation in the exercise as well as that of their client.

*And so as she was talking about it she was all very knotted up and so.. we..she described it and I asked her to expand upon all of that. And then there was just a sense of trying to move her on from being in that very knotted place and so I just invited her to get up and do some movement with me. (P6, lines 54-57)*

In terms of what the movement was specifically, the participant went onto describe this as a yoga-based exercise:

*She was already used to sort of being aware of her body and getting into that. So it would be a move on from that sort of thing. And it would be about moving and shaking out some of the stress, and feeling the tension in the body and just some kind of light, yoga type movements.*

*Right*

*and stretches.*

*Ok*

*Erm..and yeah you know, shaking it about. And also just being a bit silly aswell. Yeah*

*You know in the shaking. To sort of..you know shake her head up a bit. Right, yeah*

*And just sort of move her into a different place both in her body and in her head.*

*(P6, lines 81-91)*

The participant also described using exercise in sessions with children, as part of a number of activities that she would engage in with them:

*Sometimes you know you can just see that they're fidgety. Mm*

*or they'll immediately want to get involved in an activity. So I just engage in an activity with them. And it could be about playing games, it could about jumping around, it could be singing songs. Just do daft things. Erm..the other day, I was*
doing some kind of yoga type movements. So for example there’s a yoga type movement that mm..where you get into a position like a lion and you growl. (P6, lines 292-298)

Another of the participants had not used exercise themselves within a session with a client, but recounted a supervisee who had done so. This involved incorporating mindful walking into their work:

*I mean the concern was..anxieties..*

*Right*

*and the trainee felt it would be helpful to engage in some mindful walking.*

*Mhmm*

*And this is what.. they did.*

*Yep, yeah*

*And they worked on this and fortunately they worked in quite a big room so they could walk in the room (P4, lines 159-166).*

Although this example was not one of my participants directly, it adds to the story that we can put together of how some counselling psychologists have incorporated exercise as part of their in-session client work.

**4.2.4. External referrals for exercise**

We saw above that most of the participants suggested that they would not prescribe a specific exercise routine for their clients. However some participants stated that they would make a referral to another professional who would focus more directly on exercise, often alongside the main therapy component continued by the psychologist. The participants mentioned different types of professionals that they would refer to, for example physiotherapists:

*So panic attacks became a regular, daily feature. One of the things that we spoke about was that in order to get used to better and improved methods of breathing and to feel more in control of it she.... might benefit from doing some exercise.*

*With her physiotherapist I suggested in her case.*

*Right*
Somebody who was a pulmonary physiotherapist who worked in a lung unit and so on.
Mm
Erm so that would help her with her breathing. It would help her err gain confidence with exercise. And importantly she would also hopefully gain benefit from the exercise because of you know the chemical changes that we all… understand. (P1, lines 390-400)

Other types of professional that the participants referred to were gym staff, as in the example below:

And erm… the MMU had a project going when I was there whereby they could refer people down to the erm… I would know them as PE people.
Ok (laughs)
But I’m sure they’ve got another name (laughs). And they would go down and they would have erm a routine whereby if people were depressed and coming for counselling at the service.
Ok
They would refer them down. And they would set up a personal programme for them to become more active. (P4, lines 63-70)

Where the participants had made such external referrals, they discussed how exercise-based work conducted with the other professional affected what happened in the therapy:

Yes they would continue to see me. And the team that were there, the general feeling and I tended to agree with it, was that there was some benefit from it.
Right
That people did feel erm..different and they did feel that in this activity that they were engaged in, in terms of helping themselves. They felt better about themselves because they were doing it if you see what I mean. (P4, lines 127-132)
We see here therefore, that for some participants external referrals were a way that exercise became a part of the therapy, even if this was not something conducted directly themselves.

4.2.5. Contributing to other disciplines

We have seen how some of the participants made use of other professionals in relation to more directly exercise-focused input. However one of the participants described this exchange occurring in the other direction; they contributed to an exercise class by outlining the psychological contribution of the activity:

_In one of the cancer clinics in which I work they have an exercise person there and I actually join them in the class to talk about some of the psychological benefits of what’s going on._ (P1, lines 102-104)

This example is outside of the one to one therapeutic setting that has been discussed up to this point. It shows the variety of ways in which exercise may become part of the work of a counselling psychologist, as well as highlighting the impact of relationships held with other disciplines.

4.2.6. Influence outside counselling psychologist role

We have already seen how participants interacted with those in other disciplines as part of their work with exercise. However some of the participants also recounted examples relating to exercise when they were not officially in the role of counselling psychologist. One of the participants held dual roles of personal trainer as well as counselling psychologist. Although they were clear that they were not doing therapy whilst working as a personal trainer, they did feel like the therapeutic skills seeped into their sessions:

_When we’re kind of having a stretch down at the end and I’ll sort of say how was that, and we’ll get all these things coming out you know about what they think about themselves if they haven’t done it. And sometimes quite critical comments. They don’t normally phrase it like I do. Normally what happens is that criticism comes spouting out of their mouth. Oh I’m this, I’m that. I’m never going to .. ._
Yeah

*And then it’s my job to woah hang on a minute come in and say let’s think this realistically, what does this really mean. Erm...and so that’s where the therapeutic skills come in.* (P7, lines 272-279)

Another participant talked about her experiences of leading a dance class which was designed to build its members’ confidence. This was one of the participants who was not a qualified counselling psychologist. It should be noted that she was not a counselling psychologist when she was leading the dance class, although a psychologist. Nonetheless, in the case of both participants illustrated here, we have seen that they have had involvement with exercise in some form, and that they have drawn on therapeutic skills – whether formally or informally, to enhance the benefits of exercise.

**4.3. What has been the experience of those counselling psychologists who have incorporated exercise into their work?: Key Themes**

Above I outlined the themes developed from the research question: “How have counselling psychologists used exercise within their therapeutic work?” I will now move onto present the themes developed from the second research question, which focuses on the experiences of counselling psychologists when they have incorporated exercise. I developed six main themes from the thematic analysis conducted on the interview material for this question. Two of the themes; self of the therapist and collaboration also have sub-themes. For clarity, I have outlined the list of themes in the table below (Table 4). I then discuss each of the themes in more detail, including accompanying quotes.
Table 4 – Counselling psychologists’ experiences of incorporating exercise into their work

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub theme/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle for change</td>
<td></td>
</tr>
<tr>
<td>Holism</td>
<td>Individuality of meaning</td>
</tr>
<tr>
<td>Influence of self</td>
<td>Directiveness</td>
</tr>
<tr>
<td></td>
<td>Limits of competence</td>
</tr>
<tr>
<td>A quiet voice</td>
<td></td>
</tr>
<tr>
<td>One of many tools</td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td></td>
</tr>
</tbody>
</table>

4.3.1. Vehicle for change

The first theme that I will discuss is ‘Vehicle for Change’. This theme is focused on the participants’ experiences of how exercise functioned for their clients as part of the therapy. Specifically the participants described exercise as incorporating both direct and indirect benefits for their clients’ wellbeing. Firstly due to the physical effects of the exercise itself, but secondly they experienced exercise as resulting in other, more indirect benefits which then produced an improvement in the client’s wellbeing. Ultimately both routes led to some sort of change, that exercise had been the mechanism for. The participants also talked about this in relation to research that they were of aware of which supported such outcomes.

Here we see some of the direct benefits of exercise described by the participants:

*I don’t do physical exercise*

Yeah

*for endorphins and all that sort of thing but clearly some of that would have been going on for them there.* (P6, lines 214-217)

Some of the participants emphasised the physical benefits of exercise particularly strongly. For example, from Participant 5:

*It’s just very biological.*
Yeah

*Our bodies were made to move. And if they don’t move they don’t feel good and they get poorly.* (P5, lines 520-522)

On the other hand, we also see the participants pointing to the second type of benefits their clients experienced from exercise; those which were indirect and also broader:

*I’ve often seen it as a great bridge rather than an end in itself.* (P2, line 154)

The participants outlined examples of these, as illustrated below:

> **So for me the focus of exercise is not just the physiological wellbeing**
> *No*
> *it can create.*
> *No*
> **It’s also the social and psychological wellbeing it can create too.** (P2, lines 344-348)

In the case above, the participant pointed to the potential for positive effects on the clients' social and psychological wellbeing. Some of the participants described more specifically what the psychological impacts had been, such as feelings of mastery gained from participating in exercise. In this case it appears that exercise functioned as a mechanism for change by representing an opportunity for their clients to challenge their beliefs. This is illustrated in the following quote:

> **His ability to do that meant that he could then start to see that he had the potential to do it in different ways not just in terms of sport.**
> *Yeah, yeah.*
> **employment and all those other things..could then open up as a different thing.**
> **Well if I can do that and I can adapt to that then why can’t I do this.** (P2, lines 521-527)
Some of the participants implied that exercise acted as a mechanism for the development of the therapeutic relationship:

*But always the activity side of things was a good way of getting going.*

*Yeah*

*Getting the thing moving, getting the therapy moving*

*Right*

*Getting sort of negotiating on something.* (P4, lines 256-260)

Some of the participants cited one of the indirect benefits as connecting body and mind, as illustrated below:

*Physical exercise is a very powerful way of restating*

*Mm*

*And showing, and re-establishing a sense of physical control. So physical control can be quite a powerful way of moving onto the psychological control that people have often lost.* (P2, lines 792-795)

Some participants noted that this outcome is not unique to exercise and that therefore exercise is interchangeable with other activities. This argument links to another of the six themes: ‘one of many tools’, which I discuss in much more detail later (Section 5.3.5.). However some of the participants did reference what seemed like the unique elements of exercise; principally its involvement of the body, which seemed to bring something different for the client. This is something that links to the next theme that will be described; holism. However we first see an example below:

*He didn’t need to sort of like obsessively play with sand and bury things you know.*

*Yeah (laughs)*

*What he needed to do was this physical activity. Erm..and so it would have been him releasing some of his..whatever the stuff was through that, whether it was anxiety or stress or you know..trauma sequellae or whatever.* (P6, lines 342-346)
Let us recap the present theme of vehicle of change. We have seen that the participants described their experiences of how they saw exercise working for their clients. Exercise acted as a mechanism for change for their clients, via a range of benefits that it brought. The participants described both direct and indirect benefits, direct elements deriving principally from its physicality, and indirect ranging from its impact on feelings of control to aiding the therapeutic relationship.

4.3.2. Holism

I will now discuss the second main theme: holism. This theme spans two elements; firstly, several of the participants stated that exercise formed part of their therapy as the result of working with the whole person of the client, both physical and psychological. Secondly, the participants described the importance of considering the mind and body interlinked. But first, to introduce the former:

It seems to me that what I’ve been trained to do as a counselling psychologist is to work with the whole person.

thought
And erm.. I think that activity is erm bringing in part of the whole person. (P4, lines 380-384)

Some participants spoke specifically about trying to put together a whole picture of how their clients operate in the world. This could be seen as part of the assessment process, as in the quote below.

Trying to really understand the person’s life and the other perspectives around it.
Not just why they don’t play football anymore.

Yeah, yeah
Why they don’t go swimming anymore, why don’t go to the gym anymore you know, it’s not just about that it’s really about how does that fit into the bigger picture of their life. (P2, lines 274-278)

For some exercise formed part of the assessment process in a more methodical way:

Like often it’s just something that we would just check
initially; alcohol intake, recreational drugs, if it seems appropriate, but certainly the basics of eating and exercise because so much of that will be underlying causes of anxiety

Yeah, yeah.

or disorder. (P8, lines 118-123)

Other participants detailed a specific rationale behind conducting a holistic assessment of their client. For example, some cited that it gave them more information about their clients’ wellbeing, and within this an understanding of their clients’ attitude towards exercise and their body. For some of the participants, how the client treated their body was indicative of the wider functioning of the client. However this was not said by all, and is illustrative of the importance of the psychologist’s own views on wellbeing. Again this links to another of the themes in the study; ‘self of the therapist’, as well as its sub-theme of ‘directiveness’ as discussed later. We see some of their views below:

The client’s relationship with exercise in a way was a mirror or reflects her relationship with herself in many other ways. (P5, lines 122-123)

As much as my own philosophy is that you can not be psychologically well if you’re treating your body like garbage. (P7, lines 355-356)

Some of the participants talked about how the physical understanding of the client tends to be missed from our overall formulations or understanding of the overall wellbeing of the client. This expanded to comments about its potential value.

It’s interesting cos as you’re asking me these questions I’m actually realising how much in the training these things would be assigned to psychological health but there’s such a big overlap between the physical and the psychological that I think is hard to formulate because we’re supposedly dealing with mental health and yet so much seems physically manifested. (P7, lines 183-187)

Some of the participants talked about using an understanding of the whole of the client as a basis for exercise becoming part of subsequent therapeutic work.

So I do think it’s the bigger assessment around exercise.
Ok

*Rather than just going so you want to go swimming down this week. Yeah let’s put that down.*

Yeah, yeah

*I feel that there has to be a conversation about it.*

Mm

*To understand what that means for somebody.* (P3, lines 619-625)

As I noted above, the theme of holism incorporates two elements. Firstly as I have described above, exercise often formed part of the participants’ experiences of therapy due to their emphasis on getting a broad an understanding of the client as possible – this including physicality and therefore exercise. The second element has a slightly different twist but could be argued underpins the first element: many of the participants spoke of a belief in the therapeutic value of exercise due to a view held by the participants that mind and body are interlinked, and that therefore both are vital to the wellbeing of the client.

*And so I think that..as I said before about that whole thing that’s its not about cognitive changes just or behavioural changes or even dealing with the affect but the physiological stuff is there aswell. So it’s part of the holistic package.* (P6, lines 565-567)

Some of the participants linked the belief in the interrelationship between mind and body to their capacity as a psychologist:

*Cos I think it really is..for me anyway and how I practice and what I see in my practice, is that it’s very much about the whole..holistic.*

Mm

*And an integration of all of that.*

Right. Of the mind with the body.

Yeah. *Mind, body and soul.*

Ooh (both laugh)

*We are psychologists after all (both laugh).* (P6, lines 276-283)
So far I have outlined the two aspects to the theme of holism; the participants described exercise having formed part of their therapeutic process due to a belief in the importance of understanding the whole person. Secondly, I outlined the links that the participants made between the mind and body for wellbeing, and the space this therefore created for the value of exercise. I will now outline the first of the sub themes that form part of the present research question. Primarily linked to the first aspect of the theme of holism, we find the sub theme of ‘Individuality of meaning’.

4.3.2.1. Sub Theme (Holism): Individuality of meaning

One of the reasons why the participants valued a holistic understanding of the client was due to their acknowledgement of the subjectivity attached to wellbeing, and therefore what exercise might represent to each individual. It follows that a diverse range of meanings could be placed on exercise. This diversity is something that was frequently highlighted by the participants, and hence I will now discuss it as a sub theme to the primary theme of ‘holism’.

Allowing for such individuality around wellbeing means that for some clients, exercise may not figure in what makes them feel good. Most of the participants made reference to such a scenario. As illustrated below, some psychologists explicitly stated that they would therefore not continue to push the idea:

*I try to stay really neutral about it and just kind of probe what they’re feeling about it, what it means to them. And try to leave it..erm*  
*Mm*  
*well the ball in their court really to kind of determine what to them is health because that’s really a key thing. Being healthy is not the same thing to everybody.* (P7, lines 109-113)

Even where the clients did value exercise as part of their definition of wellbeing, most of the participants argued that they had very personal concepts of exactly what it meant to them. Such subjectivity was something that the psychologists seemed very aware of and keen to understand. This was perhaps most vividly illustrated in the present study by the participants who worked with exercise in order to lift mood versus those for whom it formed part of their clients’ eating disorder.
The less directive participants in particular also described using their understanding of what exercise meant to their clients on a personal level to shape the therapy. Some of the participants cited that benefits of exercise in therapy could only be realised if they did hold an individualised understanding of what exercise meant to that client. They argued that this understanding, including why the client may have stopped exercising was key to it becoming an effective intervention:

I think the first thing to understand is why people have stopped.
Right
There’s no point in suggesting doing something
Yep
without understanding what the barrier has been and so as part of the therapeutic process it’s important to understand where somebody is. (P2, lines 237-242)

The participants highlighted the importance of the client’s individual perspective on exercise particularly in relation to working with clients who had experienced depression or trauma. For both, many of the participants outlined using exercise as a way of reintroducing activities back into the client’s life, and especially things that they used to enjoy. The implication here is that exercise may have been a positive thing for the client in the past, and therefore held a positive meaning for them.

Some of the participants also acknowledged that what the psychologist may value for wellbeing is not necessarily how their client conceptualises it.

Being healthy is not the same thing to everybody,
No
what I do for my health won’t necessarily be the right thing for somebody else. So
I try to kind of stay a bit neutral. (P7, lines 113-116)

And I guess part of my work is to help the client come bring it back to being a healthy part of their life that actually improves their sense of wellbeing and their physical stamina rather than using it to kind of undermine themselves. (P5, lines 107-109)

This links closely to another of the themes developed from the present research question: collaboration (see Section 5.3.6.). It is clear that what exercise means to
the individual client then affects how the psychologist and the client then work with that as part of the therapy. Overall in this sub theme we have seen that part of the psychologists’ experience of working with exercise has been the understanding and exploitation of the clients’ unique vision of wellbeing, and therefore exercise.

4.3.3. Influence of self

I will now discuss another of the core themes that I developed from the participants’ stories of working with exercise: ‘influence of self’. This theme centres on the idea that the person of the therapist themselves was vital to the role that exercise played in the therapy. I will begin this section by outlining the main theme, before moving onto explore the theme’s two subthemes.

The participants talked about their own feelings towards exercise and many described their own experiences of exercise. The majority of the participants had had positive experiences of exercise. They also described how they felt this had influenced their therapeutic work, for the most part, the participants felt that this meant that they were more likely to bring exercise into the therapy, as well as be more positive about it, than they otherwise may have been.

*I have a personal sense that it’s a very beneficial thing because the physiological response you get from being in sporting activity or physical exercise activity..*

*Yep*

*is for me a very pleasant one.*

*Yep*

*Even though strangely it’s sometimes its painful there’s a real sense of pleasure with that aswell.*

*Yeah*

*I think I’m convinced of the benefits of it. So I think that’s why I feel quite comfortable engaging in discussion with clients.* (P2, lines 582-590)

We saw the participants’ own views on exercise in one of the interviews in particular. Participant 5 was especially passionate about exercise, and wrote a poem about her own experience. Below I have outlined the poem in full:
Ode to the Forty Five Minute Workout

1. Getting started

Music rhythm motivation
First five minutes: familiar muscular wake up call: I half listen and half ignore
The grumbling
Second five minutes takes a ramp up
Hard pushing against louder grumbling
It’s not just arms, legs, lungs, it’s the whole body and whole mind
Engaged
Yes with pain, and motion, oxygen, life, love, thinking
Attending to pain and ignoring it at the same time
Love coming up through the music

2. Pushing up through

Ten minutes in and the focus is on breathing,
Hard huffing out pain
Pulling in stamina

Getting hotter

There’s only one way through the barrier and that’s
Wholeheartedly

The music tells me how, and I obey, a labour of love

3. Cruising

 Comes a point, maybe twenty minutes in, when sweat beads my belly
And my hands
I realise pain has gone and joy has risen
My body is one with the music
My mind is absorbed with new ideas
(Or old ones in fresh perspective)
And I love this time
Love this time

4. Coming down
Cruising could go on a long time if I let it.
So I let it
Hold me
Thirty minutes, forty minutes, who cares? I’ll take fifty or an hour

Me and music
Me and breath
Me and motion
Me hot happy

If I didn’t have to get to work

But there’s always work to do.
And now it seems better.
I know what to do
I know how to do it

So, now,
I go out into the world, in faith. Do good. Be good. All is good².

The participant earlier in the interview had already hinted at her own passion for exercise, and how this might translate to therapy:

And as part of our therapy she actually was thinking about ways that she thought she might get kind of back on track, and be her best self. And it came to her mind that

² No line numbers are given as the poem is cited as per the participants’ version and not the interview transcription in order to respect the intention of the work.
she might like to start running again. And erm of course I thought that was a brilliant idea (both laugh). So I didn’t introduce the idea. (P5, lines 52-55).

After reading the poem she reiterates this:

**But there is something about..how a good work out makes everything better.**

Yeah

**And if it does for me, it does for every other human and it does for our clients. And I...you know...I wish I could give that sense of goodness to others.** (P5, lines 597-600).

Some of the participants also discussed the factors that contributed to their views on exercise. One participant in particular felt that their US background - where there was a big focus on exercise, had influenced the value that they placed on exercise on a personal level. It is clear that elements such as the therapist’s cultural background influences and contributes to their person, and it is this self that is being shared in the therapy room.

Another factor which contributed to the self of the therapist was their previous work experience. The following two quotes illustrate how this is manifest for Participant 6 in relation to their use of exercise in-session:

**So it didn’t sort of come from nowhere. It kind of started off because I had a remit..to do dance.** (P6, lines 390-391).

**I just draw on any skills and knowledge that I have.**

Mmn. And because you had done it, more physical focus, then that meant you were quite comfortable with bringing it in the one to one sessions.

**And open to it..because I’d seen it. And open to it because I did it then because I danced and taught dance.** (P6, lines 404-408)

However most of the participants described balancing their perspectives and experiences on exercise with the needs of the client. This brings us back to the ideas discussed in the ‘Individuation of meaning’ theme described above.
But also, to go back to the person centred bit, it’s about meeting them at where they’re at so whatever stuff works for them. (P6, lines 569-570)

Most participants stated that if the client was not comfortable talking about exercise then it would not be helpful for it to form part of the therapy. 

But you know it comes back the point that if you’re personally not comfortable with it. If it doesn’t represent your frame or your own personal life, if you’re not that enthusiastic about it or not very knowledgeable. You’re probably best not doing it. (P1, lines 547-550)

Returning to the self of the therapist more directly; some of the participants talked about this in a different way. They described about how their physicality also became part of the therapy, via for example the client observing their own body.

I know that there can be a lot of things going on in the room too where the clients..sometimes not at the beginning, sometimes at the beginning, I’ve had a few who have said that they’ve noticed my physique. I’m you know muscular kind of physique.

Yeah, yeah

And (laughs) erm I think that sometimes they form opinions and they might imagine that I want to talk about it. (P7, lines 101-107)

One of the participants also highlighted the role of the therapist’s own body in the therapy, but this time in the context of needing to be relatively in shape in order to make exercise part of the work:

I don’t want to be rude but if you are obese..

Yeah

It’s not going to look very good and very nice if you erm say to someone erm you know I think you need to do exercise because they will look at you. (P1, lines 202-205)

On the other hand, Participant 7 - who I quoted above in relation to their experiences of clients noticing that they are in shape, went onto argue that for this reason they are especially careful not to introduce exercise into the therapy from their own agenda:
I’m you know muscular kind of physique.

Yeah, yeah

And (laughs) erm I think that sometimes they form opinions and they might imagine that I want to talk about it.

Yeah

You know yeah so I try to stay really neutral about it and just kind of probe what they’re feeling about it, what it means to them. (P7, lines 104-110)

To summarise, in this theme of ‘influence of self’ we have seen that the person of the therapist appears critical to how exercise forms part of therapeutic work, if it does at all. This included the participants’ views and experiences of exercise - as shaped by factors such as their cultural background, as well as their own physicality. The influence of the ‘self’ nevertheless manifested itself in the therapy in very different ways.

4.3.3.1. Sub theme (Influence of self): Directiveness

Above I discussed the importance of the person of the therapist to the use of exercise within therapy. A key aspect of the psychologists’ ‘selves’ appeared to be their perspective on direction within therapy. Some participants had a directive stance; they spoke of introducing exercise into the session even if it was not something that the client had talked about themselves. We see an example of this below:

I will always raise it if I’m working with a patient for example if I’m working with a patient with at least one of the two primary problems, anxiety/panic attacks and depression. (P1, lines 352-354)

One participant linked her directiveness to the age of the clients that she worked with and therefore what she felt was a psychoeducational aspect to the therapy:

And you know that’s one of those very disappointing...life lessons sometimes for them is that...you know that they just can’t be spontaneous all the time, it’s just like brushing their teeth or washing their face, that they might benefit from mindfulness meditation.

Yep
They really do need to think about going to the gym, not to get into a bathing suit or this or that,
Yeah
or walking, swimming, whatever but just to keep them mentally feeling ok, as well as physically,
Yeah
and explaining about the effect that is has on them. (P8, lines 105-113)

Some of the participants linked their rationale for being the one who introduced exercise to their beliefs surrounding its research base. Furthermore, Participant 1 who we heard from above in relation to introducing exercise for depression and anxiety, cited the importance of a research base to their capacity as a psychologist:

As a psychologist ok, I don’t know about as a therapist or counsellor I happen to be registered as both. But when I operate as a psychologist..
Mm
it’s evidence-based practice and that means promoting things. Even if I don’t personally agree with them. (P1, lines 272-276)

In contrast, other participants were less directive. They put more emphasis on the client’s goals for the therapy, as well as their feelings about exercise:

I think that erm..maybe I stay a bit kind of on the fence about it until the client says that it’s important for them. (P7, lines 100-101)

Some participants detailed the risks of being directive. For example they argued that introducing exercise could be experienced as following the therapists’ own agenda and therefore risk a lack of engagement from the client.

So you can talk to them about the rationale.
Yeah
But ultimately that’ll be up to them. And what their goal is for therapy. And that might feel like my agenda rather than theirs. (P3, lines 190-193)
As we are seeing, there was a real spectrum of views when it came to the participants’ perspectives on introducing exercise into therapy. A middle ground is perhaps illustrated in the following quotes from Participant 3:

*I think within that dialogue I would probably say “you know activity is really important, getting out of the house, maybe doing some exercise”. So I might offer that. (P3, lines 205-207).*

**So that feels ok.**
*Ok because it doesn’t feel directive.*
*No. And it doesn’t feel like I’m telling them*
*Yeah*
*that exercise will be helpful.* (P3, lines 329-334)

In both cases; participants more or less directive, the participants cited the importance of the way in which any exercise intervention was delivered. We see the care with which the therapeutic relationship between the therapist and client is held:

*I think a lot of it has to do with how you explain it to someone. If you.. you know. I’m being a bit dramatic here. If you’re grumpy and say you’d better go for a walk. Most patients will feel told off. I think the way that you describe it.* (P1, lines 166-169)

In the present section we have seen that an important part of the therapist self is directiveness. This influenced if and how exercise became part of the therapy. As we have observed, some participants explicitly introduced exercise into the work whereas others preferred to follow the clients’ lead. In between we witnessed a middle ground, of tentatively suggesting that it could form part of the work. However in all cases attention was paid to how such an intervention was delivered.

4.3.3.2. Sub theme (Influence of self): Limits of competence

Another area that contributed to the self of the therapist and therefore the role that exercise played in the therapy, was the participants’ view of their competency to
incorporate exercise. Most of the participants argued that there were limits to their ability to use exercise therapeutically.

*Because exercise… it kind of feels like that’s a different competency.* (P3, line 72)

*I am very careful about how far I go. I think as a psychologist, I think all of us would understand, erm.. all of this thing needs to be taken into consideration erm… dealing with this sort of thing with medical backing in some way.* (P1, lines 121-124)

The participants talked about the importance of limits regarding their use of exercise in order to ensure the safety of their clients:

*And then you know there’s health and safety things if you’re kicking a ball around or if you’re running about you know,*

Yeah

*there’s those kind of issues about making sure everybody’s safe.* (P6, lines 529-532)

The participants linked the idea of limitations to their competency to the concern that clients could take legal action if they hurt themselves as a result of exercising as part of therapy:

*Although we may mean well we can be sued.* (P1, lines 124-125)

Some of the participants noted that although they believed there to be limits to the work they could do with exercise themselves, they valued and had profited from the expertise of other disciplines, for example in the form of referring clients to other professionals for more exercise-focused work. This way of working with exercise is one that was discussed earlier in the first research question. Here, the participants discussed the value of such multi-disciplinary working in terms of research as well as direct client work, as we see in the following quotes:

*There might not be research from counselling psychologists or even clinical psychologists there’s a wealth of research from health psychologists and sports psychologists. I think sometimes you know we would benefit, all of us, from not just sticking to our own discipline’s.*

*Ah ok*
research. (P7, lines 348-353)

I would not put together an exercise routine for a client but I know one of my colleagues would do that for her. (P5, lines 478-479)

So those elements there are not my training.

No

So those for me aren’t so much barriers but they are the limitation..

Right

to, what I would do with a client.

Mm

Erm but that wouldn’t limit the therapy per se. Because if it was really important to them that’s where we would involve multi-disciplinary teams

Ok

and gain further information. (P3, lines 509-518)

Some of the participants described how the work that the client went onto do with the other professional then became part of their therapy. Multi-disciplinary working will be discussed further in the next theme; ‘a quiet voice’. To summarise the present sub-theme however, we have seen that many of the participants felt that there were limits to how they would engage with exercise, and cited what they would not do, such as introduce an exercise routine for the client. They described using the expertise of other professionals to further exploit the intervention.

4.3.4. A quiet voice

I will now move onto the fourth core theme from this research question; ‘a quiet voice’. There are three elements to the theme; the fact that exercise did not form a large part of the participants’ therapeutic work, a lack of cross-disciplinary working in the area, and a quietness in general discussion of exercise within counselling psychology. Let us start with the first of these points; some of the psychologists emphasised that although they had used exercise with some clients, it did not form a significant part of their work:
With the depression… it doesn’t..for me it hasn’t formed a major part of any depressive treatment..

Mhmm
erm..but if it’s been in somebody’s treatment it would be consistent in their activity scheduling. (P3, lines 445-448)

About half of the participants - generally those who were not as directive, stated that exercise was not a standard part of their therapeutic work but one potential technique that they could drew upon. I will explore this idea in more detail in the next core theme: exercise as ‘one of many tools’. Some of the participants also talked about the difficulties in marrying an evidence-based approach with the desire to stay with the agenda of the client.

But I think if it’s not important for the client then it’s not important. So it’s hard thing. At the same token, excuse the pun but obesity is a growing problem and more and more of our clients are going to be coming in affected by that. (P7, lines 359-361)

The idea of a quiet voice was also linked to the theme ‘influence of self’. Some of the participants noted their appreciation for the diversity between individual counselling psychologists and the fact that this individuality influenced if and whether interventions such as exercise were brought into the therapy.

I think on a wider level I think counselling psychologists have the privilege of being trained in different ways..

Mm

and I think as a consequence to that, although we might share a philosophy..

Yep

erm..I also think we bring so much of ourselves. (P3, lines 530-535)

The quietness also appeared linked to the participants’ view that it was beyond their competency to use exercise in certain ways, as we heard in the ‘limits of competence’ theme above. For example, all the participants eschewed giving their clients a prescriptive exercise routine. That is not to say that the participants did not
see such interventions as potentially helpful. Rather, as highlighted earlier, it was seen as something that would be carried out by another professional:

*The MMU had a project going when I was there whereby they could refer people down to the erm... I would know them as PE people.* (P4, lines 63-64)

Interestingly the below participant who was also qualified as a personal trainer, stated that they would still not make such a routine part of their work:

*I wouldn’t go through an exercise programming thing where I’m telling them to do such and such, times a week.* (P7, lines 134-135)

The second point in this subtheme centres on the participants’ view that more could be made of the skills of other disciplines in order to exploit exercise as a therapeutic intervention. Some of the participants talked specifically about the expertise of other branches of psychology:

*There might not be research from counselling psychologists or even clinical psychologists there’s a wealth of research from health psychologists and sports psychologists. I think sometimes you know we would benefit, all of us, from not just sticking to our own discipline’s.*

*Ah ok* research. *Do you know what I mean? Cos the subject matter is the same isn’t it. Cos it’s all human beings isn’t it.* (P7, lines 348-355)

The final part of this subtheme relates to the use of exercise within counselling psychology as a whole. Most of the participants expressed the view that exercise was not widely discussed or used within the field:

*It’s certainly not one of the highest agendas.* (P2, line 774)

To conclude, we have seen that for the participants in the present study, exercise often did not play a significant part in their therapeutic work, nor in their view, the wider counselling psychology discourse. The participants offered a number of reasons for the therapeutic quietness including therapist individuality and competency. The participants highlighted the value of other disciplines, and
suggested that making more of these skills could help exercise grow in prominence, and its potential be further realised.

4.3.5. One of many tools

As mentioned briefly in the theme of ‘a quiet voice’ above, many of the participants saw exercise as being as one of many types of intervention that can help clients achieve their goals in therapy. We see this in the quotes below:

*I think it has its place like lots of things have their place.* (P2, line 601)

*And him being able to win, and him also being able to lose. Erm..all of that would be happening with the physical activity. But a physical medium was the way to work with him.*

*Right*

*So it was the kind of the same processes that we might have done through some other medium.* (P6, lines 350-353)

For some participants therefore, exercise appeared to be considered as equal to many other potential interventions, something to be swapped and chosen between. However this view was not held by all the participants. As illustrated explored further in the ‘directiveness’ sub theme, some argued that the particular benefits of exercise meant that they would introduce it with most clients.

For those participants who did see exercise as one of many ‘tools’, they also described the process by which they might introduce such an intervention. We see in the quotes below the value the participants placed on the input of the client, and therefore the collaborative nature of the process. I will discuss the collaborative nature of the introduction of exercise in more detail in the next section.

*We might have a framework. But if we’re looking at coming back to depression and lifting mood..*

*Yeah*

*there are lots of different options.*

*Yeah, yeah*
I’d much rather say, you know these are some options, you might have some ideas as well. (P3, lines 597-602)

More often than not I’ll think that if something comes to mind, I’ll offer it tentatively and it seems to be..an ok thing that adds something.
Something comes into your mind?
Yeah, yeah.
Ok
So it’s like having a sort of like shelf full of different these things. And physical activity in a variety of forms is there. And so I might just go ooh..
Yeah
or with this particular..with some of the..children, they might instigate that, physical activity first so then I’m just led by them. (P6, lines 446-456)

Some of the participants outlined factors which would influence their decision to choose exercise as the particular tool for a particular therapeutic encounter. For example, the participants cited the physicality of exercise as particularly useful for issues such as trauma and bereavement:

I think that the walking was a way of getting the shock out or something. Yeah
I feel like it was a way of getting something out of my body. (P8, lines 377-379)

The above quote again illustrates the interlinking between the themes identified in the present study; the participant here was talking about their own experiences. Once again we see how the therapist self is a large potential influence on whether, or how, exercise forms part of their work with clients.

Some of the participants justified the idea of exercise as one potential tool by emphasising their experience that exercise is not useful for every client. We see this highlighted in the following exchange:

I’m also not evangelistic about it.
No
I don’t kind of think it’s the solution or recipe for everybody.
No

It’s kind of.. it’s something that I feel connected to, and positive about. Erm but I don’t think it’s necessarily that way for everybody. (P2, lines 594-597)

In the present theme we have seen that for some of the participants exercise was considered one potential tool that they can draw upon in therapy. The participants highlighted elements such as the physicality of exercise as influencing whether they choose to use exercise, as well as the focus placed on the input of the client.

4.3.6. Collaboration

The final theme that I will explore is ‘collaboration’. The participants described working with exercise in a way that involved both themselves and their clients. Such a collaborative approach was manifest in a number of ways throughout the therapy. For example the participants spoke of working with their clients to make sure that certain parameters around the use of exercise were in place, as we see in the following exchange:

I encourage a kind of communication around let’s think about the pros and cons..
Mm
of what you’re suggesting. And certainly in therapy when people are talking about wanting to engage in exercise and maybe they haven’t been..
Yeah
erm for me.. Hopefully when they’re coming back to review their homework
Yeah
and things, hopefully they’re coming back saying “I did it”. So there’s also something about managing their expectations and setting realistic goals. (P3, lines 90-99)

Even the more directive of the participants described a two-way element to the introduction of exercise into the therapy:

I would never.. press someone to do something that they were uncomfortable with.
Whatever it may be. Doing homework..
Yep
for that matter even attending the next session with me.

No

If they were dithering about it I would never say you have to come back to me.

Ok

I would be the same with exercise. I would see it as a reflection of my..erm.. ability to raise an issue and promote it with the person. If they rejected it for whatever reason then so be it. (P1, lines 343-352)

Some of the participants described the importance of negotiation with their clients, as we see below in relation to increasing activity:

There were some people that dug their heels in and didn’t particularly want to do it.

Yeah

But I always found a way of kind of negotiating with them.

Right

Why don’t you give it a try and let’s talk about it when you’ve done it. Let’s negotiate something that you do feel you can do.

Ok

Which might be just going to the corner shop and coming back. (P4, lines 243-250)

The participants linked such collaboration to the importance of the therapeutic relationship between themselves and their clients. In the following quote the participant highlights the potential consequences for the relationship of how exercise is introduced:

And how has the... intervention of suggesting exercise generally erm impacted the client..

Gone down

Yeah. What’s the result been?

Usually quite well actually. Because I think a lot of it has to do with how you explain it to someone. If you.. you know. I’m being a bit dramatic here. If you’re
grumpy and say you’d better go for a walk. Most patients will feel told off. (P1, lines 166-169)

One participant described exercise engaged in as part of the therapy sessions as having a positive impact on the therapeutic relationship, arguing that it provided the opportunity to discuss what was going on between themselves and the client. The participant emphasised the utility of such an opportunity particularly when working with children:

*It’s a great way to develop a relationship.*

*Yeah*  
*and teach lots of different skills, motor and literacy skills.*  
*Erm..potentially deal with some you know..Certainly I’ve dealt with traumatic issues through playing a game of football.*  
*Mm*  
*because things come up you know. Things come up because you’re enacting them symbolically and things come up because they feel freer..more able to talk about things while they’re doing something.* (P6, lines 466-473)

In this final theme we have seen the collaborative nature of the use of exercise within therapy. The participants described this as being manifest in a number of ways; such as through negotiating with clients, and by not insisting on the introduction of exercise where the client was not comfortable with it. The participants also spoke of the positive impact that working with exercise could have for the relationship between therapist and client.
4.4. Reflexive Analysis

As counselling psychologists we aim to value the subjective experiences of our clients (Gillon, 2007; Orleans & Van Scoyoc, 2008; Woolfe, 1996). Similarly, approaching the present research from a constructionist standpoint I would also argue that the subjectivity of the researcher is an important part of the research process. I therefore need to acknowledge my own role in the research. Reflexivity forms part of such acknowledgement. Wilkinson (1988) suggests reflexivity to be in its simplest form; “disciplined self-reflection” (p. 493). Reflexivity is increasingly recognised as a mechanism for explaining how the research is conducted, and consequently what claims are drawn (e.g. Altheide & Johnson, 1998; Pillow, 2003). This has come from the wider challenge of the positivist concept that research can be ‘neutral’ (e.g. Parker, 2004). Rather, it is argued that the researcher’s openness adds rather than takes away from the story to be presented; contributing to its quality rather than denigrating it (Parker, 2004; Burman, 1997; Ball, 1990). My aim therefore in this section is to present my own position in relation to the research and the process of the research. It is not possible to include here reflections on every element of the research, but I will outline those that particularly resonated with me and their potential contributions to the present study.

An important part of reflexivity is owning one’s perspective, whilst at the same time being careful not to slip into “a narcissistic recentering of the subjectivity of the researcher” (Burman & Whelan, 2011, p. 9). It has been argued that transparency in relation to the perspective of the researcher contributes to the trustworthiness of research (Morrow, 2005; Parker, 2004; Ball, 1990). Yet there is not one set way of being reflexive (Pillow, 2003). Some have noted diverse reflexive positions, such as the personal and institutional (see Macbeth, 2001). I concur with Wilkinson (1988) in that although both elements will undoubtedly play an important part in the research process, the two are deeply interwoven. I have outlined elements of my personal position in the research section of the methodology (Section 3.4.4.). I will nevertheless reiterate by giving a brief summary here of my background regarding how I am positioned against the research. At the time of writing I am a 30 year old female trainee counselling psychologist. Regarding my personal view of exercise, it is something that I have engaged with on and off since I was a child, although it has not always felt like a positive experience! Nonetheless it is the positives that
prompted my interest in using the topic for the current study. I was interested in whether counselling psychologists ever incorporated exercise into their work and what form this may take, particularly given the ‘quick fix’ in terms of lift in mood that I often noticed myself following exercise. This is a clear example of how my own experiences contributed to the development of the present research. In terms of my own therapeutic experience, at the point that I developed the proposal for the present research, I had done little client work and exercise was not something that had formed part of my practice. However, I have noticed my views on the role of exercise changing as I have gained more client experience. At the beginning of my own client journey I feel that I did have an underlying assumption that it would be helpful for a therapist to introduce exercise into the therapy, though I did not feel confident enough to put this into practice. However as I gained experience and learned about the complexities of therapy, I found that my assumption changed and I became less certain that it should be introduced. This shift actually furthered my interest regarding what I saw as the complexities of incorporating exercise into therapy. I did not make my views explicit to the participants in the study, with the exception of one case where at the end of the interview the participant directly asked me about my motivation for choosing exercise as the focus of the study. However I think it is fair to say that the participants could have easily guessed my passion for the subject due to my selection of the topic alone. In terms of my biases and assumptions I think it is clear that I have a bias towards believing exercise is likely to help individuals. Again, I would argue coming from a constructionist standpoint that either way, these assumptions do not by default make for a better or worse piece of research but rather makes its own individual contribution to the overall process (Wilkinson, 1988).

The importance of reflexivity throughout the research process has been noted (e.g. Parker, 2004). As argued from a constructionist standpoint, each element of the research process comes together to form the ultimate research story. One of the key areas of reflection for me in the present research, was the difficulty that I had in recruiting participants. As detailed in the methodology chapter (Section 3.4.), the study received no or little responses from a variety of advertising avenues, including an advert placed on the BPS Division of Counselling Psychology’s website. Although my email to all the UK counselling psychology doctoral course directors
elicited some enthusiasm and approval for the study, it did not result in any participants. Two of the course directors specifically responded that although they thought the study was a good idea, they did not feel that they would have enough to contribute to an interview in terms of their own experiences of incorporating exercise into therapeutic work. This response in itself could be taken to mean that exercise does not form a large part of their practice. However it is possible that as course directors they do not get the opportunity to engage in much client work given their other responsibilities. Nonetheless, their concern about not having enough material for the interviews was also shared by some of those who did agree to participate. The purpose of the present research was not to establish how many counselling psychologists do incorporate exercise into therapeutic practice. Yet the difficulties that I have described in relation to recruitment cannot help but leave me with the impression that exercise is not something that forms a significant part of many counselling psychologists’ work. The value of including such reflections as part of the analysis is clear here; by virtue of adding to the stories told directly from the participant interviews. Reflections on the process of recruiting participants seem particularly pertinent given one of the themes that I developed from the analysis process; the quietness of exercise as a phenomenon within the field of counselling psychology. Indeed it is possible that my personal difficulties in recruiting participants contributed to my inclusion of this theme in the present study.

As the writer of the present report, and also the one who conducted the interviews and analysis, the intimacy of the researcher’s role in the research process is clear. It is also evident that I contributed of myself to the research process, and therefore the outcomes of the research, as eloquently surmised by Corbin Dwyer and Buckle (2009):

The personhood of the researcher, including her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation (p. 55).

Something that I therefore reflected on within this process was my relationships with the research participants. As a member of the counselling psychology profession myself, I could be classed as an ‘insider’ in relation to the role of the participants (Corbin Dwyer & Buckle, 2009; Morrow, 2005). Morrow (2005) argues that it is
even more important to pay attention to the own position of the researcher in such cases. This can be manifest through awareness of one’s own biases (Asselin, 2003). I have already explored my own views on the use of exercise in therapy above. However, again it seems clear that even within my insider status these views are a dynamic concept, as illustrated by my changing perceptions of exercise as I gained in client experience. This is a phenomenon highlighted by Chaudhry (2000). Yet they may also be illustrative of my status as a trainee counselling psychologist. As someone engaging in a significant learning process it seems likely that my views may be more fluid than a qualified psychologist with many years of therapeutic experience. Regarding its influence on the research, the change in my position may have brought with it an empathetic stance towards the diversity of views that I experienced as part of the interview process. At the same time I may not have been as challenging as other researchers. We know that researchers are often keen to justify their own experiences (e.g. Glesne & Peshkin, 1992). I am not arguing that a more fluid or rigid position is any better or worse than the other, but rather that my changing assumptions have in their own way contributed to the generation of the unique material that makes up the present research. The observation of my changing views is also interesting in terms of its potential mirroring in the participants. Indeed, three of the eight psychologists reported thinking about exercise to an extent that they had not previously done as a result of the research process, as well as feeling that their views were shifting, as illustrated in the quote below:

“it’s interesting cos as you’re asking me these questions I’m actually realising how much in the training these things would be assigned to psychological health but there’s such a big overlap between the physical and the psychological that I think it is hard to formulate because we’re supposedly dealing with mental health and yet so much seems physically manifested” (P7, lines 183-187)

It is possible that my role as an insider resulted in the participants being more open with me in their interviews than they otherwise would have been, due to a perception that I had similar experience in the therapeutic setting (Corbin Dwyer & Buckle, 2009). At the same time the participants may have been less open with me exactly because I was part of the profession and they therefore wished to maintain a certain impression of themselves. It is also possible that this dynamic was exaggerated due
to my status as a trainee. If I had recruited only qualified psychologists the interviews could have been quite different. At the same time I would argue that this would be the case even if different non-qualified individuals had taken part. As I have been arguing throughout this section, the person of the researcher will affect the research but undoubtedly as does that of each individual participant; in this way the two acting as fellow co-creators of meaning (Morrow, 2005).

The relationship between the participants and I - including my status as an insider, is not something that I explicitly raised in the interviews, it is therefore impossible to do more than make assumptions about their dynamics. However the participants did use language that was very therapeutic in nature, which appeared to reference my own status as a colleague in the field - my understanding of their meaning was not questioned. We can see an example of this below:

“I know that you’ve sort of said that exercise has been a part of your therapeutic work.
Sure.
Could you tell me what this has involved?
Yeah. Mainly in terms of prescribing exercise to patients erm in relation to behavioural activation.
Ok.
Most patients who I see will ... Erm If they have a mood related issue, or erm they erm perhaps have anxiety and so on. I might suggest that exercise, or increasing the exercise that they’re doing or indeed doing any at all, could help in their overall psychological erm recovery”.
(P1, lines 22-29).

Beyond this I feel it is not worthwhile speculating further, past acknowledging that either way how the participants perceived my status is likely to have influenced what they shared with me and therefore the course of the interviews, and eventual analysis. Relatively speaking it was not a sensitive research topic, compared to, for example, the potential impact of being an insider when exploring the experiences of bereaved mothers (Talbot, 1998-99). Overall I agree with Corbin Dwyer and Buckle (2009) in their suggestion that whether one is an insider or outsider, the importance lies in conducting the research in a way that is open and honest, and in being faithful
in reporting the research experience as it happened. This draws me back to the ethical way of being I described earlier (Section 3.5.), and again reminds me of many of the principles of good therapeutic practice (e.g. Rogers, 1957).

As well as the impact of my insider status, another area that I reflected upon was the existing relationships I had with some of the participants. I will not disclose more detail than this in order to maintain their anonymity. But it was clear to me that where I had existing relationships with the participants, I felt more comfortable with them in the interview. This potentially influenced the interviews in a number of ways. For example I was less anxious in these cases, and therefore more focused on their content, as opposed to any process issues I was concerned about such as whether the interview was going to last long enough. I also noticed that with participants where I felt particularly comfortable I made more empathetic statements and asked more questions which had the potential to further expand the interview, as illustrated below:

“And what was the attitude by your classmates or your peers on that course in having that sort of module?

...I think to understand it in context... I’ve been thinking about this as well. Culturally, where I trained in the states, in New Jersey, physical fitness is a more...socially..valued way of life.

Oh ok

And...than it is here. So erm...there’s almost a sense that if you’re not interested and engaged in some kind of physical fitness routine that you’re a slob” (P5, lines 275-281).

Asking the additional clarifying question led to the participant revealing more, as well as the fact they had thought about the issue in advance of the interview. I feel that these existing relationships are an extension of my ‘personhood’ as articulated in the statement by Corbin Dwyer and Buckle (2009) above; this example illustrates how elements of my person contributed to the material created through the interviews.

The existing relationships that I held with peers in the counselling psychology field may have also affected whether the participants took part in the study. As discussed
above, some of the counselling psychologists that I approached did not agree to take part because they felt they did not have enough experience of using exercise to draw upon. It is possible that those with whom I had existing relationships found it more difficult to decline taking part when I approached them, even though they had a similar level of experience as the others. Indeed as already noted, some of those who did engage in the research voiced concerns that exercise had not been a major part of their work. Here we see therefore, the potential influence of my existing relationships with participants not just on the content of the interviews, but perhaps even more fundamentally on those who contribute to the research at all.

A final reflection centres on the efforts of one participant’s contribution to the study. As outlined earlier (Section 4.3.3), one of the participants wrote a poem as part of her interview. This was at least partly as a result of my sending the interview schedule to her in advance, at her request. The participant outlined that when she read the schedule, she felt a desire to express her experiences in the form of a poem as a reaction to what she perceived as the philosophical nature of interview questions and a consequent wish to return to the reality of the everyday experience of exercise. I have already discussed the shifting nature of power in the research process (Burman & Whelan, 2011). This episode demonstrates the potential for such shifts. The participant clearly exerted her power, both in her request of the interview schedule before the interview itself, as well as in her choice of expression within the interview - to my appreciation.

In the present section I have reflected upon a number of different elements of the research. I have considered the nature of the insider relationship that I held as a fellow counselling psychologist, as well as the potential implications of having existing relationships with some of the research participants. The aim of such reflection is to be as transparent as possible in terms of presenting the process elements of the research, but also to ensure a comprehensive account of the multiple idiosyncratic elements that make up such a research process, including my own biases and influence.
4.5. Chapter summary

In this chapter I have presented both the results of the analysis that I undertook of the participant interviews and my reflections around that process; the reflexive analysis. First however, I outlined the themes that I developed relating to the two research questions at the heart of the study. The main ways that the participants had incorporated exercise into their work were developed into six themes: ‘exercise between therapy sessions’, ‘reducing exercise as part of therapy’, ‘engaging in exercise within the session’, ‘external referrals for exercise’, ‘contributing to other disciplines’ and ‘influence outside of role as counselling psychologist’. As for the experiences of the participants of using exercises, I also developed six main themes; ‘vehicle for change’, ‘one of many tools’, ‘a quiet voice’, ‘holism’, ‘influence of self’ and ‘collaboration’, The theme of holism contained one subtheme; ‘individuality of meaning’, and that of influence of self held two; ‘directiveness’ and ‘limits of competence’. As we know that the researcher contributes to the research process in the same way as the participants themselves, and in the name of transparency, I also presented via the reflexive analysis my consideration of the research process.
5. Discussion

5.1. Introduction

In the previous chapter I presented the themes developed from the participant interviews via the process of thematic analysis. The purpose of the current chapter; the discussion, is to explore these themes in more detail, situating the research into the existing narrative, as well as draw out its implications for the field as a whole. I will therefore now do that for the present research, which to reiterate aimed to explore counselling psychologists’ experience of using exercise within their therapeutic work. The first part of the discussion is divided up into two main sections: one for each research question, first focusing on the ways in which the participants have incorporated exercise as part of therapy, and then moving onto explore participants’ experiences of using exercise. I will then explore what these findings imply for the field of counselling psychology today before considering the methodological limitations of the research. Finally, I discuss some recommendations for research, theory and practice, before also reflecting on the personal implications of the study.

5.2. Research Question 1: How have counselling psychologists used exercise in their therapeutic work?

5.2.1. Exercise between therapy sessions

The aim of the first research question was to gain an insight into ways in which counselling psychologists have incorporated exercise into their therapeutic work. The analysis revealed that for the most part exercise was used as an intervention in between therapy sessions. We saw this in a variety of forms and from a variety of rationales. Some of the participants described ‘prescribing’ exercise; suggesting to their clients at the beginning of therapy that clients start or increase the amount of exercise that they partake in between sessions. Others said that exercise became part of the work through broader interventions centred on increasing activity, such as activity scheduling. Two of the participants had incorporated exercise in a different way; working with clients to reduce the amount of exercise they were engaged in. In these cases exercise had become part of the client’s eating disorder presentation.
Again along different lines, two of the participants described having used exercise in the therapy sessions themselves. Interestingly, other participants revealed their surprise that this was something that they might be expected to do. Two of the participants said that exercise had been part of their work through an external referral to another professional, with whom the client worked on exercise specifically. Finally, one of the participants had contributed to an exercise session run by another professional, explaining the psychological aspects of activity.

We know that exercise has formed part of mental health interventions for a range of difficulties. It is possible that such interventions incorporated the efforts of counselling psychologists. However the present study represents the first exploration of how exercise has been used within the therapeutic work of counselling psychologists. In order to situate the current research we therefore need to turn to a host of other disciplines. As explored earlier, many of the existing studies were conducted in the US and in the 1980s (e.g. Barrow et al., 1987; Burks & Keeley, 1989). Broadly, these concluded that some practitioners recommended to their clients that they engage in exercise; and that this was done to different extents. The present research mirrors these studies in terms of the fact that exercise forms part of participants’ practice. However, although one study detailed which type of exercise the therapist recommended the clients engage in between sessions (Burks & Keeley, 1989), the existing research did not specify in which way exercise formed part of the therapy, beyond the fact that it was something that they recommended. Hays (1999), broadens the discourse in her discussion of the multitude of ways in which exercise may be included within therapy, however her work is not based on empirical evidence. In the present study we see that some of the participants recommended to their clients that they engage in exercise between therapy sessions, but also that this took a variety of forms, such as part of activity scheduling, or even as part of reducing the exercise that the client engaged in if part of an eating disorder presentation.

In terms of existing UK-based research, as noted earlier we know again that some studies have focused on attitudes towards the use of exercise, however primarily as an adjunct to therapy. Such works implied that it was rare that practitioners, including clinical psychologists, recommended exercise in this way (Daley 2002; Faulkner & Biddle, 2001). The work of Faulkner and Biddle (2001) is amongst the
closest studies to the present research. Here, it was concluded that although the psychologists held positive attitudes towards exercise as a lifestyle activity, they did not generally believe in its value as an adjunct to therapy. In contrast, the participants in the current study seemed flexible in how they perceived the introduction of exercise, rather than seeing it as a particular intervention or adjunct to be applied as a ‘treatment’. Nevertheless, a similarity between this work and the present research was that exercise was considered something that may be encouraged as part of activity scheduling; many of the participants viewed it as part of increasing the amount of general activity that their clients engage in. In terms of therapeutic model, this approach sits most obviously with the behavioural activation component of CBT. Interestingly, in their study, Faulkner and Biddle (2001) described those participants who considered exercise as beneficial in this way as the half of the group who were not “very positive about the potential role exercise could play in the treatment or rehabilitation of clinical mental health conditions”, but rather who saw exercise as a “‘normalizing’ strategy” (p. 437). Again, the current participants appeared to view this intervention as one potential way in which exercise could be incorporated into the therapy.

5.2.2. Engaging in exercise within the session

The fact that two of the counselling psychologists in the present study had used exercise in session as part of their therapy suggests that some of the participants see exercise as a potential therapeutic tool whilst they are with their clients. Other participants had not used exercise as part of their sessions, and interestingly some expressed their surprise that this would be something that they would consider. In-session exercise has not been discussed in the literature specifically in relation to counselling psychologists. However in her book Working it out: Using exercise in psychotherapy, Hays (1999), dedicates a whole chapter to its use as a therapeutic activity. Hays (1999) also notes the paucity of empirical research on the use of exercise in session. Nevertheless, the experiences of Participant 6 in particular seemed to mirror Johnsgard and Johnsgard (1989), in their argument that walking with clients enabled them to become more aware of feelings in the present moment.

For the most part, the participants who discussed incorporating exercise as part of the therapy sessions themselves described what could be defined as physical activity
rather than exercise, such as mindful walking and stretching. This was with the exception of one participant who described engaging in football with their client, in the context of working with children and young people. When looking at how this exploration of in-session work with exercise sits with the writings of Hays (1999), this distinction makes her work feel somewhat irrelevant. Hays (1999) focuses largely on the implications of therapists engaging in more vigorous physical activity with clients, for example the therapist running with the client as part of the therapy. She discusses some of the potential issues relating to engaging in such activity, for example, the implications of the therapist wearing sportswear on the therapy. Nevertheless, the present study has in common the concept of the therapist sharing something of themselves by participating in any sort of activity with the client. Hays (1999), comments that “in sharing an activity with the client, the therapist becomes more known as a person” (p. 66). Hays (1999) also describes how exercising with the client may bring issues of the body and sexuality into the room more than traditional talking therapy. These issues were not mentioned by the participants who described using exercise in session. However Hays’ (1999) argument resonates with what we heard from Participant 7 in her description of clients commenting on the toned nature of her body. Interestingly these comments were not triggered by engaging in exercise, but rather by the participants’ clothes exposing her arms. This shows how the therapists’ own use of exercise came into the therapy room without exercise even being explicitly a part of the therapy. We can easily envisage, therefore, the potential contribution of the therapist self to the work if exercise actually forms part of the session itself. The role of the therapist self will be discussed further below.

5.2.3. Other ways in which exercise formed part of participants’ work

Some of the participants described referring their clients to another professional for a specific exercise intervention. Interestingly Faulkner and Biddle (2002) argued that the existence of other disciplines more focused on physical health could act as a barrier to clinical psychologists using exercise. However again it seems important that the focus was specifically on exercise as an adjunct intervention. As the current study was inclusive of any way in which exercise had become part of the
participants’ practice, we were able to include interventions such as external referrals even if they were not directly conducted themselves. Furthermore, without a specific definition by Faulkner and Biddle (2002) of what they mean by an adjunct intervention, it is hard to comment on whether this would actually involve what I have termed an external referral. In terms of other literatures, interestingly Barrow et al. (1987) specifically argue that the role of psychologists is to “recommend that patients consider initiating exercise programs, not specifically prescribe them” (p. 69). This implies that if it is felt that an exercise routine would be helpful for the clients, they would either design their own exercise programme or go to an external party for assistance, but that the psychologists’ role does not go beyond that in terms of the exercise itself. Most of the current participants voiced similar perspectives regarding what they did not see as appropriate to their role, though we saw a different approach regarding the use of movement in the session in itself for those participants who engaged in this.

Over-exercising has often been discussed in relation to its role as a maintaining factor in clients with eating disorders (e.g. Fairburn, Cooper & Shafran, 2003). An unexpected theme developed from the current research was that some of the participants described working with clients in order to reduce the extent to which they engaged in exercise, in the context of an eating disorder. Working with exercise in this way is not something that has been discussed in previous studies, perhaps because of the negative connotation attached to exercise in this presentation. Specialists in the eating disorder field such as Fairburn have suggested ways in which to work with clients to reduce exercising (Fairburn, 2008; Fairburn et al., 2003), as described by the current participants. However there have been some different approaches such as Beumont et al. (1994) who describe introducing an exercise programme in an inpatient setting, rather than imposing complete inactivity.

Some of the participants described how exercise had been part of their work outside their official capacity of counselling psychologists. One of the participants in particular highlighted how she felt she had used her skills as a psychologist in an informal way in her role as a personal trainer. This suggests that it is not necessarily the case that exercise would be ‘added’ into existing work but rather highlights the potential for exercise to be part of a two-way process, where the participant uses their skills as a psychologist in areas outside their traditional role in areas which may
incorporate exercise. This indirect work is not an aspect that has been discussed in the existing literature. However, again as we will see later, the self of the therapist appeared to play a large part in the participants’ experiences of using exercise within therapy. Therefore it makes sense that when the therapist is taken out of the traditional therapy environment, they are still in some ways bringing their self to whatever situation they are in, and as their therapeutic skills become part of that person it is natural that they may be conveyed in other situations, and especially those which are in some way a helping relationship.

In terms of this first research question, the present study has shown how a number of counselling psychologists have used exercise within therapy, in a number of different ways. Although previous research has explored the extent to which psychologists have recommended exercise to their clients as well as its use as an adjunctive intervention, the present study is unique in its openness to the diversity of ways in which exercise may have formed part of participants’ work. It is also unique in terms of both professional group and in its recruitment of participants selected specifically because they have worked with exercise. The current research therefore clearly adds to what we know about the diversity of ways in which exercise may form part of therapy, in terms of both overall approach and individual techniques. Some of the existing studies on the topic have included a discussion of the proportion of psychologists who incorporate exercise into their practice (e.g. Barrow et al, 1987; Faulkner & Biddle, 2001). It was not a focus of the present research to establish how many counselling psychologists use exercise, however this is an area that could be explored in additional research.

5.3. Research Question 2: Counselling psychologists’ experiences of using exercise

I will now move onto explore the second research question, which focused on counselling psychologists’ experiences of incorporating exercise into their work. Similarly to the context of the previous research question, the present study represents the first insight into this area. Again this means that I will draw upon research from other areas in order to situate the work and discuss its implications.
5.3.1. Vehicle for Change

The participants described a number of ways in which exercise had facilitated change for their clients. The way in which exercise had aided their clients seemed to be a big part of the participants’ own experiences, covering a lot of material in the interviews. The overarching theme was that the psychologists had experienced exercise being a ‘vehicle for change’ for their clients. The vehicle appeared to work via a number of different avenues. The participants talked about the chemical benefits of exercise, which fits in with existing research such as the endorphin hypothesis (Morgan, 1985; Petruzzello et al., 1991; Schwenk, 1995; Thoren et al., 1990). Participants also described the social benefits of exercise, another mechanism for change that is discussed in the literature (e.g. Ransford, 1992). The present theme reflects the diversity of the existing literature surrounding the impact of exercise and its mechanism for change. However, as discussed previously, much of the previous research relates to the function of exercise more widely, and not specifically as part of therapy. The theme also mirrors the research of Faulkner and Biddle (2001), whose participants described both exercise’s chemical and social catalysts for change. As discussed above both the current participants and those of Faulkner and Biddle (2001) described using exercise as part of activity scheduling. This illustrates how exercise can facilitate change, but also highlights the importance of the indirect benefits of exercise; incorporating exercise into the plan of activity was not necessarily about its physical benefits, but rather the wider meaning the clients took from it, for example in their greater confidence with social interaction.

Finally, the theme mirrors a case study from the Gestalt model of therapy (Reynolds, 1996) in which a client with depression engaged in exercise as well as counselling. Reynolds argued that as well as the physical benefits of exercise, it also led to improvements in “cognitive and affective expression” (p. 383). Interestingly Reynolds (1996) also cited a need to be aware of the physical health of the client before suggesting exercise, as well as potentially seeking medical advice first.

5.3.2. Holism

The next theme that I will discuss is ‘holism’. This theme captures the idea that for some participants, exercise was incorporated into their therapeutic work as it formed part of their whole understanding of the client, which was seen as key to the therapy.
This idea echoes Rogers’ concept of organismic experiencing; all that is experienced by the person including sensory and bodily experience (Rogers, 1959). The idea of holism also takes us back to the broad principles of counselling psychology; as not focused only on the ‘ill’, but as noted at the inaugural conference of counselling psychology in 1990 by Emmy van Deurzen-Smith; “an applied area of psychology which has the objective of helping people to live more effective and fulfilled lives” (Nelson-Jones, 1982). Such an objective surely requires a wide understanding of how the person is being in the world, including in their bodily experiences.

The other aspect that made up the theme of holism was the value placed by the counselling psychologists on both mind and body, as well as the links between the two. The issue of mind/body has often been discussed within the research examining the relationship between exercise and mental health, whether it be justifying the case for or explaining its infrequency. Faulkner and Biddle (2001) for example, identified that amongst the barriers to the use of exercise in clinical psychology practice were the view that the body is not an appropriate area for therapy, as well as a lack of practical application of the body and mind connection. In the current research, the participants voiced their belief in the relationship between mind and body, but the extent to which this was put into practice was influenced by a number of factors, as manifest in the other themes. For example, as will be explored further in ‘a quiet voice’, exercise, or even a focus on the body, generally formed a small part of the participants’ work. Nevertheless, if we look to the wider discourse it could be argued that the role of the body in mental health is becoming more prevalent. For example we see the increasing popularity of mindfulness both with practitioners and the general public; a concept which has its origins in bringing mind and body together. Similarly, we observe the introduction of mindfulness into the traditionally cognitively focused CBT, in the form of mindfulness-based CBT, with an accompanying research base (e.g. Baer, 2003; Salmon et al., 2004). Surely such shifts say something about an increasingly wider, holistic approach within mental health, or at least an openness to it. A well known exercise used within mindfulness-based practice is to help clients ‘ground’ themselves by asking them pay attention to how they are sitting, and focus their attention on their breath. Is this placing us back into reality? The body is always with us. Should we pay more attention to its strength, its omnipresence, its
rationality, in order to ultimately better meet our own needs? Perhaps an extreme view of this approach is noted by Feltham (2008), who references Miller’s The Body Never Lies (2006). Miller potentially dismisses the role of genetics in explaining physiological problems in deference to past traumas. I agree with Feltham (2008) that this is taking the perspective too far. Yet Miller does highlight the idea that past abuse remains in the body, a notion that several of the current participants referenced in their rationale for using exercise when clients have experienced trauma.

5.3.2.1. Individuality of meaning

Within the theme of holism, I identified a subtheme of ‘individuality of meaning’; the participants experienced their clients as having very individual concepts of what health or exercise meant to them. It was this personalised concept that then formed the basis of how exercise was used within the therapy. This was illustrated particularly well in the participants’ descriptions of working with clients with eating disorders. In this case, the participants worked with their clients to reduce the amount of exercise that they were engaging in, based on these clients’ ‘unhelpful’ conceptualisation of what exercise meant to them in its contribution to the maintenance of their eating disorder.

In terms of the existing literature, the importance placed on individual meanings of exercise mirrors research conducted on the promotion of physical activity amongst mental health nurses (Faulkner & Biddle, 2002). Here the nurses, based in an acute inpatient setting, although all “extremely positive” (p. 661) about the potential role of exercise, emphasised that when encouraging patients to be active, the ultimate choice to engage in activity lay with their patients. They also identified exercise as a lifestyle choice, rather than part of ‘treatment’. Again we see the importance of the meaning placed on exercise by healthcare providers, as well as their clients, in the role that exercise plays within mental health. Another argument arises around the role of health professionals in encouraging those who they undeniably have influence and power over into a lifestyle which is not the norm for the general population (Faulkner & Biddle, 2002; Messent et al., 2000). The issue is one that will form part of the discussion of ‘directiveness’. Nonetheless the issue of meaning highlights an inherent tension between encouraging exercise as an evidence-based intervention, versus the valuing and importance of client agency (which also has a
considerable evidence base behind it!). It is an issue that is frequently debated within the learning disabilities field (e.g. Messent et al., 2000). The current research extends the discussion to the use of exercise by counselling psychologists. It seems likely that, as with many other areas, effectiveness in managing the two spheres ultimately lies in the skill of the therapist. Considering the use of exercise within therapy therefore highlights much broader issues about how we work with clients therapeutically, including fundamental dilemmas of power.

5.3.3. Influence of self

The current study indicated that the ‘self’ of the therapist was key to participants’ experiences of incorporating exercise into therapy. Their ‘self’ was manifest in a number of ways, for example in the participants’ own position on exercise. For most of the participants their own experiences of exercise influenced their use of exercise with clients. This is consistent with existing research which has shown that US therapists promote exercise in relation to their own exercise habits (e.g. McEntee & Halgin, 1996). In their study, Barrow et al. (1987) examined participants’ own exercise habits, again highlighting this aspect of the practitioner self. However they did not directly examine whether this influenced to what extent they recommended exercise to clients. Interestingly though, the participants did comment on the indirect effect that their own exercise had on their therapeutic work, with more than half stating that they felt their exercise programmes had a positive impact, specifically in terms of their mood, energy levels and mental stamina.

Arguably, another aspect of therapist self is therapeutic orientation. Orientation has been considered in its influence on the role of exercise within therapy. For example, Barrow et al. (1987) found that those of cognitive-behavioural and humanistic backgrounds were more likely to recommend exercise to their clients than those of psycho-analytic or psychodynamic orientation. The consideration the current participants gave to their own influence adds weight to the idea that personal elements of the therapist, such as orientation, are likely to influence the role that exercise plays (or not) in the therapy. The importance placed on the influence of therapist self, naturally flows into the discourse on therapist self-disclosure, of mind and body. As noted earlier, one of the participants emphasised her experiences of clients commenting on her body, and in this way it directly bringing her body into
the therapy. The impact of such disclosure has been subject to debate. One of the more extreme perspectives comes from Mahrer (1997), who believes that such visual cues hamper the therapy, to the extent that he prefers to conduct therapy with both his and his clients’ eyes closed.

Taking the influence of therapist self into the context of the wider counselling literature for me, echoes the broader debate surrounding common factors in therapy; the position that it is elements common to all therapeutic models, rather than their specificities that are most important to therapeutic outcome (e.g. Norcross, 2011). Traditionally efforts have been made to minimise the influence of the individual therapist (Okiishi, Lambert, Nielsen & Ogles, 2003), seemingly with the objective of better exploiting the theoretical effectiveness that can be derived from the theoretical model. However the common factors literatures have highlighted the importance of therapist effects to outcomes. The focus of the current study is not the efficacy of therapy involving exercise, indeed if we follow the common factors standpoint, as a specific therapeutic intervention exercise may make a very small contribution to therapy outcome. However, as we have seen, aspects of the self of the therapist are likely to influence the way in which exercise is used within the therapy, if at all. The diversity of ways in which exercise was incorporated into therapy by the current participants again illustrates this point. We can therefore see how the common factors interact to produce what happens in the therapy, and ultimately, overall outcomes.

5.3.3.1. Directiveness

Within the therapist self, one of the biggest areas which influenced participants’ experiences of exercise within therapy was their directiveness – the more directive meaning the greater the extent to which the therapist lead the therapy. The study revealed that the participants held a range of attitudes towards the introduction of exercise into the therapy. Some were more directive than others, often drawing on its evidence base, as well as their own experiences to justify its introduction. In contrast, others felt that the client should drive whether it should be introduced. Although the existing research highlights differences such as the frequency with which psychologists recommend exercise to their clients (e.g. Barrow et al., 1987),
the present study represents the first time that we have been able to gain a qualitative insight into the decisions of those who do report using exercise, and particularly the variation between individual therapists. Directiveness has not previously been highlighted as a relevant issue. For me, this issue again highlights the tension that practitioners hold, and manage in different ways, between the relational and evidence-based practice (Strawbridge & Woolfe, 2010).

Interestingly, directiveness has been highlighted as one of the inherent dilemmas that exist particularly when working from a pluralistic stance (McAteer, 2010). McAteer challenges the traditional notion of directiveness, arguing that rather “direction and influence form an integral and unavoidable part of the therapeutic process, regardless of the approach” (2010, p. 11). McAteer (2010) illustrates this by describing how in his writing, he wants to make a point to the reader yet at the same time be respectful of their worldview, therefore leaving it to them as to what they take from their reading. This example is perhaps illustrative of a middling directive stance when we consider the participants in the current study, with some more or less directive in terms of their introduction of exercise into therapy. However it certainly seems logical, especially given the discussion on the influence of the self of the therapist above, that some direction cannot be avoided and arguably nor desired. Some of the participants voiced a dilemma in terms of believing in the potential benefits of exercise but at the same time holding a concern that by introducing it themselves they would be taking away from the client’s agenda. McAteer (2010) notes Rescher’s (1993) argument that in pespectival pluralism, that “we can indeed be rational in our choices between standpoints without negating our appreciation of others in the process” (p. 15). However, it is difficult to see what this approach would mean for the participants’ dilemma. It could be argued that an applied version of this principle is manifest in the ‘goals, tasks and methods’ framework for working pluralistically developed by Cooper and McLeod (2011). Certainly the issue of introducing an intervention whilst respecting the client’s agenda seems likely to be reflective of many interventions within therapy. Indeed, one of the participants noted that what she had said in her interview with me could be generalised to other areas of practice. Above we saw clearly the strength and diversity of meanings placed on exercise. It would be interesting to explore whether exercise manifests this tension more than other potential interventions. Certainly, the position of the
individual therapist on this tension with their client seems likely to impact if and how exercise is introduced into the work.

5.3.3.2. Limits of competence

Another key element of the ‘influence of self’, were participants’ beliefs relating to their competence. Many of the participants discussed what they considered limits to their competence when working with exercise. This encapsulated two main elements; a lack of knowledge about incorporating exercise into their work, and an acknowledgement of the limits to their role as psychologists in relation to exercise. The former point reflects Burks and Keeley’s (1989) study, in which the majority of the US-based participants stated that they lacked knowledge about the relationship between mental health and exercise, as well as nutrition. Hays (1999), who advocates the use of exercise with clients also highlights the importance of therapist awareness of their own competencies, and refers to the ethical guidelines of the American Psychological Association (APA). The issue of competence is also discussed by Salmon et al. (2009), in relation to the incorporation of yoga into the mindfulness based stress reduction program (MBSR) (Kabat Zinn et al., 1990). Salmon et al. (2009) argue that therapists using yoga as part of the programme should themselves gain experience of reading about and engaging in yoga, although they argue that requiring them to become formally trained yoga teachers is a step too far. In terms of UK-based counselling psychologists there is no specific guidance regarding knowledge of exercise. The HCPC standards of proficiency for sports and exercise psychologists include a requirement “to understand exercise and physical activity including determinants, e.g. motives, barriers and adherence; and outcomes in relation to mood, self-esteem and cognition” (2010, p.31). This criterion only applies to those within sports and exercise psychology. It therefore appears even clearer how the influence of the therapists’ self, particularly regarding their own knowledge (or not) regarding exercise will contribute to the role that exercise plays within their therapeutic work.

The other aspect to the theme of limits of competence was the participants’ reflection around parameters of their role in relation to exercise. Questions of boundaries in this regard mirrors the writing of Barrow et al. (1987) who make clear their view on the limits to psychologists’ competence: “their proper role is to recommend patients
consider initiating exercise programs, not to specifically prescribe them” (p. 69). This perspective on psychologists’ capacity in relation to exercise echoes the views of some of the current participants, who noted emphatically that they would not suggest a specific exercise routine to their clients. More recently, in their research, Faulkner and Biddle (2002) highlighted the view that exercise was incompatible with the role of clinical psychologists as a potential barrier to the use of exercise for this discipline. The current research is important as it highlighted that all of the participants saw working with exercise as within the parameters of their role. There was variation within the group as to what form of work with exercise they saw as appropriate, but a majority also stated that prescribing a specific exercise routine to a client would go beyond the limits of their role. Some of the existing literature addresses how such role perceptions are developed, with some arguing that the increased differentiation of psychological work means that each profession works within a narrower spectrum (Faulkner & Biddle, 2001). Either way, what is considered appropriate to the role of counselling psychologists clearly has implications for how we work with other professions and raises questions regarding what we view as their parameters. The sub-theme of limits of competence has clear links with the theme that I will discuss next; ‘a quiet voice’.

5.3.4. A quiet voice

As discussed earlier, there were different elements to the ‘quietness’ that the counselling psychologists experienced in relation to working with exercise. We know that in general, exercise is not a frequently used intervention within therapeutic contexts (Faulkner & Biddle, 2001; Feltham 2008, Wahl, 2003). The present research suggests that specifically within counselling psychology it is not a big agenda in the field, and even for the present participants who were recruited because of their experience with exercise, it was not a large part of their work. Furthermore, the impression formed is that for those counselling psychologists who choose to incorporate exercise into their work, it is not something that is worked with from a common base, that they have the opportunity to discuss with colleagues, or to learn more about. For me, this paints somewhat of a lonely and potentially risky picture.
The theme echoes one of the barriers identified as to why clinical psychologists do not value exercise as an adjunct to therapy; a lack of evidence, or a perception of lack of evidence for its benefits (Faulkner & Biddle, 2001). As discussed earlier, we know that the evidence base surrounding the benefits of exercise for psychological wellbeing continues to grow, but that further research is required regarding its therapeutic impact. In the study by Faulkner and Biddle (2001), several of the clinical psychologists suggested that “personal bias” (p. 439) was a greater influence on what interventions were incorporated into therapy than research evidence, which may in itself be fed by perceptions of evidence. This again demonstrates the influence of the self of the therapist as to whether exercise may be considered an appropriate intervention for therapy. We can certainly see the parallels here between the clinical psychologists in this study and the current participants. More recently, the study published in the BMJ (Chalder et al., 2012) certainly brought the issue more into the foreground. However it is possible that the surrounding media headlines may have further pushed exercise off clinicians’ shelves of potential interventions, and into greater quietness. Interestingly though, it was not mentioned by any of the current participants.

5.3.5. One of many tools

Most of the participants in the current study considered exercise as one of many potential therapeutic interventions available to them. Such a stance mirrors the view of Spencer (1990), who whilst promoting exercise as an adjunct to therapy, also notes that exercise should not be seen as a panacea for issues of mental health. The idea that exercise is not a panacea was specifically mentioned by a number of the present participants.

In terms of how this view of exercise fits with previous research studies, we see a similar perspective from some clinical psychologists, who saw exercise as one many potential activities encouraged as part of activity scheduling (Faulkner & Biddle, 2001). On the other hand, we have already seen that Faulkner and Biddle (2001) differentiated these participants from others who valued exercise as a specific adjunct intervention. For me, the fact that exercise was seen as one of many potential tools is linked to the ideas discussed in the ‘vehicle for change’ theme above. It is possible that viewing exercise as beneficial via a number of mechanisms
also makes it interchangeable with other potential therapeutic interventions. It could be argued that this view minimises any unique benefits of exercise. Of course, other factors are likely to be at play, such as the clients’ views on exercise, as discussed in the ‘individuality of meaning’ theme above. At the same time, those participants in Faulkner and Biddle’s (2001) study who advocated exercise as an adjunct strategy appeared to see it as helpful in its own right. Indeed, although I have developed the current theme of ‘one of many tools’, it should be remembered that two of the current participants in particular appeared to see exercise in a similar way, in this case as a default intervention that would be introduced with most clients, rather than as one interchangeable technique.

The theme of ‘one of many tools’ echoes the idea of pluralism, a concept very much aligned to counselling psychology (Cooper & McLeod, 2007). As noted by Rizq (2006), counselling psychology “endorses all the traditional approaches to psychotherapy, each of which are seen as making valuable contributions to our understanding of psychological distress” (p. 614). McAteer (2010) makes the discipline’s relationship to pluralism even more explicit, arguing that it constitutes “the very foundation of a counselling psychology approach to working with clients”, as well as the “realms beyond the consulting room” (p. 5). This mirrors the practice guidance of the Division of Counselling Psychology, which whilst advocating the exploitation of therapeutic models in order to navigate between individual’s experiences, warns “not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing” (Division of Counselling Psychology, 2008, pp. 1-2).

For some of the current participants, exercise represented one of many therapeutic methods that they considered when working with clients. We see here the direct link to the pluralistic concept that there exists multiple ways of producing psychological improvement. Importantly, pluralism also incorporates the idea that different processes may induce this improvement for different individuals at different times (Cooper & McLeod, 2007). This creates space for a huge range of potential mechanisms for change, or methods, as manifest in Cooper and McLeod’s goals, tasks and methods framework (2011). It could be argued that this space give further theoretical basis for counselling psychologists to use exercise as one of these methods. The current study has highlighted that some counselling psychologists are
already using exercise therapeutically. But does the pluralistic framework give us a firmer theoretical basis on which to hinge the intervention? Furthermore, if different methods work for different people, then should we establish in which circumstances they should be used (Cooper & McLeod, 2007)? This raises a new debate as to when it would be more or less helpful to introduce the method at the core of the present study: exercise. It seems that some of the potentially relevant elements to this decision have been discussed by the current participants, such as the meaning placed on exercise by the client, and the skill set of the therapist. Clearly this area could be explored much further. At the same time, in the UK at least there is a move towards the provision of specific models of therapy for specific presenting issues (e.g. Department of Health, 2001). It has been argued that there is increasing pressure for therapists become more homogenous (Strawbridge & Woolfe, 2010). It remains to be seen how much space such a context leaves for responding in a pluralistic way to the needs of individual clients, by incorporating a range of methods within the therapeutic encounter.

5.3.6. Collaboration

Another of the main themes developed from the analysis centred on the way in which the participants experienced using exercise with their clients; collaboratively. It may go without saying that this is the manner in which practitioners work but this approach was clearly something that the current participants wished to emphasise. Certainly, the present research represents the first qualitative insight into the way in which psychologists work with exercise; it is not something that is discussed in the existing literature. We therefore begin to see what dimensions that may be at play when exercise is a feature of therapeutic work.

We have already witnessed the variation in terms of the extent to which participants led the introduction of exercise into therapy. Yet, even amongst the most directive, there was a keen desire for the client to be alongside them in this introduction. Some participants noted that this may develop through a process of negotiation. Again this collaborative approach seemed to reflect the way in which the participants worked with interventions more generally; as reflected by one of the participants in particular who noted that many of her points could equally be applied to other techniques. I have already discussed how exercise was considered by some of the participants as
one of many potential techniques that they could introduce into their practice. However the theme suggests commonalities in the way in which the participants use a myriad of potential interventions. For example, the participants cited collaboration as important due to the potential impact of introducing exercise on the therapeutic relationship. Such points to me reflected a commonality amongst the participants that drew them together despite their diversity. The participants used exercise in very different ways; they were more or less active, more or less directive, yet at the same time demonstrated some of the fundamental principles underlying counselling psychology such as respecting the agency and role of the client (BPS, 2003) and valuing the therapeutic relationship (du Plock, 2006). As discussed above, there is an inherent tension to managing the introduction evidence-based practice versus respecting the agency of the client. However, exploring how the participants incorporate one such intervention - exercise, suggests that participants may be using collaboration as a way of bridging the two elements.

Turning to another aspect of collaboration now, some of the participants described experiences where they felt exercise had had a positive impact on their relationship with the client. Again this side of working with exercise has not been discussed in the existing research. In terms of theoretical works, Hays (1999) warns therapists introducing activity into the relationship to “understand and appreciate the various transference and countertransference implications of that increased involvement” (p. 15). Importantly, Hays (1999) sees the engagement in exercise on a spectrum, with the impact on the therapeutic process more important the more involved the therapist is with the exercise; for the most part her work focuses on situations where the therapist participates in exercise with the client. Hays (1999), introduces the idea that exercising with clients may have different effects on the relationship depending on the gender of both therapist and client. This was not something that was raised by the current participants, however as discussed previously only one of the current participants had engaged in what would be officially defined as exercise with a client as part of the sessions themselves. The work was also with a child client; one can assume that for two adults engaging in exercise together the impact relationally may be quite different. For those psychologists at the other end of the spectrum, whose engagement is based more around recommending exercise as something the clients
engage in between sessions, we know even less about the wider implications for the therapeutic relationship.

5.4. Implications for counselling psychology

In the following section I will discuss what the themes developed in the current study suggest about the field of counselling psychology today. Looking at the research as a whole picture, what story do we see? The research suggested that counselling psychologists incorporate exercise into their work in a range of different ways, including both within and between therapy sessions. It appears that exercise is often seen as one of many potential methods or techniques that could be incorporated into their practice. Exercise means different things to different clients. Counselling psychologists experience exercise as being something that is a vehicle for change for their clients. The use of exercise is influenced by the selves of the therapists themselves, including their directiveness and perceived competence. The participants saw exercise as a quiet voice within the wider field. They had experienced using exercise collaboratively with their clients. They saw exercise as something which represented an understanding of the whole person of the client, which brought mind and body together, and which held a personal meaning to each individual. So what does this mean for counselling psychology?

Surely it must raise questions for the role of counselling psychologists in relation to the physical health of the person. It cannot be without note that counselling psychologists, as well as other applied psychologists have in the last couple of years moved to be regulated by the Health and Care Professions Council as opposed to the British Psychological Society. As observed in the literature review, we know that counselling psychologists can be identified by a particular emphasis on the whole of the person, as well as a preventative approach to mental health. Yet how often is this played out in practice? Bedi et al. (2011) argue that for Canadian counselling psychologists at least, in reality areas such as prevention may be becoming less of a focus. We do not know whether this is also the case for UK-based counselling psychologists. The current study, together with previous research, certainly suggests
that exercise, arguably one mechanism for preventative work, does not have a significant presence in the field. This leads naturally onto the question of should it do? Importantly, the present research also suggested that exercise was one of a number of techniques that counselling psychologists considered within their therapeutic work. I noted in the introductory chapter the variation in terms of individuals’ backgrounds within the discipline. However the present research suggests that this also stretches to the way in which interventions are used within therapy. Huge diversity was demonstrated, even within the relatively small number of participants who also had in common their identification of having used exercise as part of the therapeutic work. This is despite the movement towards increasingly evidence-based, and therefore potentially homogenous, psychological services. One of the participants explicitly noted the diversity of practice within the discipline, and argued this should be celebrated. For me this echoes the pluralistic roots of counselling psychology.

In terms of the space that this leaves for the use of exercise within counselling psychologists’ practice, perhaps we can look to the ideas of Cooper and McLeod (2007) in their argument that pluralism does not mean to say that “anything goes” (p. 139), but rather that different interventions are appropriate for different individuals at different times. I would therefore argue that we need a clearer rationale for where exercise may be helpful as part of therapeutic work, and for whom. This will require further, specific research. However the current study has shown us that exercise is something that some counselling psychologists are using as part of their practice, and therefore experiencing as part of their therapeutic careers. And if that is the case then let us be open about that and make further inquiries as to how this is done and how this may best be done. As mentioned by some of the current participants, it seems more could be done to exploit the knowledge of our fellow professionals and indeed, to share that of our specialism. This is not a new argument, and one that extends much broader than exercise. But if we can at least raise awareness of the fact that that exercise is something that counselling psychologists can consider in their work, perhaps this would open up the doors to more collaboration at least in this area.

The present research also raises the issue of evidence-based practice within counselling psychology. The identity of the counselling psychologist is underpinned
by alliance to both the reflexive and the scientist-practitioner (Martin, 2010). Goldstein (2010), notes that “the advent of the National Institute for Clinical Excellence (NICE) implies that all providers of treatments, whether psychological, surgical or pharmacological, must practise in the light of scientific evidence” (p. 673). Together with requirements for continuing personal development (CPD), Goldstein argues that these terms do not carry as much meaning as may first appear. Certainly, on the side of the scientist-practitioner psychologists are increasingly required to justify their work according to accepted evidence, which has been argued leads to the ‘McDonaldization’ (Ritzer, 1993) of the human encounter via prescribed therapeutic models (Strawbridge & Woolfe, 2010). This is exemplified most recently in the UK by the growing dominance of CBT (Strawbridge & Woolfe, 2010). Exercise does not explicitly form part of many mainstream therapeutic models. This raises a host of questions as I have implied above, but perhaps a key one is the extent to which practitioners are working to such singular models. If this is the case, then where is the room for physical or health elements such as the body, and consequently exercise? So far I have only talked about more purely therapeutic work. In other, less structured roles, it is possible that exercise could be more easily incorporated, though this moves us away from the focus of the current research question.

Many of the participants pointed to evidence which suggests that engaging in exercise has positive implications for mental health. But the present research implies that the desire to introduce exercise into therapeutic work was tempered by the desire to place the client at the centre of the therapy; following the humanistic principles that most counselling psychologists would agree underpin the identity of the discipline. How do we balance these two elements? And is it always the case that this is an either/or situation? It is clear that this dilemma is not just applicable to exercise, but the present research illustrates one example of its reality in therapeutic practice. The external context of UK-based counselling psychologists makes the dilemma particularly pertinent. As noted above, especially for those counselling psychologists working in the NHS, there is an increasing push towards the use of evidence-based therapies for particular disorders, as designated by NICE. Does this also mean that if an intervention has been found to be effective it is introduced into the therapy? Some of the participants were emphatic in their argument that they
would not incorporate exercise unless it was something that the client had initiated. This exact dilemma is introduced as early as page 5 of the *Handbook of Counselling Psychology* (Strawbridge & Woolfe, 2010); described in terms of the tension between “‘being-in-relation’ and ‘technical expertise’”. It seems clear that such dilemmas are also likely to apply to other professionals engaging in therapeutic practice, such as counsellors and psychotherapists. Indeed it has been argued that counselling psychology in theory nor practice is as distinct from counselling as it makes out (Feltham, 2013). Certainly it seems that the quietness in the use exercise in client work remains another thing in common.

How about if we turn outside of the UK? In the US, the common factors movement has a more dominant voice (Wampold, 2001; Luborsky et al., 2002; Lambert, 2004). At first sight this might provide an argument against using exercise, which certainly could be considered one of the ‘specific’ ingredients. However as the common factors literature has moved on, it has moved away from the idea of separate ingredients, but rather towards their interaction as what becomes important for therapeutic effectiveness (Castonguay & Beutler, 2006). This for me mirrors the current research in highlighting areas such as the importance of the self of the therapist in their experiences of incorporating exercise therapeutically, as well as in their collaborative approach, something that was a clear theme of the participant interviews. It also reflects the push more recently to not just move away from the either or debate in terms of which therapeutic model is best, but also to move away from such either or questions in terms of whether one is of the school of specific ingredients or common factors (Castonguay & Beutler, 2006; Cooper and McLeod 2007). Increasingly, it seems that genuine interactions between such elements are what are important. It is clear that more research needs to be done before the role of exercise as can be counted as ‘technical expertise’. However the present study implies that this dilemma is a dominant part of counselling psychologists’ experiences when considering incorporating exercise into their therapeutic work, and seemingly already potentially a barrier. Within this debate, if we are going to take exercise as an intervention forward, then we first need to recognise its potential as a part of the therapeutic encounter.
5.5. Methodological discussion

Before going onto explore the wider implications of the study for counselling psychology, I will, in the present section, engage in a discussion of its methodological limitations.

5.5.1. Participants

Firstly, with regards to the participants who took part in the study, as noted earlier for most of them exercise had not formed a large part of their therapeutic work. The first of the study research questions focused on exploring the different ways in which counselling psychologists had incorporated exercise into practice. The fact that the participants had not used exercise to a great extent will therefore potentially have limited the number of ways that I was able to explore in the research. Furthermore, for the second research question, this factor will to some extent have limited the experiences of using exercise that the participants could draw upon. The quietness reflected in the work is likely to be mirroring the lack of specific training and potentially expertise, that the participants had in working with exercise therapeutically, something that was explicitly mentioned by some of the participants. At the same time, it should be noted that some did reflect on training that they had had which they used in their therapeutic work. This will also have influenced the research.

As could be seen in the table detailing participants’ demographic information, the participants were from a narrow demographic range. However there was a range of training orientations, though it was clear that CBT was one of the most used model backgrounds. This would appear to make sense in terms of CBT’s focus on behavioural principles such as using activity – which could be exercise – in order to prompt improvement in mood for example. The purpose of the study was not to explore the experiences of those from all the different training orientations, however a fuller picture of the backgrounds that the participants come from does add to the understanding of where the participants were likely to be coming from in terms of their therapeutic work, it ‘constructs’ a fuller picture of their likely influenes and values.
Linked to this is also the probability that those who have had a negative experience of working with exercise in therapy would have been unlikely to volunteer for the study. Even within those who did volunteer, it is possible that the participants would have been unlikely to have shared any negative experiences of working with exercise as part of their interviews, due to their perception of what I desired from the interview. These type of dynamics, I would argue, certainly will have shaped the interviews, and consequent analysis. However, as indicated in the constructionist stance, I would argue that this is not necessarily a negative point, but rather is a reflection of the particular research that was undertook with the present researcher and the particular participant.

However as discussed in the reflexive analysis, the difficulties I had recruiting participants and the concerns that some participants expressed about not having much to say about exercise, are indicative in themselves of what the research was trying to achieve; that is to examine how exercise is experienced by those in the profession. These elements add to and builds on the overall ‘quietness’ of the areas, one of the themes within the research, which as has been explored raises much broader questions around how issues such as the body are incorporated into the work of counselling psychologists. In this way it appears the study has been able to meet what Burman and Whelan (2003) describe as the “art” of good qualitative research (p. 7); that is a question sufficient to be explored in depth, whilst connecting to deeper questions for the field.

Finally, the present study focused on the experiences of those counselling psychologists who have used exercise as a part of their client work. This reflected the research questions of wanting to explore what it was like for those counselling psychologists where exercise did feature as part of the therapy. However it is again likely that the research would have been quite different if it had also included the attitudes towards exercise of those who did not incorporate exercise into their work.

### 5.5.2. Existing relationships

As discussed in the reflexive analysis, I had existing relationships with some of the participants in the study. However, the research was not something that I had discussed with them before I asked if them if they wished to take part. Linked to the idea that I had existing relationships with some of the participants is my position as a
trainee counselling psychologist. Given the topic of exploring counselling psychologists’ experiences this means that I was an ‘insider’ as well as the researcher in relation to the research process (Morrow, 2005). Earlier I discussed this position in terms of my personal reflections, however it is also important to note from a methodological perspective due to its undoubted influence on the content of the interviews. One of the ways in which this was manifest was through the language used by the participants; they used terms that were very specific to the counselling field. Further to my insider role as a trainee counselling psychologist, the participants may have considered me as part of an in-group in terms of someone who also uses exercise in their therapeutic work, or at least believes in its value. This is not something that I checked out with the participants; however again such a dynamic is likely to have contributed to the shape of the interviews. At the same time, participant perceptions of me as an insider may not have been as influential as in research exploring more sensitive topics (e.g. Talbot, 1998-1999). Corbin Dwyer and Buckle (2009) argue that an insider role held by the researcher means that participants tend to be more open, and that therefore the data generated is from a more genuine position. However it is possible also, that an insider role can mean the research is detrimentally subjective (Adler & Adler, 1987). Corbin Dwyer and Buckle (2009) also point out that an assumed familiarity on the part of the participant regarding what they are sharing can lead to them not fully explaining their meaning.

5.5.3. Interviews

I will now discuss the form of interviews undertaken in the study. As noted by McLeod (2003), interviews are informed to a large extent by the person of the interviewer. The quality of the data generated in the interview is therefore influenced by the relationship that is formed between the interviewer and interviewee (Polkinghorne, 2005), including the level of rapport and trust (McLeod, 2003). I have already spoken in the reflexive analysis about some of the elements that I felt differentiated the interviews in the present study, including their quality. However, as ultimately McLeod (1996) is pointing to, there will always be some differences where there is such human involvement. Importantly, two of the interviews in the present study were conducted over the phone rather than face to face. This is likely to have influenced the dynamic of these particular interviews. Nevertheless, as I noted previously counselling psychology has at its heart the
relationship built with the client. I would therefore hope that my skills as a trainee counselling psychologist regularly engaging in therapeutic work, will have allowed me to have attained a positive relationship with the participant, in which trust was able to form, in both the face to face and telephone interviews.

5.5.4. Physical activity versus exercise

Another methodological issue which is likely to have influenced the research was the terms used throughout the process. As noted in Section 2.3 above, exercise is a specific subcategory of physical activity, however there is considerable overlap between them. In the present study I did not give the participants a definition of exercise, for example, defining what I meant by exercise at the start of the interviews, or differentiating exercise from the broader category of physical activity. This left the participants to explore what they themselves considered exercise. Perhaps inevitably therefore, at times some of the participants discussed what would be technically defined as physical activity rather than exercise. However, leaving the topic open gave the participants the opportunity to bring in anything that they considered to be relevant to the research according to their own beliefs and experiences.

5.5.5. Summary

In the present section I have discussed several methodological issues relating to the study; focusing in turn on the participants that took part in the study, the existing relationships that I held with some of the participants, the form of the interviews, and the potential implications of the distinction between exercise and physical activity. The limitations of the current study lead naturally onto ideas for future research. I explore this in the section below.

5.6. Recommendations

It is standard practice that recommendations form part of such a research project. A number of recommendations can be derived from the current study. As exercise has received so little attention in the fields of counselling psychology, counselling, and clinical psychology, before thinking about recommendations for practice it appears that the primary area for future development needs to be research; strengthening our understanding of the role of exercise within therapeutic work particularly. As I have
discussed above, the pluralistic framework represents one way of incorporating exercise into therapeutic work, by bridging the either/or traditions of common factors versus the medical model specific ingredients. However such an approach does require, as does the counselling psychologists’ identity as scientist practitioners, to feel confident in the evidence base around the incorporation of exercise into therapy, in a way that respects the different needs of different individuals at different times and which also acknowledges its interaction with elements relating to the self of the therapist, amongst other factors. Specifically I would suggest that further research required includes studies centring on the impact of using exercise within therapy. As suggested by the first research question in the present study, incorporating exercise can take a variety of different forms, including both between and within therapy sessions, and this should be reflected in the research. It should also include both quantitative and qualitative client experiences. At the same time, if possible, I would suggest that further research is conducted in collaboration with sister disciplines such as health, sports and exercise psychology. As mentioned earlier it will also be important to have an understanding of the wider attitudes of counselling psychologists towards the use of exercise in therapy. Such research will then be able to inform future practice. At the same time, additional research exploring the perspective of counselling psychologists more generally; and particularly those who are not recruited on the basis of their using exercise would be valuable, and facilitate a more global insight into how counselling psychologists see the role of exercise in therapy.

In terms of theoretical recommendations, it again appears that this will be dependent on the results of further research in the area. However I would suggest that there needs to be a theoretical openness towards the use of exercise within therapy, as well as the role of the body more generally; for example by seeing exercise as one potential method that may benefit some clients. The present research illustrated the importance of how the therapist experiences their own competence in introducing such interventions. I would therefore recommend that physical health and its relationship to psychological wellbeing, including elements such as exercise, be incorporated into counselling psychology doctoral training programmes with access post qualification via continuing personal development (CPD) units. I would recommend that this is done in collaboration with professionals from health, sports
and exercise psychology in order to exploit their expertise, as well as further their understanding of what counselling psychology can contribute in this area. I would also recommend that further work is considered regarding how beyond teaching, the disciplines can work together to move forward in developing a holistic way of working with individuals, which may incorporate exercise.

5.7. Personal Reflections

Above I highlighted a number of recommendations for the wider field, but how about the implications of the current research on my own therapeutic practice? Although I remain very open to exercise becoming part of the work, I do not believe that I incorporate exercise more frequently than prior to commencing the research. I feel this is because of own concerns around lack of training, as well as the dilemma voiced by many of the participants in the study around wishing to respect the clients’ own agenda and agency. Nevertheless I think that conducting the current study has raised my awareness of the role of the body within therapeutic practice, and particularly my attitudes towards it. I have reflected in particular about a role play that I took part in before I did the participant interviews. I was ‘playing’ the therapist and at one point my ‘client’ stood up, voicing that he wished to get out of his chair and move around. Yet I stayed in my chair feeling rather uncomfortable, but unsure as to why and did not join the client in his standing or movement. Pretty quickly, the client sat back down. Doing the present research has changed my view of this episode. It highlighted to me that perhaps the cause of my discomfort was the client bringing in more of a physical element, in both changing his physical stance and suggesting that he would like movement to be part of our encounter. Having done the study I cannot say that I would do any differently in a similar context, I feel quite sure I would still feel some discomfort. However I may feel more confident in naming what was going on in that particular moment, and I hope that this would be helpful for both the therapy and therapeutic relationship. In this way I do feel that the current research has moved my own therapeutic practice forward.

5.8. Chapter summary

In this final chapter I have aimed to deepen and consolidate the analysis developed in the research, as well as to situate it against the existing literature. I started by focusing on the first research question, reflecting on the ways in which the
participants had incorporated exercise into their work. Although most of the participants emphasised that exercise had not made up a large part of their work, a clear range of forms in which it had been part of the therapy was still evident. These included the negotiation of the client engaging in exercise in between therapy sessions, as well as within the therapy sessions themselves. I also discussed a range of other ways in which exercise had come into the work, such as through working with professionals from other disciplines, and even where participants had used their skills in working with exercise outside their formal capacity as counselling psychologists. I then went onto discuss the second research question; focusing on the participants’ experiences of working with exercise. I developed six main themes from the analysis, and reflected on these in turn, looking in particular at how these experiences compared to the little research that had previously been conducted.

I drew the research together by looking at the implications of the study for the wider field. I discussed how the research had highlighted that the physical health of the person, although theoretically a key part of the identity of counselling psychologists, may not form part of actual practice, including the body more generally. I highlighted the potential role of exercise as a way of bringing such a philosophy to life. At the same time I considered the diversity within the participants’ practice and reflected on the pluralistic framework (Cooper & McLeod, 2007) as a way of incorporating exercise as one of the potential interventions available as part of therapy, yet at the same time acknowledging differences within both clients and practitioners. Looking at exercise within this frame, it becomes clear that a clearer rationale is needed for when it may be useful for individuals as part of therapy. I highlighted the wider context of counselling psychologists; of the movement increasingly towards evidence-based practice, and questioned whether using research evidence with this level of prescription leaves space for individuality of practice and therefore potentially exercise. It also became clear that by sharing their experiences of incorporating exercise, the participants had highlighted an example of the inherent tension that seems to exist between working from a sound evidence base, yet respecting the agency of the client. I then took the issue wider to how the participants’ experiences also seemed to reflect an interaction of both ‘specific’ and ‘common’ ingredients. However I noted that the first step in furthering the role of exercise will be to recognise its potential contribution to therapeutic work.
Following these arguments I moved onto explore the methodological issues relating to the current study. Next I outlined some recommendations that I developed as a result of the research, before finally taking time to reflect on the impact of the research on my own attitudes and practice as a trainee counselling psychologist.
References


Green R.M. (1951) *A Translation of Galen’s Hygiene (de Sanitate Tuenda)*. Charles C Thomas Publisher, Springfield, IL.


Shumaker, E.B. Schron, J.K. Ockene, & W. L. McBee (Eds.), *The Handbook of Health Behavior Change* (pp.189-212). New York: Springer.


McLeod, J. (2001). Developing a research tradition consistent with the practices and values of counselling and psychotherapy: Why Counselling and Psychotherapy Research is necessary. *Counselling and Psychotherapy Research, 1*(1), 3-11.


Appendix A

Research Advert placed on DCoP website

Are you a qualified counselling psychologist?

Has exercise ever formed part of your therapeutic work?

My name is Ruth Gordon and I am a trainee counselling psychologist conducting research into the role of exercise within counselling psychology practice. It is well established that exercise has great physical and psychological benefits. Yet we know very little about how exercise may come into the work of counselling psychologists and indeed how it fits with our philosophical identity. The aim of this study is therefore to explore counselling psychologists’ experiences of the use of exercise within their therapeutic work. If you are a qualified counselling psychologist for whom exercise has formed part of your therapeutic work in any way, I would be grateful for your participation in this research.

Participants in the study will complete an interview with the researcher lasting 45-60 minutes, at a place and time convenient to you. The interviews will be audio recorded; all data will be treated confidentially and in accordance with BPS guidelines.

The research forms part of my doctoral research at the University of Manchester and has full ethical approval. The study will be supervised by Dr Terry Hanley (Terry.Hanley@manchester.ac.uk).

If you would like to participate please contact me on ruthgordon879@hotmail.com. Feel free to contact me too if you have any further questions.
Appendix B

Study Information Sheet

Counselling Psychologists’ Experiences of Using Exercise Within Therapy

Information Sheet

You are being invited to take part in a research study as part of a counselling psychology doctoral thesis. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully and feel free to ask any questions you may have. Take your time to decide whether or not you wish to take part. Thank you.

What is the aim of the research?

Exercise is well known to be beneficial for both physical and psychological health. In recent years exercise has been used more frequently as an intervention for mental health. However little is known about the counselling psychologists’ experiences of incorporating exercise into their therapeutic work. The aim of the research is to plug this gap and gather a greater understanding of how counselling psychologists have used exercise as part of their client work, and their experience of doing so.

Why have I been chosen?

You have been asked to take part because you are a UK-based counselling psychologist who has reported previously using exercise as part of their therapeutic practice.

What would I be asked to do if I took part?

If you agree to take part, you will be asked to take part in a face to face or telephone interview which will last between 45 minutes and an hour. The interview will be audio recorded. Within this interview you will be asked about your views on the use of exercise in counselling psychology, both in relation to the profession as a whole and in your own practice.

What happens to the data collected?

The audio recording of the interview will be deleted after transcription and the electronic document containing the transcription will be kept in a password protected file. Any paper copies will be kept in locked storage. Only the researcher will have access to the transcribed interview. Some quotes may be used in the write-up of the
research, but these will be in no way identifiable: where there is uncertainty, the researcher will check this with you. After transcription you will be sent a copy of the document for you to check over, as well as the themes generated.

**How is confidentiality maintained?**

All efforts will be made to ensure that confidentiality is maintained. As mentioned above, the electronic data will be kept in password protected files and there will be no identifiable information contained within the write-up of the report. Any hard copies of the transcript will be kept in locked storage. You will be referred to by a pseudonym in any written reports and any quotes used will be non-identifiable. These safeguards are in compliance with the University of Manchester regulations on data protection.

**What happens if I do not want to take part or change my mind?**

Participation in this research is voluntary. You will have two weeks with this information sheet before you will be asked if you would like to consent to take part in the study. If you have any questions during this time do not hesitate to contact the researcher. If you do agree to take part there will be a number of points where you will have the opportunity to change your mind if you wish. If you sign the consent form but then change your mind at any point in the interview being recorded you can withdraw from the research. Finally, you can change your mind and withdraw from the research after reading both the transcript and a cursory analysis of the data, if you choose to see this.

**What is the duration of the research?**

The interview will last between 45 minutes and an hour, with additional time commitments of checking the interview transcript and themes generated if you choose to see these.

**Where will the research be conducted?**

The interview will be conducted at a mutually agreed location or over the phone, depending on the location of the participant.

**Will the outcomes of the study be published?**

The outcomes of the study will form part of a University thesis, and there may be further publications in academic journals. As detailed above, in these publications there will be no identifiable information written about you.

**Contact for further information**

*Researcher:*

Ruth Gordon, Trainee Counselling Psychologist at the University of Manchester
Email: ruthgordon879@hotmail.com / Phone: 07913 154143

**Supervisor:**

Terry Hanley, Joint Programme Director of the Doctorate in Counselling Psychology at the University of Manchester

Email: terry.hanley@manchester.ac.uk / Phone: 0161 2758815
Appendix C

Text of email sent out to branch member of the North West DCoP

Hi all, I'm one of the trainee counselling psychologists at the University of Manchester. For my thesis I am researching counselling psychologists' experiences of using exercise within therapy. If you are a qualified counselling psychologist for whom exercise has formed part of your therapeutic work in any way, I would be really grateful for your participation in my study. It would involve taking part in an interview with me of around 45 minutes, either over the phone or face to face.

The research has full ethical approval and will be supervised by Dr Terry Hanley (Terry.Hanley@manchester.ac.uk). Further information can be found in the study information sheet which is attached to this email. If you have any additional questions or would like to participate in the research please contact me on ruthgordon879@hotmail.com.
Appendix D

Email sent to editors of e-letter

Hi there,

I am one of the trainees on the counselling psychology doctorate at the University of Manchester. Joanna Orlimsky of the North West branch gave me your details as I am currently looking for research participants for my thesis; I am researching counselling psychologists' experiences of using exercise within therapy. I am therefore looking for counselling psychologists to do a face to face or telephone interview with me on this topic. Would you be able to send out my research advert in your next newsletter?

If so, I have written some introductory text and also attached the information sheet for the study:

Hi all, I'm one of the trainee counselling psychologists at the University of Manchester. For my thesis I am researching counselling psychologists' experiences of using exercise within therapy. If you are a qualified counselling psychologist for whom exercise has formed part of your therapeutic work in any way, I would be really grateful for your participation in my study. It would involve taking part in an interview with me of around 45 minutes, either over the phone or face to face.

The research has full ethical approval and will be supervised by Dr Terry Hanley (Terry.Hanley@manchester.ac.uk). Further information can be found in the study information sheet which is attached to this email. If you have any additional questions or would like to participate in the research please contact me on ruthgordon879@hotmail.com.

Many thanks,

Ruth Gordon
Appendix E

Email sent to doctoral course leaders

Dear Course Leaders,

My name is Ruth and I am one of the second year trainees on the counselling psychology doctorate at the University of Manchester.

I'm at the stage in my thesis where I am looking for research participants. My research question is looking at counselling psychologists' experiences of using exercise as part of their therapeutic work. The reason for my email is to see if exercise has ever been part of your client work, and if so, whether you would like to take part in the study?

Participating would involve taking part in an interview with me of around 45 minutes. This could be over the phone or face to face. I have attached the information sheet for the study to this email to give you some further information.

If personally you don't wish to participate I would still really appreciate it if you could pass this email on or let me know the details of other counselling psychologists you think may be interested in this topic.

Many thanks,
Ruth Gordon
Appendix F

Interview Schedule

• To get started, could you tell me how you would describe your modality of working?

• Has exercise ever been part of your own therapeutic work with clients?
  • If so, what has this involved?
  • Could you give an example of where exercise has formed part of your work with a client?
  • What was the impact for the client?
  • What was your experience of incorporating exercise into your therapeutic practice?
  • What do you feel are potential barriers to using exercise in work with clients?
  • How do you feel about the use of exercise within the counselling psychology profession as a whole?
  • How do you see exercise as fitting in with the philosophy of counselling psychology?
### Consent Form

If you are happy to participate please complete and sign the consent form below

<table>
<thead>
<tr>
<th></th>
<th>Please Initial Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information, ask any questions and have had these questions answered satisfactorily</td>
</tr>
<tr>
<td>2.</td>
<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason</td>
</tr>
<tr>
<td>3.</td>
<td>I understand that the interviews will be audio recorded and transcribed</td>
</tr>
<tr>
<td>4.</td>
<td>I agree to the use of anonymous quotes in any write-up</td>
</tr>
<tr>
<td>5.</td>
<td>I agree that any data collected may be published in anonymous form in academic books or journals</td>
</tr>
</tbody>
</table>

I agree to take part in the above project:

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix H

Study Debriefing Sheet

Counselling Psychologists’ Experiences of Using Exercise Within Therapy

Participant debriefing document

Thank you very much for participating in this research study, which aims to explore counselling psychologists’ experiences of using exercise within therapy.

It is not anticipated that taking part in the study will have caused you any physical or psychological discomfort or distress. However if you do experience any discomfort or distress as a result of your participation in this interview, you might consider seeking further support or information from an appropriate source.

Possible sources of support might include:

- British Association of Counselling & Psychotherapy (www.bacp.org.uk)
- The British Psychological Society (www.bps.org.uk/psychology-public/find-psychologist/find-psychologist)

If you have any questions, comments or concerns about any aspect of the interview data, please don’t hesitate to let the researcher know. You can contact me either by email (ruthgordon879@hotmail.com) or by phone (07913154143). A copy of the transcript will be emailed to you following the interview.

If you would like to withdraw from the study, you are entirely free to do so without consequence. If you would like your data to be destroyed during the withdrawal process, please confirm this with the researcher at the point you withdraw from the project.

If you would like to make a complaint about any aspect of this study, or its procedure, please contact in the first instance the research supervisor overseeing this study, Dr Terry Hanley at the University of Manchester. Terry can be reached on terry.hanley@manchester.ac.uk.

Thank you again for participating in the study!
Appendix I

Sample Interview Transcript (Participant 1)

Ok so here we go
Right
so to start us off I wondered if you could tell me a bit about how you would describe
how you work in terms of modality?
Errm in terms of brand name you’re thinking?
Er yeah.. models of therapy
Brands: Systemic, narrative, cognitive-behavioural,
Yep
Time limited
Ok. Cognitive behavioural and time-limited.
Yeah?
Ok. How many sessions does it tend to be?
Erm anything from 1 to 20. But I mean I’ve seen some people for 15 years so
Ahh
erm I don’t really do a very specific one. Obviously I do it just to help someone
overcome their problem.
Sure ok thank you. Erm so the main part of the interview is about the role of
exercise within therapy.
Sure
So I’ll start to ask you some questions about that now.
Sure ok
I know that you’ve sort of said that exercise has been a part of your therapeutic
work.
Sure.
Could you tell me what this has involved?
Yeah. Mainly in terms of prescribing exercise to patients erm in relation to
behavioural activation.
Ok.
Most patients who I see will … Erm If they have a mood related issue, or erm they
erm perhaps have anxiety and so on. I might suggest that exercise, or increasing the
exercise that they’re doing or indeed doing any at all, could help in their overall psychological recovery.

Ok

It may also be part of their rehabilitation. I see some patients who have medical problems and, for a variety of reasons. Might be an important part of their I suppose prescribed medical prescribed….rehab from the doctor. Obviously I’m not going to tell them to do things or suggest that they do things that would put them in any jeopardy at all.

No.

But err importantly, just mainly really for the therapeutic value of the therapy, so to speak.

Ok, ok

Yah?

So it tends to be part of the behavioural activation type of intervention?

Exactly, yes.

Ok. Erm.. And would that, would you generally have talked about exercise or the client have talked about exercise already, erm in your work, or would that be..?

Not necessarily no. I might the person who initiates that conversation.

Ok

So you know I might be talking about the cognitive effects of whatever is going on but it might be my introduction to them saying well you know you’ve got some thoughts here..and that is There is evidence that exercise could actually further improve the experience that you’re going through or help them to settle more quickly etc. So

Ok

Yeah?

Ok, ok

No typically patients wouldn’t raise it themselves.

No, ok.

Yah?

And when you’re talking about the evidence for it.

Yep
What kind of sort of what kind of effects do you describe in your sell of exercise, if you like.

Sure. It depends obviously on what their problem would be.

Mmm

It might be along the lines of. That it would..At a chemical level might help to release endorphins which may lift mood, improve a sense of wellbeing.

Yep

Erm.. It could be erm also in relation to suppressing the release of cortisol which we associate with stress. Obviously general wellbeing because if someone has been immobilised due to health issues it may be of benefit. Mainly along those lines.

Ok

I might describe some of the chemical benefits. And also err.. general medical ones. But I might also link it a bit to erm… the idea of what they may do with somebody else. And that is that you know exercise taken on its own may be also be something that, may be a consideration. Maybe they want to do it with someone in which case you know that produces a new aspect of it.

Yeah?

Ok, ok

How has it it tend to have?.. What’s the response generally been from the client? Have they? Have they? Do they usually take you up on your suggestion? How does it work out?

Yes they do actually, surprisingly!

(Both laugh)

It tends to be obviously. I think because the way I describe it is something that is doable and achievable. I mean I certainly don’t say to people I think you should now train for the marathon.

No

It tends to be you know moderated. Erm and the erm..The kind of ideas would be You’d only have to do it for a few moments per day or several times in the day. You know, I always start it off by saying What I’m going to describe to you now, you don’t necessarily have to take out a gym membership or anything like that

No
Everything that we’re going to talk about now is stuff that you can do yourself and
erm therefore doesn’t require a financial output. And... and... that is important because
I think if people have a “yes, but” response to what one’s about to say, then they are
less likely to do it. Erm... I think something a no expense, b... putting on a pair of
trainers or something like that. In one of the cancer clinics in which I work they
have an exercise person there and I actually join them in the class to talk about some
of the psychological benefits of what’s going on.

Oh right
And then they do a class together of very simple stretching and so on. You might not
describe that as formal exercise. But you know for many patients who are just
coming in from an operation or whatever

Mmm
a couple of weeks before. Some people just had an operation, that’s quite a
challenge obviously. We would do that sort of activity alongside... the... obviously
the erm... exercise classes they’re going to. Yeah?

Ok
So that’s an important part. The way that you describe it is often stuff that can be
done at no additional expense.

Exactly, yes.

Erm, and you’ve mentioned things that they can do in the home. Would that extend to
say suggesting walks or running?

Yeah oh definitely start with what is reasonable at one level. It would be graded,
incremental stuff. So if they’re able to do that we may suggest something obviously
a little bit more... erm I don’t know... rigorous later on. I am very careful about how
far I go. I think as a psychologist, I think all of us would understand, erm... all of this
thing needs to be taken into consideration... Dealing with this sort of thing
medical backing around in some way. I think that if you... although we may mean
well we can be sued. You know if we tell a patient that they need to do 20 press ups.
(I’m making that up, I don’t think any of us would do that). And they dislocate a
shoulder or whatever. Erm you know as unpleasant as it is it’s in their rights to
come back at you. So you know... always with medical advice, that caveat.

Ok
It doesn’t mean they have to go to their doctor. But you need to put in a sentence there somewhere. You know, you must or may want to check this out with the doctor that’s looking after you at the moment. That sort of thing

Yeah?

Yep. And you have mentioned

Yeah

that some of your clients have irritation from health issues.

Yeah

Is it sometimes not the case or is it always the case that they have, where health is an issue for you to suggest exercise in this way of clients. Or are there some clients that don’t.

I’m not sure if I.. in what context, say that again.

Erm, is it.. Are there clients

Yeah

where there aren’t health issues that you suggest health issues in this way

Yeah yeah yeah. Oh yes definitely. Oh yeah that would be for those with mood related issues.

Yep yep

And I might explain to them in terms of behavioural activation the relevance and importance there. It may be for example when they’re mood’s down. That’s sort of what happens when mood is down. You tend to become more sedentary, more withdrawn, you don’t want to go out.

Mhmm

You know, all of those sort of obvious things. However you know we’re going to need to try to counter that.. what we would call.. automatic thought or whatever and one way in which to do that is to actually do some of the things that you don’t feel like doing. So you know, forgive me but exercise may be part of it. You may grump and groan about it but it could be a very good thing for you to be doing. So most patients actually get that. That’s the bit that’s not directly related to physical health obviously.

Great ok thank you.

Yah?

And how has the… intervention of suggesting exercise generally erm impacted the client
Gone down
Yeah. What’s the result been?
Usually quite well actually. Because I think a lot of it has to do with how you explain it to someone. If you.. you know. I’m being a bit dramatic here. If you grumpy and say you’d better go for a walk. Most patients will feel told off. I think the way that you describe it. And I think making it accessible, easy to do. Benefits come in quite quickly. Something simple, something they’re probably doing already or put more effort into it.
Mm
That’s much more likely to be a success. And most patients when I do recommend it actually come back and say yeah, fine it’s worked.
Oh great
Whether that’s the actual issue that’s caused the improvement is always difficult to say.
Mmm
But if the improvement’s come back and this is..That’s what they state and that’s one of the things that has led to it then that’s good news…. Most people are actually quite surprised. Like ooh I didn’t realise how you know easy it was going to be or something like that.
Oh right
Or you know… I’m cynical about exercise but look at me know… Yeah?
That’s good. And… how do you feel erm.. about the use of exercise within counselling psychology as a whole?
I think the problem is that we’re not taught enough about it. I don’t think that at university level there are enough.. lectures, let alone courses on the benefits of it. I think you know there’s a bit of the silo mentality. And that is you know we have sports and exercise psychologists but they are.. you know a speciality apart. Erm But there’s not enough cross-teaching here. And I think in two areas. I mean sports and exercise psychologists would benefit hugely from learning from counselling psychologists
Mmm
on how to engage with people, how to motivate. Motivational interviewing. How to deal with people who are struggling or who fail in some way. Very importantly I
think that we have a Very rudimentary insight into this. And I also think there is a 
reluctance. Many therapists themselves many of them don’t do exercise (laughs)
No
And therefore why would they promote it?
Yeah
I don’t want to be rude but if you are obese..
Yeah
It’s not going to look very good and very nice if you erm say to someone erm you
know I think you need to do exercise because they will look at you. And it may be
that they take you as some form of role model, and err.. you know they’re not very
motivated by that. Equally as I said I think from a medico-legal point of view there
may also be issues. If a client comes to the patient and you know they haven’t
suggested that, they perhaps consult with their doctor that could backfire on us. And
the other is that you know For some people it may not be consistent with their model
of therapy.
No
You know, if it’s very reflective. If it’s very erm.. what else could we say
erm….client-centred and that sort of thing. You know, where is the model that
supports activation in that? So I think that it may be too strongly linked to CBT,
which is unfortunate, because actually when you read the research in this particular
area…..you know if you read the research in this particular area it could actually be
transtheoretical. It doesn’t just necessarily just have to you know relate to those who
do CBT
No, no
Or exercise, or anything like that. So..there.. Slightly long winded answer but that
would be my feeling as to why it’s not developed sufficiently.
Mmm. No that’s interesting about the transtheoretical side of it.
Yeah, yeah
Have you..What have you read in relation to that?
There’ve been some very good papers in the American Psychologist and the APA
monitor. I mean I’m a member of the American Psychological Association and I
think they look at it much more. Erm and you know these are… these are magazines
and journals that go across different specialisms.
Mmm
If you read...I’m going to make it up let’s say there’s something called the British Journal of Exercise and Sports Psychology.

Yeah

Which counselling psychologists subscribes to that?

Mm

They don’t. So I think we’re not sharing enough information between one another about these kind of benefits. And err as I said I think also there may be personal issues. Many therapists suggest, offer, promote things that they’re personally comfortable with. Sorry Ruth I’ve actually just stepped outside. You can probably hear the traffic.

Yes (laughs)

If you’re interested in meditation or yoga or..going on retreats or a brand of therapy of a particular kind. You know exercise may not be... it may not fit with that at first glance. And the effect of all that is that it’s not going to come up in conversation.

No, no. So the personal..

And the other.. I’ve got another thought about it too. Exercise is often about telling patients or instructing them to do things.. whereas most of us you know are trained in a mode of therapy which is non-instructional.

Yes, yes

So you know, to say to someone I think you should tell your mother about your feelings. That’s quite an instruction. These days therapists would be very very cautious about such a statement. Whereas exactly the same would apply, I think you know you need to get on the treadmill for 10 minutes each day, ermm I think can have the same effect. The therapist may be uncomfortable. The client may not be comfortable hearing the suggestion themselves. So it just stays out of the room.

And of course the other bit is that it’s activity outside of the room. If you are a therapist who believes that every aspect of therapy and all change happens because of what happens in the therapy room

Yes

it’s an anathema. What is the relevance of someone say cooking nice food for themselves

Mmm, mmm
For example if you really believe that all emotional nourishment comes from what happens in the room. And that may seem a bit cynical about therapy but, gee there are a lot of therapists who believe that.

That really wouldn’t fit in with what they, their repertoire?

Exactly, exactly, yeah.

Ok, ok.. erm..and..would you, do you feel then, that erm…they should be more open minded in a way? Or..

Yeah, oh yeah, I mean as you can hear. Because I think any modern therapist must bring to their every bit of available information. At the end of the day you know, As a psychologist ok, I don’t know about as a therapist or counsellor I happen to be registered as both. But when I operate as a psychologist

Mm

it’s evidence-based practice and that means promoting things. Even if I don’t personally agree with them. Promoting them because that’s what evidence says. We have a duty to get people moving and improving as quickly as possible. So I think in that respect, ermm the answer should be yes. You need to know what you’re doing though. This is the bit where erm I think it is important where we have lectures and formal education. And who knows maybe textbooks and things.

So that takes it back to the teaching again if we’re going to..

Absolutely. Because you I think you know If we look at most therapy courses. Well I’ve been involved in almost every counselling psychology course in the country, either taught on it, set it up or been an external examiner. I don’t know any courses that teach this. I may not be up to date with the last three or four years but I don’t know any courses that teach this as an important intervention.

No

You’d be lucky if a CBT lecture carries a bit on behavioural activation and on top of that the benefits of exercise. And probably literally that on the benefits of exercise.

Mmm

I don’t know anyone who’s taught how to introduce it. What the place of it is in therapy, How to monitor it, you know, what the legal aspects are and so on. It’s just.. I..I can get a strong sense of what your project is about and I think it’s a brilliant idea for that reason and surely what must happen next.

I was surprised

Yep
when I started looking at it how little there was and.
Yeah.. yeah. I think the American literature will be stronger.
Mm
I think.. over here we're still stuck in counselling and psychotherapy model instead
of counselling psychology which is err.. a bit of a shame.
Ok, ok so you talked a bit there about.
Yeah
talked a bit about if there was teaching what you feel it should involve really.
Yeah I think all of those are the sort of like.. headings you know effectively. I’m
sure if I think a little bit harder I’ll think of a few more. But I mean the essence is
how does this fit in my model? What is the evidence of the benefit? Am I
comfortable suggesting something I don’t monitor directly? How do you introduce
it to a client, are there any medic-legal issues that we need to be aware of. How do
you measure progress anyway? And how do you attribute it to exercise? Which is a
good question. You can ask your client to do a hundred things how do you know
that your suggestion’s actually helped them. You know so I think these are all good
points for us to consider.
Ok ok., erm….you have..hinted at some of these.
Yep, yep.
What do you feel are the potential barriers to using exercise in counselling
psychology generally and also
Yes
with a particular client?
I think it’s as I said I think it actually starts with the therapists. You know, you can
suggest anything to a client provided it’s evidence-based if you can support what
you’re saying.
Mmm
Erm but I think for some people they’re not trained to think in that way ermm or
that of the benefits. The other is that doing things may be different to reflecting on
feeling. Erm..obviously feeling competent or comfortable with the thing that you’re
asking the person to do anyway. I think all of these things really are the initial
barriers.
Ok..And is there anything..
And perhaps also you know the sound, not sound the profound lack of knowledge as
to where it actually fits. Where is the evidence that it can actually help? And what
sort of problems does it help with? And how does it help? What’s the you
know..physio kinetics. I’m not even sure what the right word would be here. But
you know yeah what are the physiological changes that produce psychological
outcomes?
Ok..yep
I know it’s common sense or should be you know but I’m sure many people are not
familiar with that.
No, no. It’s true.
Erm Have there been times when you… haven’t used exercise with clients, and what
were the reasons behind that?
Erm….I think in every clinical situation where I think it is appropriate I will raise it.
When you say use it I..I would never.. press someone to do something that they were
uncomfortable with. Whatever it may be. Doing homework..
Yep
for that matter even attending the next session with me.
No
If they were dithering about it I would never say you have to come back to me.
Ok
I would be the same with exercise. I would see it as a reflection of my..erm.. ability
to raise an issue and promote it with the person. If they rejected it for whatever
reason then so be it. I will always raise it if I’m working with a patient for example
if I’m working with a patient with at least one of the two primary problems,
anxiety/panic attacks and depression.
Ok
Just because I know that the evidence is particularly strong there.
Yep
What may prevent me from doing that is if the patient is not even in a position to
hear that.
Ok
Or there may be a physical issue that I’m not aware of. It may be health related, it
may be disability related erm and so on that may interfere. Potentially it may also
have something to do with the patient’s own resources. It may sound strange but
you know somebody who’s incredibly who say, let’s say they’re bedridden. They
don’t have you know, a disposable income. They don’t even have a pair of trainers
of whatever. I might talk about exercise as a general thing, just in terms of just by
lifting your arms and doing whatever you can help yourself. But I would need to take
into consideration their… needs and limitations as well. It would be rare that I
wouldn’t raise it. I would tend not to see patients you know... with that degree of
infirmity. Most of my patients are ambulatory. They can move around. Most of
them if they have a major problem they’re already being looked after by a doctor, so
we’d already know what their exercise capabilities are. And you know just you
know by pure luck at least have resources to be able to buy a pair of trainers. If
necessary for some of them to have a one-off session with a personal trainer
sometimes you know. Many people can afford… I don’t know what a personal
trainer costs, mine costs £45. I think most people can do a one-off in that area.
Ok, ok, thanks.
Yeah?
I wonder if you could talk me through erm... a case where exercise... you did suggest
exercise and how it progressed... throughout the therapy.
Sure, yeah. Therapy was actually very short because progress came quickly. There
was a patient I was seeing who had cancer of the lungs. She had her lungs both
stapled. There’s a particular name for this which I forget.
Yep
So she had reduced lung capacity. The effect of that was that it was triggering
terrible panic attacks. For two reasons. The one is that her brain was not getting used
to the reduced oxygen levels available to her.
Uhuh
And secondly she was obviously understandably very distressed by what she was
going through. So panic attacks became a regular, daily feature. One of the things
that we spoke about was that in order to get used to better and improved methods of
breathing and to feel more in control of it she... might benefit from doing some
exercise. With her physiotherapist I suggested in her case.
Right
Somebody who was a pulmonary physiotherapist who worked in a lung unit and so
on.
Mm
Erm so that would help her with her breathing. It would help her err gain confidence with exercise. And importantly she would also hopefully gain benefit from the exercise because of you know the chemical changes that we all… understand. And literally within a week, the changes were dramatic. The panic attacks were much reduced. They seldom go away obviously within in a whole week.

No, no

You know whereas where they might have happened ten times the previous week, I think it was two times the next time.

Oh right

Confidence had improved, wellbeing had improved, mood had improved and so on.

And my recommendation was not that we carried on meeting

No cos actually the patient was travelling very far to see me and actually that on its own would have been a considerable stress. But that she continued to work with the physio and to provide me with updates and how progress had developed. And err all of that has been very good and very positive. So not a total cure but rapid progress and high levels accomplished, quickly.

Sounds good. And was the first step was then for her to contact the physio herself?

And then it was them that..

Yes

..organised what type of exercise.

Yes, yes that’s right.

Exactly exercise was not you know… She was referred to me for panic disorder basically. And you know my assessment was. Panic attacks are a symptom. What is the symptom here? My assessment was twofold. The one was there is obviously an emotional component of what she’s going through and the other was the physiological change that her body was struggling to adapt to. And the effect of all of that was to kick off the problem. So we found two ways of intervening. One was a compassionate err interview with her, understanding what she’d been through and was responding to, the emotional aspects of the medical crisis. And the other was her physiology which to me really was an important component of the panic attacks.

And so after that session erm.. she went off and met with the physio.

That’s right. Yep, yep.

And so that was the suggestion from you in this case?
Exactly. And sort of pivoted around me formulating the problem in that way. I mean you know if you go to let’s say a psychiatrist, they may say you’re having panic attacks we’re going to give you an SSRI or a nurozipan because that will help you. Not all psychiatrists would do that, but that might be a stereotype. My formulation was different, and that is you know your panic attacks are not just due to psychological distress but they’re actually due to physiological distress as well. And you know as I said Erm… that being a.. erm.. level of insight that she was able to gain into her condition. And I think obviously from the patient’s perspective she was worried she was just losing control, and that she would never be normal again. And instead I was able to erm.. you know convey to her that there were reasons as to why she was going through what she was going through. And that there was treatment and probably recovery from what we’re talking about as well, but I had to stress that that would not all go away overnight. It was a gradual progress this recovery. But she did even better than predicted right from the beginning. Mmm. And how did she feel about the… the link between the physical work that she was doing and her improvement?

She was comfortable with that. And err.. you know that was rewarding. I’m sure there are cases where patients don’t like to hear that and they are resistant for a variety of reasons. Erm.. you know There tend to be patients that reject all sorts of things. Not only exercise as an issue. They might reject any kind of homework.

Oh yeah.. It could be that you know they reject coming back to the next session. They could reject your formulation. They could reject a homework assignment which is can you… you know keep a food diary over the next week. And you know that doesn’t mean the patient has done something wrong or gone wrong. That means that we have not fully understood what they are experiencing. In other words we have to go back to our formulation. So for me I don’t have a problem if someone hasn’t followed the exercise recommendation that I’ve made. I need to then think why are they not doing it. Maybe they feel shy or embarrassed, or overwhelmed or erm… something like that. In which case I need to consider that. You know I would treat that as any piece of information in therapy. You know everything that a patient does gives you feedback about where they’re up to. So I’m not fussed if they don’t follow something that I have recommended. But I’m obviously curious as to what ways I can better understand their situation.
Ok, thank you.

Erm, you mentioned erm in that case that at one point it was rewarding erm..

Yep

erm to see the progress that she was making. I wondered how more generally you experienced introducing exercise as part of your work.

Erm..I mean personally, I find it quite rewarding too. Because these days my focus or ethos in therapy.. It doesn’t matter if I’m doing short or long term therapy, as I said you know I work across the spectrum. But I have an ethic. And that is to help people to get benefits as soon as possible.

Mmhmm

from whatever if they’re feeling depressed or anxious or have a relationship problem or an addiction. It doesn’t matter what the presenting psychological problem is. I want them to start to feel better soon. Firstly I think it’s good for therapy so people gain confidence in the process that they’re in. And importantly it’s good for my relationship with them.

Mm

Because you know you can not keep going back to something that’s not helping. I want people to see evidence of that quite rapidly. And I think exercise is actually a very..elegant way to achieve that kind of err progress at quite an early stage. So you know I enjoy talking about it because it also moves me away from ‘tell me about your childhood for your moment.

Mm

All that is terribly important and we do look at people’s pasts and antecedents and so on. But you know whether you want to label it CBT or anything else. I’m quite strongly inclined towards behavioural activation.

Right

If you do things differently, you will feel differently.

Mhmm

And that’s doing things of course in a wide range of areas. But exercise might be one. So you know to get… feedback from someone that they’ve joined the gym or went for two swims in a week. It’s fantastic you know. They’re obviously firstly trusting you and listening to your advice. Erm and the other is when they come back and say mmm I see what you mean.

Yeah
Erm I think that’s good too. It’s not only rigorous exercise that I might recommend. Yoga, erm stretching classes, pilates and so on. Erm.. you know I think it’s about doing things and it’s often about going out to do them. And it might sometimes involve going out and being with other people doing them. But I think there are a number of different components.

Ok, thanks. And you mentioned the relationship there aswell.

Yep How has..would you say it’s impacted the relationship or.. has it always been..?

Yeah I think mostly positively, because I think it comes back to how you explain it or promote it with patients. If you say “go and do it” obviously in a fierce, pushy, aggressive way then you will damage the relationship. If you can be persuasive but without burdening the patient cos they have to do it otherwise you know you will be displeased with them, erm you know it can improve the relationship. So I think it cuts one of two ways. But I think a lot depends obviously at that moment on your rapport with the person. And I think that’s where counselling psychology surely you know has special expertise. You know our client-carer relationship should be second to none.

Mm We should be able to read people and their reactions and feelings better than anyone else I would think.

Great ok, thank you. Erm.. you have hinted at this aswell as bit but I wonder how you see exercise as fitting in with the philosophy of counselling psychology. Erm and the humanistic element.

Yeah, I mean I’m not sure I see counselling psychologically as fundamentally humanistic.

Ok Erm you know I think humanistic is an approach.

Mhmm I would say that there is a client centredness to it of course. And I think that is slightly different. And client centredness is obviously doing the best for that client in front of you

Mm which you know as we’re discussing today can involve a wide range of things yep
talking, doing, reflecting, etc. Erm I think if you work on the premise that therapy is just about listening to people, then I don’t think it does fit, very well, because you know we’re not meant to be very facilitative or instructional. And that may be fine, I’m not being critical of it. But it would be very different.

But I think to say that all counselling psychologists you know work from a fundamentally humanistic approach suggests that you know we’re all for example psycho-analysts and we all share that in common. We don’t.

Humanism is a psychotherapeutic approach. Client centredness is both an approach but it’s also a stance towards people and it deviates slightly maybe from the medical model and so on.

So I do think that there is a place for it. But you know it comes back the point that if you’re personally not comfortable with it. If it doesn’t represent your frame or your own personal life, if you’re not that enthusiastic about it or not very knowledgeable. You’re probably best not doing it.

Really, finally, is there anything else that springs to mind for you when thinking about exercise and your experiences which we haven’t covered so far?

Not really. I mean I think it comes back to the point that we were talking about earlier on. And that is that I think there’s a modelling effect here. And that is the absence of input at course level.

especially. Not much in the literature that any of us have easy access in the general counselling and psychotherapy journals. You know we’re not promoting it at that level so it probably doesn’t get taken up until we do say let’s say more advanced training as we learn about these sort of things as CPD which is a shame.

Most colleagues that I know don’t even talk about it..as a facet of therapy other than people who share a similar therapeutic background
Yeah
to me. So I think there’s a lot that needs to be done here. But erm, yeah I think
that’s all I would say without incriminating myself.
I did notice. It seems to be quite different in some ways from perhaps areas like
sleep or relaxation, could be considered very similar. How..Do you think that there’s
more input…or there’s something about exercise that’s different from those type of
areas?
Mm good point. Yeah I’m going to repeat myself here a bit I think. Erm two reasons:
the one is it may not be part of the therapist’s life
Mhm
and knowledge and experience, all of us have had a sleep problem
Mm
or a tension problem. We might not have all had panic attacks, and mood issues, and
things that require activation. Erm I think that is one reason. I think the other is with
the risks and dangers of getting it wrong.
Mm
Erm..Don’t resemble what it could do with exercise. When most of us think of
exercise we think of an Achilles heel. We think of a broken bone. We think of you
know somebody causing injury to themselves and worrying what may happen there.
I don’t think we think about that when we’re helping somebody with stress and sleep
problems. That may be a difference.
Ok
And the other is that those things are taught much more vigorously, I think within
courses.
Ok,ok well that’s it for me.
Ok, excellent.
Erm..thanks very much for your contribution
I hope that’s helpful.
Yes it is. And yes.. I will send you the transcript once I’ve written that up..
Yep, ok
for you to have a look at if you wish to do so.
Erm and I’ll also email you.
Mmm…I don’t mind not looking at it.
You don’t mind not looking at it.
If you just remind me of the address.

Great I’ll send that to you.
Appendix J

Sample Summary Sheet (Participant 1 Interview)

RQ1
Prescribing exercise – behavioural activation
Join in class – explain psych benefits of exercise
External referral for exercise – to physio
Mood, anxiety

RQ2
Client safety
Initiate discussion
Evidence to justify
Chemical benefits
Social benefits, connected to other aspects of problem
Need for achievability
Client resources
Incremental
Legal concerns
Part of challenging behaviour. Directive. Even if don’t want to do it.
Existing resources/likes
Could be one aspect of things that have worked
Therapist education – understanding how works/how to introduce, beliefs about what should be taught.
Silo mentality
Therapists’ own exercise habits/therapist body/what client takes from that
Therapist model of working – how client centred
Research important – evidence
Therapist comfort with subject
Therapist beliefs – stuff outside of the room or not
Reject if client uncomfortable/client not ready to hear.
Physical issue could be barrier
Making physical part of understanding/assessment/formulation

Rewarding to work with, enjoy.

Wants to see the quick benefits. Progress early on useful.

Positive for relationship

Imp tool within behavioural activation. One of many things – pluralism?

Challenging beliefs – vehicle for change

Way of delivering imp important

Not talked about/used more generally

Risks – concern about causing hurt physically
Appendix K
Themes Across Summary Sheets

Research Question 1:

Part of behavioural activation/activity scheduling
External referral
Low mood, anxiety
Hasn’t formed major part of depressive work
Mindful walking part of session
Mindfulness incorporating exercise
Movement in session
Facilitate dance in the community
Suggest do at home for relaxation`
Activities with children in the room
Spectrum on in session work- why can’t be part of work – ruled out on competency

Research Question 2:

Multi faceted benefits
Vehicle for engagement in life/way of understanding how engage (e.g. throughout therapy, how depressed)/challenging/reflection of relationship with self/marker for functioning/part of self care
Existing client resources/opinion/value system/client previous resources –tap into what used to do/what those meanings were/individuality of meaning/not for everybody/Benefits can combine together for stronger effect
- Mastery – gradual/realistic important
- Visible benefits
- Speed of bens – lift at beginning
- Challenging beliefs
- Vehicle for change – not bout exercise in itself/knock on effect/bridge/catalyst
- Control
- Mind and body, control of body, control of mind, more connected to body/getting more in touch with body
- Move into different place/need more than just mind/trauma – release/something that affects senses
- Social bens
- Pleasure
- Chemical bens/adrenaline rush
- Client agency/doing something for self
- Pos impact on mood
- Self esteem/confidence
- Something outside the therapy room/something ‘real’/coping mechanisms

Therapist self

- Comfort
- Own experience of ex – felt bens personally/what ex/health means for them
- Caution/ limits of expertise/ links to training
- Wider background
- Individual fields of interest/reading
- What mean by exercise – not intense necessarily/activity
- Positive experiences of working with/get something from it self

Spectrum of directiveness

- Not exercise regime/wouldn’t do exercise programme
- Whose agenda – t agenda can go too far/need to match with client need/t agenda vs client goals
- Some – strong feelings against being directive/if t agenda. Only if initiated by them, on c agenda. Risk imposing something on them. T stays neutral. Some strong beliefs for.
- Tentatively suggest
- Differences health issue vs Risk judgemental
- Imp – client led
- Encouragement with reluctance

Client safety

- Inc legal concerns
- Physical concerns
- Physical limits
- Health and safety
- Danger for e.g. all or nothing thinking
- Achievability important
- If very depressed, no

One of many things within therapy

- Different things for different people
- has its place
- one method
- one option
- same principles can be applied to other things

What means to client

- what health means to them
- client comfort imp
- need to meet the client where they are
- Client motivation
- what does exercise mean to client/help client understand this too
- part of wellbeing
- Can be a problem e.g. eating disorders – work is how to reduce/like with bens
- what is the meaning/reflection of how feeling about self
- part of self care
- part of health
- danger for all or nothing thinking
- mind and body – technical things that are good for the person
- exercise part of basics

Whole/holistic view of the person/particularly where complex needs – back to basics/

- where does exercise fit in?
- Part of understanding of client
- part of assessment
- understanding of how might help
- marker for functioning
- part of self care
- understanding of functioning
- body creates experience

Experience as not talked about

- lack of engagement
- more research
- multi disciplinary working
- needs to be part of philosophy
- missed out of formulations
- not thought about much about
- Multi disciplinary area
- links to competence limits
- research there in other disciplines
- Use of research/evidence
- More research needed
Collaborative with client / how deliver important/collaborative goals/ achievability important

- psychoeducation/sharing evidence with client
- negotiation with client
- transparency
- encourages immediacy (in session work)
- Positive for therapist/client relationship – feel empowered within relationship
Appendix L

Revised Themes across Summary Sheets

Multi – faceted benefits

*Therapists experience exercise as something that provides clients the opportunity to experience many benefits. This different from vehicle for change? All benefits add up to vehicle for change?*

- Benefits from exercise in itself e.g. chemical, social, mastery
- Mind and body subtheme in itself or
- Vehicle for wider change e.g. mastery spread to other areas
- Something outside the therapy room
- Has its place/one element?

Holism

*Exercise forms part of a holistic/whole understanding of the client.*

- Marker for functioning
- What means to client / individuality of meaning. Can be problem
- Multi disciplinary area – not much?
- Has its place /One element, within whole picture?

Directiveness spectrum

*There was a range of views on initiating the introducing of exercise into the session, from introducing it to tentatively suggesting to only talking about if initiated by the client.*

- Client motivation? /agenda
- Use of research – not much? Here?

Collaboration

*Where exercise was used psychologists experienced it as a joint intervention between themselves and the client. Link to directiveness?/self of therapist?*
- Transparency/psychoeducation
- Tap into existing resources
- Prompt for immediacy

**Self of therapist**

_The opinion and experience of exercise of the therapist plays an important part in how they feel about incorporating it in their work._

- What mean by exercise here?
- Spectrum directiveness here?
- Own feelings about exercise
- Limits of competency

**Client safety**

_A common concern was the management of the physical and psychological safety of the clients._

- Limits to competency - multi disciplinary area

**Experience as not discussed**

_Counselling psychologists experience exercise as not something that is widely used or talked about within the discipline._

Mind and body – spread over areas?

Talk about exercise vs activity here?

**Individuality of meaning**

_Counselling psychologists experienced their clients as seeing exercise as meaning very different things for them._
## Appendix M

### Sample of Quotes Relating to Themes (Vehicle for Change theme)

| Vehicle for change | 2 – I think the first thing to understand is why people have stopped. Right There’s no point in suggesting doing something Yep without understanding what the barrier has been and so as part of the therapeutic process it’s important to understand where somebody is. I may want them, because of the therapeutic structure would be good for them to be in a certain place. But there’s not point in even trying to think about doing that until you understand where the person is. 2 - And if they did it, damage to the heart something like that. And it may cause them damage. So they’ve now got a belief that says I can’t do exercise anymore. Mm Because actually doing exercise is potentially dangerous to me. So it’s understanding the mindset that the person has. (challenging beliefs?) 2 - But what I’ve found is that if you can really understand how exercise.. I understand exercise in a much more broader sense. Rather than just being in the gym Yep or something very formalised. For me it’s walking, it’s kind of just being out and |
| Therapists experience exercise as something that provides clients the opportunity to experience many benefits. This different from vehicle for change? All benefits add up to vehicle for change? - Benefits from exercise in itself e.g. chemical, social, mastery - Mind and body subtheme in itself or - Vehicle for wider change e.g. mastery spread to other areas - Something outside the therapy room - Has its place/one element? - Specific and generalizable benefits – and therefore generalizable approach. Here? How say this? |
physically moving your body,
Yep, yep
rather than just being very sedentary and
sitting at home and being very detached
from the world,
Mm
watching TV. You know those sort of
things that often occur where people
withdraw into a very small space.
2 - So for me the focus of exercise is not just
the physiological wellbeing
No
it can create.
No
It’s also the social and psychological
wellbeing it can create too. Those two things
are very very
Mm
important in the trauma work I do for sure.
2 - So once we’d found that then actually the
rest of it, getting back involved with people
and engaging, became very easily. But if
we’d never have found that…
No
I think I could have spent the rest of my life
trying to encourage him to do things or kind
of engage with him to do things but he
wouldn’t have done it.
2 - So that shook his very foundations of his
sense of himself in the world. And more
importantly his sense of himself in the
world. Which caused him to withdraw.
Mm and so that led to him realising the
importance of finding an activity that he could..
For him it was all about I don’t just want to be a participant.
No
I want to be somebody that can excel.
2 - And certainly wouldn’t have gone with his friends to the event. Cos his friends had asked him time and time again.
Yep, yep.
Why don’t you come and do this why don’t you come and do that.. it had been refusals all the way down the line.
Yeah
But erm it was only when he kind of realised the sense of why he was doing the things he was doing. It was that sense of understanding yourself really
Yeah
wondering why you’re motivated or not motivated to do things. (therapy first! To make change. As 7 said, once start feeling better).
2 – (catalyst) Erm the knock on effect, is cos he was always used to being involved in sport,
Yep
was that he found a way of then doing that and adapting to his changed situation. And that helped in lots of other ways. It had a bigger, much wider knock on effect.
Mm
His ability to do that meant that he could
then start to see that he had the potential to do it in different ways not just in terms of sport.

Yeah, yeah.

employment and all those other things.

Yeah
could then open up as a different thing.

Well if I can do that and I can adapt to that then why can’t I do this.

2 - But one of the big issues in trauma work particularly is a real…clients’ real sense of loss of control. So having one of the last vestiges of control

Yep

that we have is our body. So physical exercise is a very powerful way of restating

Mm

and showing, and re-establishing a sense of physical control. So physical control can be quite a powerful way of moving onto the psychological control that people have often lost.

2 - And so exercise..I have very positive experiences of it often being a bridge for people to look at other things.

2 - And exercise I have experienced, and clients have experienced that I’ve worked with has been a really nice bridge to start rebuilding..that sense of control, that sense of erm security in the world again.

Yeah

That.. If I can control my body, if I can have a sense of security in my body
Yeah through exercise then maybe I can start to think about looking at other things too, from a more psychological point of view.

Yeah I’ve often seen it as a great bridge rather than an end in itself.

3 - And certainly in therapy when people are talking about wanting to engage in exercise and maybe they haven’t been

Yeah Erm for me.. Hopefully when they’re coming back to review their homework

Yeah and things, hopefully they’re coming back saying “I did it”. So there’s also something about managing their expectations and setting realistic goals

3 - Exercise is useful in the sense that it’s quite holistic. It is the mind and the spirit

Yeah, yeah and the body.

3 - But it allows us to tap into is there anything in relation to the depression

Mm

That actually got in the way of engaging in the process.

4 - That people did feel erm..different and they did feel that in this activity that they were engaged in, in terms of helping themselves. They felt better about themselves because they were doing it if you see what I mean.
| 4 | And so I wouldn’t say it was the... it wasn’t a cure all but there was a sense of err feeling better about themselves and their self-esteem increasing. Erm... and that had a bit of a knock on effect in terms of other things that they were likely to do. So they might be more active in other parts of their life aswell. |
| 4 | And erm again, not..erm... I wouldn’t say it was a massive...erm... end result. |
| Mhmm | But always the activity side of things was a good way of getting going. |
| Yeah | Getting the thing moving, getting the therapy moving |
| Right | Getting sort of negotiating on something. |
| Ok | Allowing them to feel well actually there is something I can do for myself. |
| 4 | At some point I guess the work hopefully you would hope to get to a point where their thinking and feeling would change such that they would want to be more active.. The way I’ve been trained to look at it is that you can start that process, get the activity going first then the thinking and the feeling |
| Right | is likely to follow |
| 5 | And.. we spend time kind of rebuilding her positive sense of self. |
| Right | |
And her sense of pride and self-respect. And I think that her building up her running is a way of her building up her pride and self respect. And you know we’ve worked very directly on; how could you compare your fitness level now to how you were in the army?

5 - It’s just very biological.
Yeah
Our bodies were made to move. And if they don’t move they don’t feel good and they get poorly.

6 - And also just being a bit silly aswell.
Yeah
You know in the shaking. To sort of..you know shake her head up a bit.
Right, yeah
And just sort of move her into a different place both in her body and in her head
Mmm
To sort of shift her from that urgh to a place of like ohh, feeling different.

6 - I don’t do physical exercise
Yeah
for endorphins and all that sort of thing but clearly some of that would have been going on for them there.

6 - But I think..in my own personal experience, not as a therapist as a person yep
I was aware that I had learnt to understand my stuff
Mhmm
But it was still a problem. And done the cognitive changing but it was still a problem. There still could be those triggers. And it felt like there was just some body type thing,

Mm

there was just an energy around. It was still something that...something else. And then I began to understand about the whole...the theory about a lot of these things. So trauma in its broadest sense that you know that if something bad happens to us no matter what it is it’s trauma.

6 - So he didn’t need to sort of like obsessively play with sand and bury things you know.

Yeah (laughs)

What he needed to do was this physical activity. Erm...and so it would have been him releasing some of his...whatever the stuff was through that, whether it was anxiety or stress or you know...trauma sequellae or whatever. It would be him releasing some stuff through that. It would be relationship building.

Vehicle – 6 - Certainly I’ve dealt with traumatic issues through playing a game of football

Mm

because things come up you know. Things come up because you’re enacting them symbolically and things come up because they feel freer...more able to talk about
things while they’re doing something.
Yeah
So erm..I mean certainly with children.
6 - Yeah because the therapeutic err..process
there was about helping him think about
how he would keep himself safe
Mm
when he was doing these risky things,
climbing on roofs and jumping off
yeah
and all that kind of thing outside. And also I
think some it aswell is about hurt. You
know so sometimes you can have
conversations about if you do something you
know….if you land a bit and you go aah,
ooh, phwoar that was a bit..or something.
Oh did you hurt yourself? And you can
have conversations about well did you hurt
yourself and if you did is that ok to hurt
yourself?
Mm
There’s lots of..sort of just therapeutic
conversations can come out of just being
active,
8 - So I’m not saying that it’s the thing that
made the hugest difference but it certainly
was one of many factors.
No
If you took that component out of either of
those cases or quite a few cases it would
be..erm I would think that you wouldn’t get
the same result.
8 - And erm..so there was that and I also
think that if you can’t see results..It’s one thing..there are a lot of things that are so helpful in the talking therapy but I think people need to be able to feel better in themselves and also see results.

Yeah

And I think that helps. And also thinking if you’re thinking about mood regulation, you’re thinking about different behaviours and different ways that you can cope with difficult times. And therapy will never sort everything out.

No, no

As much as I’d love to think so!

I think that the walking was a way of getting the shock out or something.

Yeah

I feel like it was a way of getting something out of body.

I suppose like a cleansing thing or some sort of.. I don’t know I’m just picturing toxins. Something like that yeah.

Mm

I don’t know what it was but it was easier to think when I was in motion cos if I was sitting and thinking I would get so down I couldn’t move or eat or do anything. But if I was in motion at least..Maybe it was also getting out and having the distraction of the world.

Yeah

Maybe you can’t do anything too silly cos
you’re in public.

Yeah

But I’d usually be walking out in nature and things and it just really helped, and it made me rethink too, when we see people with post traumatic stress here,
Appendix N
Thematic Map

What has been the experience of those counselling psychologists who have incorporated exercise into their work?