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'The Blind Leading the Blind': A Phenomenological Study into the Experience of Blind and Partially Sighted Clients with a Sighted Therapist

'The Blind Leading the Blind': A Phenomenological Study into the Experience of Blind and Partially Sighted Clients with a Sighted Therapist

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<u>Abstract</u>

The focus on blindness and partial sightedness and improving the lives of those living with blindness and partial sightedness has increased in UK public policy and discourse over the last decade. However, there has been little focus on the psychological and emotional needs of those living with sight loss and how emotional support services may work effectively with this client group. This investigation, using Interpretative Phenomenological Analysis (IPA), examines the experience of nine blind or partially sighted people, aged between 22 and 75 years of age, living in the UK who have had psychological therapy with a sighted therapist in the last two years. The findings highlight various aspects of the participants' experience under four meta-themes: 1) Struggles between the two worlds, 2) Bringing the 'elephant' into the therapy room, 3) Non-verbal communication and 4) Verbal communication and the power of the therapeutic relationship. The discussion highlighted areas for consideration for sighted counselling psychologists and other mental health professionals who may work with clients who are blind or partially sighted. It also explores three major areas: (i) for counselling psychology as a profession to consider how it supports clients who are blind or partially sighted, (ii) for sighted counselling psychologists and other mental health professionals to examine their own attitude toward disability and how they work with this in their profession and (iii) for sighted counselling psychologists to challenge traditional ways of working with touch, silence and talking when working with blind or partially sighted clients.

Keywords: blindness, partial sightedness, counselling psychology, disability, verbal communication, client, sighted therapist, eye contact, non-verbal communication, society

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Introduction and Purpose

Addressing the needs of blind and partially sighted people is something that international governmental policy has highlighted as an area that needs attention (Tate *et al*., 2005). Suitable policy to address the needs of the population living with sight loss is required. Current policy in the UK seeks to understand and address the needs of blind and partially sighted members of the population, both on a practical and an emotional level. On a national level there is a lack of suitable emotional support services for blind and partially sighted people and the need for such services is not meeting the current demand.

Research conducted with blind and partially sighted clients into their experience with medical professionals has reported how they felt 'talked about by experts' in the medical profession, which left them feeling disabled and powerless (Dale, 2008b). These particular professions interestingly include medical professionals in the area of ophthalmology and sight specialists.

Counselling psychology, being located within the field of mental and not medical heath, has been described as different from other psychological approaches in that it questions the medical model of professional-client relationships with a move toward a more humanistic value base (Woolfe *et al.,* 2003). Ironically within the professional field of counselling psychology, including academic research and training, there is a tendency toward not questioning the medical model when it comes to disability in general. This in turn facilitates a lack of understanding the emotional needs of blind and partially sighted people and how counselling psychology as a profession could possibly help address the needed emotional support of this individual population.

I am a sighted counselling psychologist who has no lived experience of being blind or partially sighted. This investigation is focused on the experience of adults who are blind or partially sighted who have had psychological therapy with a sighted therapist. My goal is to reflect the voice of these clients and explore what the experience was like for them and to document that voice for other practitioners, both sighted and non-sighted, to hear.

This study aims to offer a contribution to counselling psychologists, counsellors and psychotherapists working with adults who are blind or partially sighted who maybe accessing psychological services. My initial research idea was borne out of my own experience of working for as a counselling psychologist for a London based Improving Access to

Psychological Therapy (IAPT) as part of the National Health Service (NHS). In this service, I had many blind and partially sighted clients referred to me for psychological treatment and this experience highlighted my own professional 'blindness' in working with this population.

Over the past three years I planned the research, then recruited, interviewed, transcribed, coded and analysed the material gained from nine adults, using Interpretative Phenomenological Analysis (IPA) (Smith *et al.*, 2009). The participants were seven females and two males who are blind or partially sighted and who have had psychological therapy with a sighted therapist in the past two years.

The research began as an exploration around my main research question: what is the experience like for a blind or partially sighted client having psychological therapy with a sighted therapist? Sub-themes included: describing the meaning given to the difference of sight within the therapy, how verbal and non-verbal communication was used, and the experience of the therapeutic relationship where sight was a differentiating factor. What the sighted therapist did or did not do inside and outside the therapy room that was helpful therapeutically for the client was also considered. These themes underpinned the semi-structured interviews within the investigative framework that I used with all nine adults whom I interviewed.

This qualitative research sought to explore personal meaning rather than general occurrences. The qualitative researcher is interested in how people interpret their experiences, how they construct their worlds and what meaning they attribute to their experiences (Merriam, 2009).

This social constructivist position assumes in the sphere of social and psychological inquiry there is no *fixed* external reality to be *objectively* known. Rather it's a fluid social reality that is co-constructed. One of the implications of this philosophical position is that qualitative researchers do not claim to generate universal truths or scientific laws; rather they are striving to build meaningful *local knowledge* (Dorst, 2008).

Rooted in my own philosophical values as a counselling psychologist, my aim is that this research informs and extends practice within counselling psychology on an academic and practical level. As a discipline, counselling psychology is strongly connected with humanistic values and principles. Counselling psychology argues in favour of a scientist-practitioner model that is practice-led, phenomenologically focused, respectful of diversity and interested

in the uncovering of subjective truths (Woolfe and Dryden, 2004). I prescribe to this model and its ideals in conducting this research.

By using IPA on data derived from the accounts of a small number of participants, my aim is to explore the experience of the adults who are blind or partially sighted who have experienced psychological therapy with a sighted therapist. Exploring their experience is to help inform the existing limited research, theory and practice for sighted therapists working with adults who are blind and partially sighted. The meta-themes and sub-themes emerged from the interview extracts of the adults I spoke with. It is their words and experiences that drive the findings and bring their voice into the field of counselling psychology and psychotherapy.

I refer to clients as *blind and partially sighted* as this is the terminology used by the Royal National Institute of Blind People (RNIB), the leading charity in the UK offering information, support and advice to almost two million people living with sight loss (RNIB, 2015).

In writing up this project I have changed the names of participants and some details to preserve confidentiality and anonymity.

<u>Contribution to the field</u>

Overview

My choice of research methodology was IPA. IPA focuses on the exploration of participants' experiences, understandings, perceptions and views. The *processes* referred to include all the aspects of self-reflection and refer to the way IPA assumes that participants seek to interpret their experiences into some form that is understandable to them (Reid *et al.,* 2005).

Participants' accounts using IPA are explored within this context. Psychological research and literature is used to elucidate the discussion around what participants experienced. Too, historical data and background information are beneficial to contextualising this research.

The following headings consider the history of blindness in the UK, the need for and current state of emotional support services for this population, the role of counselling psychology in providing emotional support and finally the relevance of this research to clinical practice in light of current practices.

Blindness and partial sightedness in the UK – past and present

The UK has a long history of recording numbers of its citizens who are blind and partially sighted. The population of blind people in Britain has been recorded since 1851. Initially, this consisted of a declaration of blindness on census returns. The National Assistance Act in 1948 set up the current system of registration, with local authorities required to establish registers of people with disabilities, including those blind and partially sighted, and to administer statutory services to which the visually disabled are entitled (Pritt, 1963).

This Act required that any person seeking registration as blind or partially sighted is required to see an ophthalmologist who certifies that the person is eligible for registration. A person is certified as blind if they are *so blind that they cannot do any work for which eyesight is essential*. There are now two categories of blindness and partial sightedness: *sight impaired or partially sighted* and *severely sight impaired or blind* (Tate *et al.*, 2005).

In 2009, nearly two million people were living with sight loss in the UK. This included 360,000 people who were registered as blind or partially sighted with severe and irreversible

sight loss. Estimates suggest that blindness and partial sight loss in adults cost the UK economy £22 billion a year (Tate *et al.,* 2005). Sight loss has both a personal cost to the person living with it and also an economic one due to the services needed to address this specific disability.

The RNIB has identified five leading causes of sight loss in the UK: refractive error, age-related muscular degeneration, cataract, glaucoma and diabetic retinoplasty. According to the National Eye Institute, age-related muscular degeneration (ARMD) is the most common cause of serious sight loss in those aged over 50, resulting in a loss of vision that cannot be rectified.

Blindness and partial sightedness predominantly affects older people, with about 8 out of 10 people being over the age of 65. The population of this age group in the UK is forecast to increase by 24% by 2020 and the prediction is that blindness and partial sightedness will rise by around 35% by this time, so the demand for eye care services will increase. (Department of Health, 2004). As a whole, the number of people in the UK with sight loss is expected to increase dramatically and it is predicted that by 2050 the number of people with sight loss in the UK will double to nearly four million (Tate *et. al.,* 2005).

Vision 2020 is the global initiative for the elimination of avoidable blindness. It is a joint programme of the World Health Organization (WHO) and the International Agency for the Prevention of Blindness (IAPB) with an international membership of professional associations, eye care institutions and corporations. The objectives of this initiative are to increase awareness within key audiences of the causes of avoidable blindness and the solutions to the problem, advocate for and secure the necessary resources to help facilitate the planning, development and implementation of national Vision 2020/Eye Health programmes in all countries including the UK (World Health Organisation, 2015)

Vision 2020 UK as part of the Vision 2020 global initiative, is the governmental umbrella organisation which leads collaboration and co-operation between organisations within the UK. Organisations such as the RNIB and Action for Blind People focus on blindness and partial sightedness and operate on a national and regional basis as part of Vision 2020 UK and the extended Vision 2020 global initiative. Vision 2020 UK has a number of special interest groups under its work as an umbrella organisation such as counselling and emotional support services and dementia and sight loss. The work of Vision 2020 UK is as a supporting member of the Vision 2020 global initiative (Vision 2020 UK, 2015).

The UK Vision Strategy was developed in 2008 by the leading eye health and sight loss organisations across the UK to enable them to deliver a united approach to delivering change. The Strategy is the UK's response to the World Health Organisation's Global Action

Plan for the Prevention of Avoidable Blindness (formerly the Vision 2020 Action Plan). The UK Vision Strategy was developed following a comprehensive consultation process with over 650 organisations and individuals and sets a strategic framework for improvement to the UK's eye health and outcomes for people with sight loss.

UK Vision Strategy team works closely with the umbrella organisation, Vision 2020 UK. The UK Vision Strategy seeks a major transformation in the UK's eye health, eye care and sight loss services. The Strategy is a cross-sector initiative, uniting all those in the UK who want to take action on issues relating to vision. The Strategy aims to transform the eye health of the UK and to enable those with sight loss to receive timely treatment and support so they can live independent lives.

The UK Vision Strategy is turned into reality by partners working together in each country of the UK. Strategy progress is monitored by a UK Vision Strategy Leadership group which consists of the key eye health and sight loss organisations across the UK. Supporters are enabled to deliver the Strategy by a dedicated UK Vision Strategy team who are led and funded by RNIB. The UK Vision Strategy team works closely with the umbrella organisation, Vision 2020 UK.

The 2012 consultation on the UK Vision Strategy shows that its original aims remain valid and that significant progress has been made. The Strategy was refreshed in 2013.The UK Vision Strategy (2013-2018) seeks to achieve three outcomes: 1) Everyone in the UK looks after their eyes and their sight**.** 2) Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate support. 3) A society in which people with sight loss can fully participate**.** The next review of the UK Vision Strategy is planned for 2018 and progress will be monitored annually. (UK Vision Strategy, 2015).

With the growing population of people living with sight loss in the UK and the focus on the emotional support needs of this population, this places counselling psychology in a potentially position to address and meet these needs. How is it doing this?

Why the need for emotional support services?

As previously mentioned, blindness and partial sightedness predominantly affects older people, with approximately 8 out of 10 people being over the age of 65. The population of this age group in the UK is forecast to increase by 24% by 2020 and the prediction is that

blindness and partial sightedness will rise by around 35% by this time, so the demand for eye care services will increase. (Department of Health, 2004).

The need for professional emotional support services is vital as the link between blindness and partial sightedness and impaired psychological well-being is well established within psychological research. Research has found the prevalence of depressive symptoms amongst older adults who are blind and partially sighted in some studies was greater than 50% (Burmedi *et al.*, 2002).

Older adults with sight loss may face the same declines in health and finances as their peers. In addition, the special challenges of declining vision put them at particular risk of experiencing depression. Brody *et al.,* (2001) found that rates of depression amongst older adults with age-related macular degeneration were twice as high as that reported in the general population of older adults.

A diagnosis of sight loss in later life can be a trigger for depression. Horowitz (2003) findings suggest that the initial experience of vision loss can be a trigger for depression and that higher levels of depression have been associated with the recent onset of blindness and partial sightness. Horowitz and Reinhardt (2000) proposed two possible explanations for the strong associations: even a moderate degree of vision loss can have a dramatic effect on an older person's ability to manage activities of daily living, and too, vision loss evokes an intense fear of dependence.

For an older person the impact of sight loss impacts greatly on daily activities in their lives. Activities that are especially valued, such as reading and driving, are directly affected. Reading for information is needed to perform many activities of daily living safely and connects the individual to his or her social community and the larger society. Driving is more than a way to get around; it is closely related to a person's sense of autonomy and independence and is one of the most feared losses associated with blindness and partial sightedness (Horowitz, 2003).

Older adults living with sight loss may lose interest in activities they once enjoyed. Everyday tasks take longer and require more effort and as a result, some activities are given up or handed over to someone else to do. The combination of sight loss and functional loss may leave the older person vulnerable to depression (Horowitz, 2003).

Looking at the association of depression and functional vision loss of adults aged over 20 in the United States, research found that one in 10 adults reporting loss of visual function meet criteria for clinically significant depressive disorder, and an additional 1 in 5 exhibits mild depressive symptoms (PHQ-9 score of 5-9). These rates of depression are comparable to

rates of depression in persons with other chronic conditions. Blindness was ranked as the fourth most feared health condition, after AIDS, cancer, and Alzheimer's disease. People with any kind of visual function loss are more likely than those with none to report depression, especially in key activities of daily living such as driving. Even after considering possible confounding factors, adults with visual function loss are at least 90% more likely to have depression than those without (Zhang *et al.,* 2013).

For some people sight loss is not an age related condition, rather it is acquired through a traumatic incident. The optic nerve is a paired nerve that transmits visual information from the retina to the brain. The optic nerve is vulnerable to indirect and direct trauma causing functional impairment of vision. Optic nerve injuries occur in the setting of head injury which is often a consequence of road traffic accidents, falls or other traumas. Too, the diagnosis of optic nerve injury may be delayed by the presence of other life-threatening injuries (Sarkies, 2004).

In the UK, since the start of the conflicts in Iraq and Afghanistan, the numbers of young service personnel who have sustained a combat-related blindness and partial sightedness have increased. A cross-sectional study examined the mental well-being of ex-servicemen (aged 22–55 years) who are blind or partially sighted and determined if the mental health of those with combat-related blindness and partial sightedness differed from those whose blindness or partial sightedness is not combat-related. This study found that mental health problems were prevalent among blind and partially sighted younger ex-servicemen. No statistically significant differences were found in the prevalence of mental health problems among ex-servicemen with a combat-related blindness and partial sightedness compared with those with a non-combat-related blindness and partial sightedness (Stevelink *et al.,* 2015).

Adjusting to the changes brought by acquired sight loss in life was examined in a study to explore the pattern of adaptation in patients who have been diagnosed with sight loss. It revealed that patients who have lived with sight loss for over 2 years reach significantly higher acceptance and lower denial levels compared to those of patients who had recent vision loss of less than 2 years. They also found acceptance was positively correlated with well-being and denial with depression, while acceptance was negatively correlated with depression and, likewise, denial with well-being (Bergeron and Wanet-Defalque, 2013).

The impact of blindness and partial sightedness was also reported to have a negative effect on psychological well-being more than hearing impairment. One study found that although both forms of impairment were associated with greater risk of depression, only blindness and

partial sightedness was associated with poorer social relationships (Carabellese *et al.,* 1993).

Living with blindness or partial sightedness is further documented to have a significant negative impact on people's lives, restricting leisure activities and the ability to work and live an independent life, which can in turn affect other socio-economic factors. For those from the lowest socio-economic backgrounds accessing practical and emotional support for blindness and partial sightedness can be more challenging. As a result, this can heighten their risk of social exclusion and have a negative impact on their wellbeing. This can also hinder their progression into education and securing meaningful employment (Williams *et al.,* 2007).

The emotional impact of living with blindness or partial sightedness has been observed to be pervasive across the lifespan of the person living with it. The experiences and needs of younger and older people are different due to the developmental stage they are at in their lives.

An adolescent living with sight loss has to deal with the difficulties of his or her physical impairment as well as the specific difficulties of adolescence. In considering the impact on adolescents, one study assessed the psychological adjustment of 11 to 16 year olds with blindness or partial sightedness and their sighted peers. It compared 158 adolescents who were blind or partially sighted and 158 adolescents who did not. They found that students who were blind or partially sighted had more peer and emotional problems. With regard to the latter, they observed that differences between students with and without blindness or partial sightedness increased with age. This effect can be explained by an accumulation of stressors associated with adolescence and with blindness or partial sightedness. For example, belonging to a peer group and building intimate relationships are important developmental tasks in adolescence, and students with blindness or partial sightedness have reported more difficulties with mastering these tasks than their sighted peers (Pinquart and Pfeiffer, 2012).

Further research looked at comparing rates of depression between blind and sighted adolescents. This study examined whether the incidence of depression was greater among blind adolescents than among a sighted comparison group. A sample of 22 adolescents, legally blind since birth, and 29 sighted adolescents participated in the study. The adolescents in both samples were between the ages of 12 and 18. The findings indicated that the incidence of depression among the blind adolescents was significantly higher than among the sighted adolescents. There were no significant relationships between demographic variables and depression (Koenes and Karshmer, 2000).

Adolescents living with sight loss are vulnerable to other mental health difficulties as well as depression. Bolat *et al.,* (2011) conducted a cross-sectional study with 12 to 17 year olds. They compared rates of anxiety amongst 40 adolescents with congenital complete blindness and partial sightedness and 40 sighted adolescents. Both groups were matched in terms of age, gender and socio-economic status. Anxiety levels of the adolescents with blindness and partial sightedness were significantly higher than those without.

A significant positive association was found in the area of psychological well-being with both age and social support. Interestingly, when it came to older adults living with blindness and partial sightedness, this suggests older individuals and those who report more social support have higher levels of psychological wellbeing such as improved self-esteem (Guerette and Smedema, 2011). This reinforces the benefit of emotional and social support in the well-being of younger and older adults who are blind and partially sighted.

Counselling psychology is well placed as a profession to assist blind and partially sighted people who may need emotional support and help them improve their psychological wellbeing. Cited benefits of attending personal therapy include improved self-esteem, symptomatic improvement and improvement in social life (Woolfe *et al.,* 2003). The current state and availability of access to emotional support services for blind and partially sighted people will be next considered.

The current state of emotional support services

Blind and partially sighted clients are a unique population of service users who may wish to avail of services counselling psychologists and psychotherapists provide. Having insight into the learned experience of blind and partially sighted clients who have had psychological therapy with sighted therapists can provide valuable information into how to assist and work effectively with them. As has been previously discussed, living with congenital and acquired sight loss can have a negative impact on the psychological well-being of the person.

In this regard, clients who receive a diagnosis of having a condition that will impact on their sight or clients who are born blind may be referred or personally access emotional support services to assist them in dealing with this and other factors associated with living with sight loss.

The accessibility and availability of psychological therapy specific to sight loss is occasionally available through local associations around the UK and there are a few therapists, whether sighted or blind or partially sighted, who specialise in this area (Southwell, 2005). However, on the whole, the need for low-cost, accessible counselling far exceeds the supply. A study in 2008 reported that only 2% of recently registered blind or partially sighted people had received formal counselling or emotional support of some kind in the first year after diagnosis, highlighting this discrepancy (Douglas *et al.*, 2008).

Given that the link between a diagnosis of sight loss with depression and the negative impact on emotional well-being, there is a significant amount of work to be done in the emotional support being offered to people who experience sight loss diagnoses.

Support and information for people living with sight loss in the UK is sadly not reaching as many people who need it. The RNIB in Great Britain has branded this, '*a national disgrace.*' Findings by the charity has revealed that of the 100 people who lose their vision *each day*, only *eight* will be offered some form of counselling. It said these people are at high risk of suffering depression or even considering suicide (Optician, 2009). Since counselling psychology advocates and publicises the benefits of emotional support for all people and contexts, is it currently addressing the emotional needs of blind and partially sighted people?

Counselling psychology's role in providing emotional support

There is something missing within the general field of psychology in addressing the pervasive effects on the emotional well-being people living with a disability such as sight loss, given the emotional impact that living with blindness or partial sightedness can have on a person. In considering this Olkin (2003) concludes, "*Disability studies and psychology can join hands, but they haven't yet,*" (Olkin, 2003, p.303). The metaphor of the joining together of hands suggests that one can support the other.

This not joining together of hands between disability studies and psychology leaves a significant gap in trying to work as a counselling psychologist with clients who are disabled and is the experience I had with working with clients who were blind and partially sighted. When I went seeking information in the literature on working with this client group, I found information was very limited. I was left empty-handed in gaining assistance in working with my blind and partially sighted clients.

This lack of information and the segregation between the profession of psychology as a whole and disability is prevalent in the field of counselling psychology. One study (Foley-Nicpon and Lee, 2012) reported on an exploratory content analysis of disability research in 5 major counselling psychology journals between 1990 and 2010. The goal was to review the counselling psychology literature to better understand the prevalence of disability research, identify research methods most often conducted, and elucidate the types of concerns most studied. They found that disability research continues to comprise an extremely small amount (less than 2.7%) of the counselling psychology literature, with the frequency of articles plateauing in recent years. The research design of articles published has changed, with an increased number of empirical articles and a decrease in literature reviews.

As there is such a low percentage of research conducted by counselling psychologists into disability, the authors concluded by calling for increased empirical investigation of disability among journals specific to counselling psychology to recognize disability as an important aspect of diversity within the field (Foley-Nicpon and Lee, 2012).

Psychology as a training profession has not yet included disability training as part of the mainstream curriculum when studying at under or post-graduate level. Historically in the US, clients who presented with a disability such as blindness or partial sightedness were treated traditionally by specialist rehabilitation counsellors. This decision was primarily due to the misconception that the disability was the sole reason that they were seeking therapy in the first place. Yet disability, whether it is visual, auditory or physical, is something that is part of human existence just as much as culture, sexuality or family. In spite of this, university programmes that train counselling psychologists and therapists still do not include it on their training programmes (Pledger, 2003).

When it comes to students themselves on courses to become psychologists, the segregation on the part of counselling psychology to properly address disability is evident. The findings of research (Lund *et al.,* 2014) into the experience of trainee clinical and counselling psychologists with disabilities at university sadly showed that the majority of the participants reported experiencing disability-related discrimination. Indeed, less than one third had received mentorship from psychologists with disabilities. Most participants in this research did not disclose their disability during the undergraduate or postdoctoral application processes. This research suggests that even at the training stage with students who have disabilities, including sensory ones, that the profession is not doing enough to address the needs of this particular population.

The focus and aims of this research for counselling psychology

My choice to focus this study on working with clients who are blind and partially sighted has been a professional and personal one. As previously mentioned, as a sighted counselling psychologist working with clients who were blind and partially sighted, I experienced the lack of research that is available in the literature of working with this particular clinical population. I felt very *blind* in doing this work and was groping for information to help illuminate my work with this particular population.

The aim within this research is to adhere and extend the reach of research within counselling psychology on this particular topic. Clarkson (2008) discussed with regard to the discipline of counselling psychology that:

> "*Counselling psychology on the other hand is perhaps the mental health discipline which, because of its very youth and recent emergence in this country (UK), its philosophy of openness and inquiry, and its lack of dogmatic adherence to singular approaches, methods or ideologies, could be the most hospitable to the development and celebration of less traditional and perhaps more innovative and experimental forms of integrating research and practice,*" (Clarkson, 2008, p.16).

I sought to have an open inquiry into the experience of blind and partially sighted clients who have had psychological therapy with a sighted therapist. It seeks to help '*join hands'* between disability studies and psychology and increase the 2.7% amount of research that is conducted in the field of counselling psychology into disability.

Research has shown that therapists need to acquire knowledge about various forms of blindness and partial sightedness; the impact these impairments have on daily functioning; and the interactions of these impairments with societal demands to become more effective in working with this population. In addition, therapists need to explore their attitudes about blindness and partial sightedness (Harsh, 1994). The importance of the therapist's attitude is discussed in the findings section of this research as a factor that can exert a positive or negative influence on the therapeutic relationship.

There is a gap in current research exploring the difference of sight when working as a sighted counselling psychologist with blind and partially sighted clients. While current research conducted by blind and partially sighted therapists looks at working with this client group, it does not address the difference of sight and in some cases challenges whether sighted counselling psychologists should be treating blind and partially sighted clients at all (Thurston *et al.*, 2013).

This limited research concluded that the depth of understanding offered to the client by the therapist who was also blind or partially sighted was important to the client, given to some extent a shared lived experience. It raised the question within its conclusions as to whether a therapist with no vision problems and having full use of sight could offer such a sufficient depth of understanding (Thurston *et al.,* 2013).

Given my own experience, I was also curious about this particular aspect of current research. Did the clients that sat with me feel I could not offer a depth of understanding into their lived experience when I was fully sighted and they were not?

The application of my research within the field of counselling psychology may address an even larger issue within counselling psychology of working with difference in general between therapist and client. Would clients who have specific needs or disabilities be reluctant to engage in therapy with a counselling psychologist who has no lived experience of that particular matter? It may help to shed light on the issue of working and managing client and therapist difference in therapy. In my own training to become a counselling psychologist, I received no teaching or training with regard to working with disability, let alone working with clients who are blind and partially sighted.

Cultural or physical diversity between therapist and client can be anxiety provoking for both, as the difference can be perceived as a barrier to facilitating a therapeutic alliance (Lau Chin *et al.,* 1993). Working with differences between client and therapist is a common situation and one that may need to be addressed to aid establishing a working relationship.

I have worked with many clients who are blind and partially sighted within my career as a counselling psychologist. In some cases I have treated the same client on more than one occasion. I currently work for an NHS mental health trust into which blind and partially sighted clients are referred. I have been working with this trust for over five years now and have had no training on working with blindness and partial sightedness.

As I work for an NHS trust that is London based, I have received training on working with cultural difference. I have regular mandatory training on working with equality and diversity, particularly different ethnic groups. This training is to ensure I have good insight into these groups and remain understanding and respectful. Again there is inequality here in the training offered to work with cultural difference, but not with clients who have a visual disability.

Given the statistics regarding the number of people who are living with, or could in the future be living with blindness or partial sightedness in the UK, coupled with the evidenced psychological impact of living with such; counselling psychology at present does not seem to

be addressing this need on an academic, research or training basis. My own experience of feeling *'blind'* when working with this client group and looking for guidance into how to do so in a way that will be most helpful for my blind and partially sighted clients, has led me to conducting this research.

I have been mindful and aware of my own reflexive position in conducting this research. I am aware that my own biases, characteristics and ideas will naturally play a part in this research process. The etymological root of the word reflexive means to "*bend back upon oneself*" (Finlay and Gough, 2003).This has been an interesting and challenging position to hold as I am not blind or partially sighted and conducted the research as a sighted person seeking to gain access to a world that I have no personal experience of.

In holding this reflexive position, I sought be a researcher whom Bruner (1986) described as one whom *"…appears not as an individual creative scholar, a knowing subject that discovers, but more as a material body through whom a narrative structure unfolds,"* (Bruner, 1986, p.150). I want my material body and research to reveal the narrative of the clients that I was privileged to interview.

Review of related literature

Overview

Lather (1999) suggests that a literature review should synthesise the information on the topic being discussed and, in doing so gain a new perspective and clarify what has been done and what still needs to be done. Such a synthesis enables the literature review to clarify and resolve inconsistencies and tensions in the current literature with the purpose of making a genuine contribution to the state of knowledge in the field. I have sought to follow this approach when it comes to placing my research within the current psychological literature on the subject that I have chosen.

I sought to review the published literature around the subject of therapy for blind and partially sighted clients, on five main areas:

(1) Psychology's historical relationship with the sense of sight.

(2) Psychology's current relationship with the sense of sight.

(3) Psychology and psychotherapy's relationship with disability.

(4) Definition and models of disability.

(5) The actual experience of working therapeutically with clients who are blind and partially sighted.

My subsequent findings highlight, as Lather (1999) mentions, areas of needed clarity and what still needs to be done within this area of visual disability and counselling psychology.

(1) Psychology's historical relationship with the sense of sight

Historical as well as societal perspectives toward the blind, reveals an erratic course over the ages (Lowenfeld, 1976). Historically the blind and other disabled individuals were considered liabilities. This was largely due to limitations imposed by such disorders in carrying out activities (e.g., hunting, building shelter) requisite to survival. Later, in Greek and Roman civilizations, people with disabilities were discarded by death as infants as they were

viewed as a burden to society and did not have any other merit to warrant living (Sisson and Van Hasselt, 1987).

With this historical perspective prevalent toward people with disabilities such as blindness, this pervasive attitude seemed to also permeate scholars at the time when philosophy was investigating human existence and what constituted and influenced human perception and consciousness. Since its beginning, the discourse of philosophy has for the most part either taken the visual interpretation of philosophical thought for granted or else explicitly proclaimed it. As Heidegger (1962) observed, *"From the beginning onwards the tradition of philosophy has been orientated primarily toward 'seeing' as a way of access to beings and to being,"* (Heidegger, 1962, p.187). Historical philosophy has extolled the act of seeing and sight in a very literal sense and deemed it necessary in interpreting the world around us and making meaning of our existence based on what we can literally see with our eyes.

Since the days of ancient Greek philosophers sight was regarded as the most important of the senses. Aristotle stated that it's the sense yielding the most knowledge and excelling in differentiation (Jonas, 1954). This classical view holds that sight as a sense is superior in aiding us in our perception of the world around us through the sensory information that sight affords us.

This philosophical position of sight being so important, as a result did not consider the experience of living with sight loss and how that impacts psychologically, emotionally or philosophically for humans. In the times of Aristotle, disability was regarded as burdensome to society and laws allowing infanticide for disabled infants were in existence, therefore sight and ability were regarded as superior abilities to possess and in essence actually saved the person's life in some instances. There was a clear distinction toward those who were *abled* and *disabled* within society.

It has been argued that the discourse of philosophy is itself a historical construction that has often relied heavily on a vision generated vocabulary and way of thinking. This bias toward the visual and the literal sense of seeing has influenced the discourse of philosophy and some of the concepts that it has brought to bear (Gavin and Levin, 1999).

This visual bias can be seen in the use of such words in philosophy as *speculation, observation, insight, reflection* and also in the use of metaphors such as *mirroring, clarity,* and *perspective.* It is also seen in certain methodological concepts as *analysis, reflective detachment* and *representation.* (Gavin and Levin, 1999). The discourse and language used within these expressions highlights a visually biased vocabulary. Historically, the field of philosophy and its evolution into psychology as we know it today, in general was visually biased. Society's position on disability influenced this historical position and as will be

discussed in the findings, this current position on disability still has a significant impact on blind and partially sighted people living in society today.

(2) Psychology's current relationship with the sense of sight

With this early dominance of philosophy being heavily influenced by the visual and the sense of sight, Rorty (1981) discusses that philosophical thought in the twentieth century moved away from this dominance of sight and took a *linguistic turn.* In the analytical schools of Bertrand Russell and Ludwig Wittgenstein and in the continental schools of Edmund Husserl and Martin Heidegger, the authority of vision held by early philosophers as the archetype of knowledge, truth and reality was overthrown and replaced by a paradigm in which language is given a determinative role. This philosophical challenge was a turning point for current philosophical and psychological thinking with regard to challenging the position occupied by the literal sense of sight and what that means to human consciousness (ibid.)

An example of this change and challenge is recorded by Nietzsche (1968) in his book *Twilight of the Idols.* Here Nietzsche wrote that, *"one has to learn to see, one has to learn to think, one has to learn to speak and write: the end of all three is a noble culture,"* (Nietzsche, 1968, p.6). This shift away from inherent sight as a means to understand and enlighten, focuses instead on sight as a culturally defined term and is something that we *learn* rather than being an inherent, accepted part of the human condition. Sight therefore moved from a literal position to a symbolic one, which opened it up to differing interpretations and meanings.

Given that certain twentieth century philosophical discourse moved away from the supremacy of sight in understanding the human condition and was focused on the part played by other senses, in particular language, did the study of psychology and its related fields follow?

It has been argued that modern culture is shaped by the visual and as a result this can lead to bias and again a preference for sight as a superior sense. Television, computers, social media, art and photography all rely heavily upon the visual aspect and the visual format plays the greatest role in this (Arlen, 2000). Psychology may also suffer from this visual prejudice, again defending this historical, default position of sight being the primary sense and holding this literal and not a symbolic position as is observed in some psychological approaches.

Psychological theory traditionally relies upon the existence and availability of eye contact between the therapist and the client. Eye contact between therapist and client has been discussed in relation to being a central aspect and therapeutic tool of psychological treatment. The assumption is that eye contact can create distress between therapist and patient and also create an atmosphere where the patient feels embarrassed to disclose something and make them feel self-conscious (Gabbard, 2010). Within psychiatry when trying to assess a patient's mental health state by examination, eye contact is a factor in determining key diagnostic and treatment implications (Foley and Gentile, 2010). Again the popular default position of sight as a superior sense is being upheld. The importance of the literal act of seeing is defended and the symbolic meaning of sight is ignored.

Some psychological therapies place great emphasis on the use of eye contact within the therapeutic alliance. Gestalt Therapy often focuses on where energy is in the body and how it's used and can be causing an emotional blockage. Blocked energy is seen as a form of resistance and avoiding eye contact is seen as one of these blockages that maybe inhibiting awareness (Corey, 2005).

For clients who are unable to see, this aspect of Gestalt Therapy considering lack of eye contact as blocked resistance is redundant as this interpretation can't be made. In this instance, lack of eye contact is seen as pathological and indicative of a psychological defence mechanism. This assumption again holds that lack of eye contact on the part of a client is clinically significant in interpreting their emotional state of mind and reinforces the literal use of sight.

Another example of a psychological therapy which places great emphasis on sight is Eye Movement Desensitisation and Reprocessing (EMDR). This is a treatment that claims to resolve long-standing traumatic memories within a few treatment sessions. During EMDR treatment, the client is asked to hold in mind an image of the trauma, a negative connotation, negative emotions and related physical sensations about the trauma. While doing so the client is instructed to move their eyes quickly and laterally back and forth for 15 to 20 movements, following the therapist's fingers. The client then reports the images, cognitions, emotions and physical sensations that emerged. This recursive procedure is repeated until the desensitisation of traumatic material is complete and positive self-cognitions have replaced the previous ones (Wilson *et al.*, 1995).

The literal use of sight in psychological treatment is again reinforced here. Given that some blind and partially sighted clients acquire these conditions as a result of a traumatic incident such as an accident, EMDR could be very helpful for them dealing with that particular

traumatic experience. However, its emphasis on the literal use of the eyes within the treatment makes it redundant for blind and partially sighted clients.

This bias toward the visual is further seen in the part that eye contact plays in managing interpersonal relations. Eyes preface most new relationships, overshadowing other sensory inputs while transmitting a wide assortment of emotional cues. Visual behaviour may at times prove decisive in assuring survival, in amorous encounters, and in clarifying interpersonal motives.

Ocular performance, a common pathway for many social, cultural and emotional determinants, is a crucial factor in defining relationships and in allowing reciprocal influences to be exchanged as persons relate. In psychiatric patients, ocular behaviour may provide clues to diagnosis. A frequent finding in such persons is gaze aversion, a social avoidance phenomenon which indicates a desire to attenuate the interpersonal experience and thereby decrease anxiety (Grumet, 1983). Literal lack of eye contact is seen as pathological and is interpreted as defining pathology within the patient.

Some psychologists and educators have speculated that 90% to 95% of the perceptions of sighted children come from vision (Hatlen and Curry, 1987). This again returns to the visual bias that exists within psychology when it comes to the value placed on literal sight.

Just as some areas of psychology seem to reinforce the literal use of sight, there are some sectors that are challenging the bias of sight and seeking to understand perception and also blindness and partial sightedness from a different perspective (Cattaneo and Vecchi, 2001). The field of neuro-psychology is trying to understand sight not from the sole perspective of thinking about vision strictly in literal terms of "*seeing with the eyes*" (ibid.).

Studies in neuro-psychology consider that mental images are not solely generated by the brain when we actually physically see something; rather we can generate a mental image of something that we have never actually physically seen (Pietrini *et al.,* 2004). This challenges the literal use of sight as a means to understand the world and brings the symbolic nature of sight, as previously mentioned by Nietzsche (1968) back into the argument.

The symbolic interpretation of sight is illustrated when a friend describes something new, such as an item of clothing or furniture they have bought. Although we have not physically seen it we can generate a mental representation of what we *think* it looks like in our mind. Although the object is not directly in front of us and we cannot *literally* see it, we can build a *symbolic* picture of it in our minds and *see* what it may look like. This is a shared experience of both sighted and blind and partially sighted people.

This example implies that a blind person and partially sighted person can also experience vivid mental representations of things that have not physically seen (Cattaneo and Vecchi, 2001). They can generate mental representations in their minds, without the need to physically see something. This ability to do so is not just the privilege of the sighted.

For those who possess sight, imagery processes are mainly visually shaped because we rely heavily on sight and visual input in perceiving the world around us. This may lead those with sight to be visually biased in how they interpret the world around them. This again is considered in the findings as something that sighted therapists engage in which can lead to challenges in working with blind and partially sighted clients.

Research has concluded that touch and hearing can provide sufficient information for a blind person to generate a reliable internal representation of the external world. There are regions of the brain that, even when there is no sensorial deficit, process information regardless of its original source and respond to a specific object when this is either seen or touched (Pietrini *et al.,* 2004). Neuro psychological research concluded that mental representation does not strictly need vision to be produced as that may be generated through information acquired in other sensory modalities, such as touch or sound by accessing semantic information stored in the long-term memory (ibid.).

Such studies in neuro-science into the nature of vision and the brain, consider how the brain is *supramodal*. This refers to the neural integration or combination of information from different sensory modalities (the classic five senses of vision, hearing, touch, taste, and smell), rather than the reliance of the brain just on sight to help process information. This area of psychology challenges other traditional fields of psychology (including counselling psychology) that have concluded that sight is needed for perception and mental representation.

The present position that psychology occupies when it comes to the sense of sight is divided between the classical and historical position of sight being vital to perceive the world around us and the importance of the visual in psychological treatment. This is being challenged by neuro-psychology's position of sight being a *symbolic* process that is far more detailed and intricate involving far more than actual eyes that see. The view that neuro psychology has reached is one that states that our brain does not need our eyes to *see.* (Cattaneo and Vecchi, 2001). As will be discussed in the findings, lack of literal sight in the therapeutic relationship can be creatively replaced by other senses which facilitate effective communication and demonstrate the *supramodal* ability of the brain.

The ability to express mental images without actually seeing them is observed in the music of Stevie Wonder. Stevie Wonder was born premature and as a result his retinas detached

and he never had the ability to see. In his music, he had lyrics that spoke about images and objects that he has never *actually* seen. His ability to do this is an example of the *supramodal* ability of the brain to use the other senses apart from sight to process information and make mental representations of objects that have never actually been physically seen. Stevie Wonder described his ability to do this when he said, *"Just because a man lacks the use of his eyes doesn't mean he lacks vision,"* (Ribowsky, 2010, p.2). Our perception of the world is highly integrated and unitary and does not involve just one sense.

(3) Psychology and psychotherapy's relationship with disability, including visual disability

Although blindness has existed since the beginning of recorded history, it only became a societal concern after the First World War, when hospitals were filled with blinded war veterans. The men who were perceived as powerful and praised for heroically leaving to fight in the war, were now perceived as weak and helpless due to losing their sight (Cholden, 1958).

Following the Second World War, rehabilitation professionals began to analyse and consider the issues of living without sight as this was being observed in men returning from war. Initial psychological theory with regard to sight loss focused on the psychological death of the sighted individual and his rebirth as a blind man (Cholden, 1958). This transitional model considered that changes in identity from a sighted person to non-sighted was problematic for these men and thus facilitated emotional distress.

Common psychological reactions to vision loss as observed by professionals at the time included anger, resentment, shock, depression, and grief (Chevigny and Braverman, 1950). Further analysis examined the losses in psychological security, basic skills, communication, financial and occupational status, and personality that result from blindness (Carroll, 1961). Carroll, in his book, Blindness, What it is, What it Does and How to Live With it (1961) states:

> *"It is superficial, if not naive, to think of blindness as a blow to the eyes only, to sight only. It is a destructive blow to the self-image which man has carefully, though unconsciously constructed throughout his lifetime. A blow almost to his being himself,"* (Carroll, 1961, p.11).

Carroll was suggesting that psychological adjustment to disability, in particular sight loss, involves recognition of the changes that the loss of sight have wrought, not just on an actual physical level, but also a psychological level connected with the self-image of the person. He

suggests that a restructuring of the ego will allow for the incorporation of one's self-image to include the disability of sight loss. He further suggested until this psychic restructuring takes place that a person is not able to adjust to their life situation or move forward toward rehabilitation of planning for their life ahead. The impact of sight loss on personal identity is discussed in the findings section later on.

In line with the above, the traditional grief model was applied to people who experience the irrevocable loss of sight in adulthood and go through emotional and psychological reactions associated with grief. The five-stage grief model proposed by Kubler-Ross (1970) moving from denial to acceptance was applied to adults who had lost their vision. Yet, counselling psychology falls short of researching the psychological impact of sight loss on the person.

As has been previously mentioned, one study on five major counselling psychology journals between 1990 and 2010, found the amount of disability research to be less than 2.7% (Foley-Nicpon and Lee, 2012). Studies of working with disability including visual disability within counselling psychology are not well established and are in the minority when it comes to the foci of research.

Part of the reason for this lack of focus on disability, in particular visual disability, may be due to the difficulty in defining blindness. Blindness is a difficult term to define because it is not completely specific. It represents a vast range of ability to perceive the outside world (Warren, 1994). For example, the term 'legally blind' describes many conditions, however only 25% of the legally blind see little or no light (ibid.).

Of all the definitions of blindness, legal blindness is perhaps the most agreed upon. This definition encompasses people who, with correction, have a vision of 20/200 or less in their better eye and/or a visual field of less than 20°. While these criteria were developed for purposes of aid distribution, children with the same vision can have vastly different visual experiences. In schools, a visual acuity of 20/60–20/70 is required to receive special education and between 20/60 and 20/200 a child is said to be blind or partially sighted (RNIB, 2015).

Many different mental health conditions and disabilities are rated on a scale of functioning and experience and blindness is no different. It is another disability that depending on the individual person has a specific impact on their functioning and lived experience. What actually constitutes disability is not clearly definable either. In disability and social science research, such as psychology there is no consensus on what constitutes disability. There are no commonly accepted ways to define disability including visual ones and to measure it. This struggle to define disability and its implications is next discussed.

(4) Definitions and models of disability

Disability, including visual disability has been subject to many definitions in different disciplines and for different purposes. It has been described from medical, sociological, and political perspectives, and definitions of disability have been developed and used in different contexts. Various operational definitions have been used for clinical circumstances and administrative programmes, and several theoretical models have been developed (Altman, 2001).

Many disability scholars recognise that no single model can totally explain disability, including visual ones, as noted by Pfeiffer (2001). It is with this openness toward a disability definition that this research is placed, seeking to understand the unique experience of the disability of blindness and partial sightedness rather than a definitive assumption of what visual disability is.

The traditional medical (or biomedical) model of disability considers it to be a problem of the individual that is directly caused by disease, injury, or some other health condition that requires medical care in the form of treatment and rehabilitation. The medical model attributes the problem to the individual, who has a condition that is unwanted and that places him or her in the "*sick role*" (Parsons, 1975). It is strongly normative as people are considered disabled on the basis of being unable to function as a *normal* person does. It makes a clear distinction between *ability* and *disability.*

This medical model has been criticised on different grounds, including its normative strength (Amundson, 2000). Hailing back to traditional thinking about disability discussed previously, this model sees the person with a disability as being *less than able* in comparison to the rest of society and so are therefore deemed as being without certain abilities. This model and mentality leaves people with disabilities open to stigmatisation, discrimination and pathologises the person with the disability. No social or individual abilities are taken into account.

Underlying this medical model is the assumption that pathology is present and that disabilities are objective things that exist within themselves. Bickenbach (1993) describes the model in this manner:

> *"The most commonly held belief about [this model of] disablement is that it involves a defect, deficiency, dysfunction, abnormality, failing, or medical 'problem' that is located in an individual. We think it is so obvious as to be beyond serious dispute that disablement is characteristic of a defective person, someone who is functionally*

limited or anatomically abnormal, diseased or pathoanotomical, someone who is neither whole or healthy, fit or flourishing, someone who is biologically inferior or subnormal. The essence of disablement, in this view, is that things are wrong with people with disabilities." (Bickenbach, 1993, p.61).

The medical model places people with disabilities into stigmatising categories, therefore allowing others to view them in their category, such as the blind, the deaf or the mentally ill. (Nagi, 1969). Its lack of attention to the individual's environment and its focus on the individual, places the disability as existing totally with the individual. Accordingly, the individual who is responsible for the *problem* of the disability in the first place should also be responsible for the solution (Kiesler, 1999). This reinforces seeing disability and sight loss as pathological and does not take into account any of the other *abilities* that the person with that particular disability may possess. It is generalist and not individualist in its approach.

Speaking about this medical model of disability, blind psychologist and family psychotherapist Adriene Asch (2001) asserts medical understandings of disability are based on erroneous assumptions. It deems life with a disability to be an unremitting tragedy that is forever disrupted by it. It also assumes that the disabled person experiences isolation, powerlessness, poverty, unemployment or low social status due to the consequences of living with the disability. Pointedly, Asch herself became blind at a few weeks old from retinopathy of prematurity and went on to become a scholar and professor at Yeshiva University in New York, demonstrating her personal *ability* and not *disability.*

This *old paradigm,* as it is often referred, stands in contrast to the social model of disability. The social model has at least nine different versions and in general sees disability as a social construct. Disability is not the attribute of the individual. Instead, it is created by the social environment and requires social change. Disability activists in the Union of the Physically Impaired Against Segregation (UPIAS) developed the UK social model, at the heart of which lies societal oppression. (Oliver, 1990). This model moves from the general to the specific, in stark contrast to the medical model.

The core definition of the British social model comes in the UPIAS document 'Fundamental Principles of Disability', an edited version of which is reprinted by Oliver (1996):

"In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society." (Oliver, 1996, p. 22).

Inherent in this social model of disability are three aspects: 1) People with disabilities must define disability. 2) People with disabilities must refuse to allow '*experts*' or *'professionals'* to

define the disability, determine the outcome of their lives, or judge the quality of their lives. 3) People with disabilities refuse the *disabled role* of pathology. In this model it is not professionals who define what the disability is and the experience of living with that, rather disability rights activists assert their rights of self-definition and self-determination (Smart and Smart, 2006). This position enables the '*experts*' who are the people living with the disability to define what they can and can't do, not medical *'experts.'*

In this regard, medical professionals including psychologists are not the 'experts' on disability and what it is, rather this belongs to the person who is disabled using the unique, lived experience that they have in living with the disability. This topic is picked up in the findings as something that sighted therapists need to be mindful of when working with clients who are blind and partially sighted.

As previously discussed, there is lack of training and research within psychology and counselling psychology toward disability in general. The lack of training, research and failure to provide specialist services for people who are blind and partially sighted may be due to the strong influence models of disability have on the training received on psychological training courses. These powerful models of disability determine in which academic disciplines the experience of disability is studied and taught (Pledger, 2003).

Thomas (2004) highlighted that in the field of mental health, only rehabilitation counsellors were trained in disability issues. This reductionist approach holds that a disability such as sight loss is the sole focus of the person who lives with it and that this is their pathology. With such a focus, only those practitioners who work with such clients and presentations should be trained in dealing with clients living with this particular disability.

This stance leaves psychological practitioners with no training about working with disability, including visual ones, when they are in education and training or even after they have qualified as psychologists. It leaves counselling psychologists *blind* when working with a blind or partially client presenting themselves for psychological therapy. There is no *joining of hands* between disability and psychology.

It is in this social model of disability rather than the medical model of disability that this research is placed. The social model as opposed to the medical model places disability in a non-pathological role and sees disability as being a social construct rather than a medical pathology. As a sighted counselling psychologist, I was not the '*expert'* on the people that I interviewed, so I had to hold the social model of disability to understand what being blind and partially sighted meant to the individuals I interviewed.

Psychologists, doctors or medical personnel in general are not the '*experts*' on disability. I hold to this position as the researcher. I was not, and am not, the '*expert'* on the visual disability of the participants that I interviewed, rather they are and it's their lived experience and voice which is the focus of this research.

The final section will consider the actual experience of working with blind and partially sighted clients and what this has revealed.

(5) The actual experience of working therapeutically with clients who are blind or partially sighted.

Disability research in general and working with blindness and partial sightedness within counselling psychology is very limited, as has been previously mentioned (Foley-Nicpon and Lee, 2012). Within mainstream psychological literature and grey literature, there are limited studies and information of the actual experience of working therapeutically with clients who are blind or partially sighted. This reinforces yet again how under-researched the area is.

The provision of psychotherapy and counselling psychology to the general public may be anticipated as one that is an enlightened space where people with different abilities and disabilities feel understood, appreciated and empowered. This space can potentially provide a reprieve and a positive experience from some of the stigma and marginalisation that they may feel by society in general. This can be seen when working with patients that maybe experiencing this societal stigma in areas of sexuality, gender or culture (Clarkson, 2008).

The act of disability or disabling the client can be sadly seen when clients with a disability present for psychotherapy (Reeve, 2000). What is experienced is a reinforcement of societal stigma and not the empowerment as already mentioned. Good psychological practice requires the therapist to really *"look and see the phenomenology of behaviour that the client is presenting to the therapist"* (Prouty, 2001, p.35). This requires the therapist to be aware of their own assumptions and attitude toward disability and be open to the person that is in front of them and not reduce them to their disability.

Observing this phenomenology of the client also requires the therapist to be introspective and aware of what is happening personally to them as they work with disability. There is a need for the therapist to carefully watch their own readings and understanding of what is informing their perceptions. Therapists often need to be taught with methods that are

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applicable and particular of the disability of the client that they are treating (Titchkosky, 2007).

This suggests a more individualistic approach needs to be adopted when dealing with clients with particular disabilities such as sight loss and not a general approach to disability. It also suggests that therapists need teaching and training in working with this client group. This again reinforces the individualistic social model and not generalist medical model toward working with disability as you could not work the same way with a blind client as you would with one who is paralysed. The existing attitude of the therapist could reinforce the societal stigma the person feels and not fostering personal growth.

When working with clients who are disabled, including those with a visual disability, therapists who maintain a general approach of treating the disabled client in the same manner as they would a non-disabled client may actually be doing more harm than good. Humes *et al.,* (1989) suggested that therapists have not facilitated the personal growth and development of their clients with disabilities. They concluded when assessing research into working with clients with disabilities including sight related ones that:

> *"The literature includes many testimonies of persons with disabilities…who have achieved successful careers despite roadblocks they perceived to have been imposed by counsellors."* (Humes *et al.,* 1989, p.145).

This highlights the need for psychological practitioners to be informed regarding working with clients who have a disability and to have an awareness of the client's needs and also their own attitude toward disability. Due to the lack of training and research into working with clients who are blind or partially sighted, sighted therapists may struggle with relying on how they work in general with sighted clients and this could be doing more harm than good to the blind or partially sighted client. A tailored approach is needed rather than a general one. This mirrors the reductionist, generalist medical model of disability and makes redundant the societal model that looks at ability and personal meaning.

When working effectively with this client group, it has been highlighted that people with disabilities want respect and not sympathy when engaging with psychological therapy. Sympathy and lower expectations maybe considered prejudicial and stigmatising to the client who has a disability. It can also reinforce the '*expert'* role that the therapist is assuming.

Sympathy may also result in the therapist withholding honest feedback. It can foster dependence and subtly communicate the message to the client with a disability that standards will be lowered for them because they are not perceived by the therapist to be

capable (Harris, 1992). Such communication could be a default position of *ableism* on the part of the therapist and also the field of psychology in general.

Ableism is a form of prejudice towards people with disabilities which illuminates society's influence in disability discrimination. An '*ableist'* is a person influenced by society's assumption that those without disabilities are more capable than those with disabilities. Thomas Hehir (2007) explains that an ableist perspective asserts that it is preferable to read print rather than Braille, to walk rather than to use a wheelchair, to spell independently rather than with the aid of a spell-checker and to socialise with non-disabled people rather than disabled people (Hehir, 2007). It segregates ability and disability, with ability portrayed in a positive light and disability in a negative one.

Assuming that there is only one *right* way to learn, walk, talk, paint, read, and write is the root of fundamental inequity or ableism (Hehir, 2007). These ableist perspectives may present themselves in the room by the sighted therapist and as a result enter the therapeutic relationship. An ableist attitude is demonstrated in the sighted therapist treating the blind and partially sighted in the same manner as a sighted client. Examples of this are discussed in the findings section.

In the peer reviewed literature there is scant research in this area generally of the experience of blind and partially sighted clients who have had psychological therapy with a sighted therapist. There is documented research into the psychological effects of living with blind or partial sightedness and the emotional impact of this. When it comes to how to work with this particular client group and the potential individual needs that they may have, unfortunately this is not well documented.

Blindness and partial sightedness is positioned together in working with disability in general, rather than seeing it as its own unique population with unique needs. In so doing it does not take into account the developmental stage of the person living with blindness or partial sightedness and the role that this plays in their lived experience. This can leave the blind and partially sighted client vulnerable to experiencing some "*roadblocks"* as Humes *et al.*, (1989) discussed earlier.

In addition to the published scientific studies, more material is found in the grey literature from organisations such as the RNIB and The Thomas Pocklington Trust which focus on addressing and meeting the needs of people who are blind and partially sighted. The reach of these organisations is broad and includes both practical and emotional support for people who are blind and partially sighted.

Such articles from The Thomas Pocklington Trust have included *'The Opinions of People with Sight Loss on Visual Impairment Research,'* seeking to give voice to people living with sight loss. They also produced an article entitled *'Emotional Support to People with Sight Loss.'* The RNIB also offer leaflets to members of the public regarding emotional support when dealing with sight loss and how to access the services that they offer. Such services include telephone based counselling and also face to face counselling at certain centres around the country run by the organisation Action for Blind People. This goes some way to help highlight the needs of this client group.

The value of grey literature from organisations like The Thomas Pocklington Trust and RNIB although not peer-reviewed or disseminated through a publisher, can report useful scientific findings. Grey literature is recommended for inclusion in systematic reviews and is used to inform policy and best practice (McLaughlan, 2008).

One particular study examined grey literature from 2001 to 2008 concerning emotional well-being in people with sight loss. This research identified 24 studies that either investigated emotional well-being or evaluated an intervention for its influence on emotional well-being in working age adults and older adults with sight loss. Some of the findings of this study suggest there is sufficient demand for an emotional support service by those who are blind or partially sighted and that such a demand is not being met (Nyman *et al.,* 2010).

This study recommended that future research needs to address how people want to be emotionally supported and if their needs are being met in services that provide emotional support for blind and partially sighted clients. In order to address the emotional support that blind and partially sighted people need, it is imperative that they are asked what these needs are and this support is subsequently tailored to their individual needs (Nyman *et al.,* 2010).

A study conducted in association with the RNIB evaluated a service that offered emotional support and counselling to older blind and partially sighted people in Bristol. Clients in the study were offered between six to twelve sessions of counselling. In evaluating the outcomes of service users positive outcomes were uncovered. It was shown that clients reported increased confidence and a purposeful conquering of physical barriers, such as finding new and creative ways to perform everyday tasks and maintain hobbies. They also reported better relationships with others and interestingly an alleviation of internalised prejudice towards their disability (Hodge and Barr, 2010).

This study highlighted that when emotional support services are tailored to the individual needs of blind and partially sighted clients, the experience is a positive one. Again this study was a very general approach to the impact of the emotional support on the blind and partially sighted people who received it. It did not offer any insight into the actual experience for the

client or the therapist and what was said or done within the therapeutic space that made the therapy a positive experience. This gap in the research was not discussed.

A paper is available through the RNIB called, '*Different Horizons; Information and Resources for Counsellors Working with Clients who are Blind or Partially Sighted.*' This paper contains practical information for counsellors who work with clients who are blind and partially sighted, and discussing ways in which to make their room and personal approach helpful for this particular client group. It talks about matters such as accessibility, lighting and also relational dynamics.

In the paper, Dale (2008) concluded:

> *"How we respond to difference, and our own thoughts and feelings about being blind will affect the therapeutic relationship, and being genuine about our not knowing seems key to enabling blind and partially sighted clients to engage with the therapeutic process. As ever, it is important to remain self-aware and check out with your client what sight loss may mean to them, and what (if anything) they need from you."* (Dale, 2008, p.30).

This discusses the importance of the need for sighted therapists to be mindful of how they respond to the difference of sight and also to stay with the individualistic and not generalist approach to sight loss. It also speaks about not assuming what the client needs from us, rather it is important that the client is asked what their needs are. Again, this area is discussed in the findings section.

Dale (2008b) also described the personal narratives of the experience of sight loss by clients in a counselling context. Her paper interviewed two clients who were blind or partially sighted about their experience of counselling using narrative practices. Both participants in this paper discussed how the medical model of sight loss had silenced and isolated them. Their being able to tell their stories and be listened to by the counsellor enabled them to feel connected with positions of strength, rather than when they were "*talked about by experts",* which left them feeling disabled and powerless. This again reinforces the need to personally question attitudes about disability.

In this paper the difference of sight between therapist and client was not considered and although it captured the experience of sight loss in a counselling context, it did not examine the phenomenon in detail with regard to a sighted therapist having therapy with a blind or partially sighted person. No information was offered with regarding to what occurred in the therapeutic space that made the experience a positive experience for the client.

Additional research (Thurston, 2010) inquired into the emotional impact of sight loss and the counselling experiences and needs of blind and partially sighted adults in the United Kingdom. Part of the research included qualitative results based on semi-structured interviews with blind and partially sighted participants regarding their counselling experiences and needs. Within this research it was reported that all participants described their experience of being a client and mentioned that there was evidence of a power imbalance between blind and partially sighted clients and sighted clinicians. The difference of sight was perceived as a possible '*roadblock'* in the therapy.

This research cites the difference of sight as the source of the power imbalance. When asked about their perceptions and experiences of counselling, it was reported that all participants generally had a negative view of counselling. It was further reported in the interviews that there was some distrust of a sighted counsellor's ability to understand a blind or partially sighted person's lived experience. Some reported that counselling with a sighted person would be a waste of time and that a sighted person could never fully understand the world of a blind or partially sighted person (Thurston, 2010).

Thurston (2010) highlighted the key role that therapy can play in helping people through the stages of the transition of sight loss, particularly at the time of diagnosis and during rehabilitation. It also highlighted the importance to blind and partially sighted people themselves of receiving counselling from someone who understand the experience of being blind and partially sighted, underlining the need for specialist counselling services for people with this disability.

It also highlighted the potential issue for sighted therapists who work with blind and partially sighted clients. With no lived experience of living with sight loss, they could never fully assist this client group. This puts sighted therapists in a difficult position. How can they help blind and partially sighted people when the difference of sight is inherent in the therapeutic relationship?

The research of working with blind or partially sighted people was followed by a further study by Thurston *et al.,* (2013). One of the researchers is blind or partially sighted therapist who worked with a blind or partially sighted client. The paper consisted of a single case study of counselling for sight loss. Part of the findings was that the therapist being blind or partially sighted was helpful for the client in facilitating a shared lived experience.

The areas for future consideration questioned whether a therapist with no vision problems could learn to offer a sufficient depth of understanding to a blind or partially sighted client. This seemed to reinforce the position again that a sighted therapist could not really help a

blind and partially sighted client as the difference of sight in the therapeutic relationship was a '*roadblock'.*

Examining the actual experience of working as a sighted therapist with blind and partially sighted clients, a sighted therapist wrote about his experience of working with an older client group who were blind or partially sighted (Nicholls, 2005). He discussed the process of 'demystifying' blindness and partial sightedness as a therapy issue. Providing for a previously poorly represented group was the most significant learning curve and one that took both research and hands-on experience to comprehend.

He further discussed that in order to make the therapy process accessible, he needed to think about the different elements of the therapy space, including lighting, contrast and décor. Too, he had to consider how to use creative tools such as tactile objects for representation, contrasting media of dark paper and bright chalks and large print. He also needed to consider how to use metaphor, symbolism, and visualisation.

He also reported that some clients expressed the feeling that no one else could possibly understand their predicament unless they were blind or partially sighted themselves, with the perception that there would be deeper empathy from a blind or partially sighted therapist, and perhaps a potential role model (Nicholls, 2005).

In contrast to considering the similarity of sight loss between therapist and client as something advantageous to the therapeutic relationship, an additional article examined a three year study of psychological treatment between a blind therapist and a blind client. The difference of sight was not a factor. The blind therapist was supervised by a sighted supervisor who wrote the paper on the findings that came out of the supervision (Borg, 2005).

One of the matters arising from this paper is that the client's choice of choosing a blind therapist reflected a belief that the therapist would be able to recognize something deep and hidden in her, as if only another blind person could recognize the unreachable. This reinforces the belief from the Thurston (2010) and Thurston *et al.,* (2013) studies that therapy between a blind and partially sighted therapist would be preferable than therapy with a sighted client.

Borg (2005) reported when the therapist told the client about her vision loss, the client in an expression of empathy responded that she knew what that was like for the therapist. The paper reflected that, that could not be true, as the client had been blind from birth and therefore could not really know what the therapist had lost. The client's experience of knowing or understanding her therapist was based on an important, but fantasized,

identification. In addition to their symbiotic collusion, it seemed as though therapist and client were experiencing complex cross-identifications, in which they recognised disavowed and dissociated aspects of themselves in each other (ibid.).

This paper stands in contrast to the previous research regarding blind or partially sighted therapists being better placed to work with blind and partially sighted clients. Instead of the similarity of sight loss being a beneficial factor, here it was a '*roadblock'* as the similarity in therapist and client facilitated a fantasied projective identification in the client which had a negative impact on the therapeutic relationship. Here similarity, and not difference, is observed as being problematic.

Summary

This section has examined the actual experience of working therapeutically with clients who are blind or partially sighted. Research within this area questioned whether a sighted therapist could psychologically assist a blind or partially sighted client as they do not have the same lived experience. Questions have also been raised as to potential power dynamics which can operate in the therapeutic relationship when the therapist is sighted and the client is not.

My research asks blind and partially clients who have had psychological therapy with a sighted therapist of what their experience was like. It documents this experience from the perspective of the client and thus aims to address the difference of sight in the therapeutic relationship and associated potential power dynamics. It also examined positive and negative factors which occurred during the therapy.

It aims to question ways of working with clients who are blind and partially sighted and to give a voice to these clients so that sighted counselling psychologists can be aware of working with this particular client group in a way that will be client focused. Finally, it aims to open debate and dialogue with regard to improving emotional support services for clients who are blind and partially sighted.

Methodology

Overview

The aim of this section is to provide a more comprehensive appreciation and understanding of the philosophy and methodology that underpins this study and how the research came together. The subheadings that follow outline my philosophical background, epistemological position, choice of methodology and how I position myself within the research.

Philosophical background

My own philosophical perspective and how I work as a counselling psychologist has directly influenced how I approached this research. I will discuss this, and also the methodological choice of IPA (Smith *et al.*, 2009) as the qualitative research method for examining how people make sense of their life experiences.

My initial introduction into the field of psychology was gaining my psychology degree. As part of my primary psychology degree I concurrently undertook a secondary degree in psychoanalysis. This exposed me to the psychoanalytic teachings of Freud, Lacan, and Jung amongst others. The two perspectives of psychology and psychoanalysis helped give me a contrasting perspective with regard to models of mind.

The psychoanalytic perspective is concerned with subjective experience and takes a dynamic and not a static view of the mind, seeing movement, energy and conflict as intrinsic to mental life (Milton *et al.*, 2011). This model of the working mind as dynamic, conflictual and not static was cognisant with my own emerging psychological perspective with regard to how people make sense of their lived experience.

My counselling psychology training took place at Trinity College, Dublin, Ireland. The baseline ethos of this course is the humanistic approach and this is incorporated within an integrative framework. This approach, as theorised by Carl Rogers (Thorne, 2013) insists on the centrality of the subjective experience. It has its roots in phenomenology and existential thinking and shares similar concerns about the nature of human existence and consciousness.

This humanistic perspective pertains to the phenomenological tradition which holds the belief that we all behave in accordance with our subjective awareness of ourselves and the world that we inhabit (Thorne, 2013). I hold this position and attitude within this research as I seek to interpret the world of clients who are blind and partially sighted a world that I do not inhabit and have no actual lived experience of.

This humanistic method considers, '*what makes us human?*' It begins from the assumption that every person has their own unique way of perceiving and understanding the world and that the things they do only make sense in this light (Schneider *et al.*, 2014). This position appreciates an individual's subjectivity, considering what it is like to be *this* person, rather than taking an objective view of the person. It proposes that we all have *free will*. This humanistic approach does not attempt to break human behaviour down into more behavioural processes. The approach is holistic, than reductionist.

As a sighted person, it was necessary for me to be subjective and not objective with the people I interviewed, as I have no lived experience of what it is like to live as a blind or partially sighted person. The humanistic approach to research also favours methods that allow an understanding of a person's subjectivity. Qualitative research methods are preferred as these facilitate an insight into the subjective position that the person holds rather than quantitative which considers generalised application of data. The humanistic approach influenced my choice of methodology in doing this research and favouring IPA as the qualitative research methodology.

My training was within this humanistic approach, but also in a larger framework of integrative therapy. With regard to theory, the integrative approach seeks to combine theories of human development such as psychodynamic, behavioural and affective within a perspective of human development (Erskine and Moursund, 2011).

I have been practising as a counselling psychologist for the past eight years both in Ireland and the UK. To this day I have applied an integrative approach to my clinical work. Similarly, in conducting this research, I also do not favour one theoretical model over another.

The act of thinking allows us as humans to question our existence, what we know and how we know it, just as Descartes proposed in the *Cogito*, 'I think, therefore I am.' This proposition became a fundamental element of Western philosophy, as it was perceived to form a foundation for all knowledge. While other knowledge could be a figment of imagination, deception or mistake, the very act of doubting one's own existence serves as proof of the reality of one's own existence (Williams, 1978).

Building on Descartes' philosophy regarding knowledge, epistemology is concerned with the theory of knowledge and the role of science (Finlay and Ballinger, 2006). This commits to a philosophical position regarding how we view the world and ourselves in it. Epistemology is the theory of the origin, structure and validity of knowledge. The positivist perspective with regard to research was prevalent in the 20th century. Behaviourists such as B.F. Skinner argued that psychology needed to concentrate only on the positive and negative forces on behaviour in order to predict how people will behave. Everything else in between (like what the person is thinking) is irrelevant because it can't be measured (Ruiz, 2015).

In a positivist view of the world, science was seen as the way to get at truth, to understand the world well enough so that we might predict and control it. Positivist researchers believe they can reach a full understanding based on experiment and observation. Concepts and knowledge are held to be the product of straightforward experience, interpreted through rational deduction (Cresswell, 2013).

Opposition to positivist epistemologies has come from feminism, post structuralism, critical psychology, anthropology, ethnography and developments in qualitative research. Critics of positivist epistemologies (Dorst, 2008) have insisted that divisions between objectivity and subjectivity, or public and private knowledge and scientific and emotional knowledge, are socially constructed. Post-positivist approaches in research are interpretive and this has led to an emphasis on meaning, seeing the person, experience and knowledge as multiple, relational and not bounded by reason (Henriques *et al.*, 1998).

I have positioned this study in the emerging ideology of the post-positivism theoretical perspective. Where the positivist theoretical perspective believed that the goal of science was to uncover the truth, the post-positivist believes that the goal of science is to hold

steadily to the goal of getting it right about reality, even though we can never achieve that goal (Creswell, 2013).

Within the post-positivist ideology, constructivist epistemological models holds to the post-positivist theoretical perspective. Constructivism rejects the view that there is an objective truth waiting to be discovered. Rather truth and meaning is constructed out of the engagement of our minds with the world.

The constructivist epistemological stance maintains that different people may construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998). The constructivist epistemological position also holds that designing in itself is not research unless it is also accompanied by reflection upon the process of making (Dorst, 2008). My constructivist epistemological position as a post-positivist researcher was key in my choice of methodology and also how I conducted the research. I did not go looking for absolute truth, rather I wanted to uncover the truthful individual meaning of the experience of the participants interviewed.

The constructivist paradigm further indicates that human beings try to make sense of the situation they are in and therefore social phenomena are the result of human interpretation. This cannot be measured via quantitative research methods, and here is where the qualitative research has its place. This concurs with my post-positivist ideology and constructivist epistemological position.

My post-positivist research approach is based on the assumption that the method to be applied to a particular study should be selected based on the research question being addressed (Wildemuth, 1993). I believe that this holds true to this research of the experience of blind and partially sighted people having therapy with sighted therapists.

Within my integrative model of working as a clinician, as a research-practitioner I am conscious of approaching my participants in a similar holistic manner whilst respecting the subjective experience that they have of living as a blind or partially sighted person. My approach was not to build and test a hypothesis or to modify an existing one. Therefore my use of IPA as the qualitative research design and not quantitate design was applicable.

In conducting this research, I was not interested in the experience of the sighted therapist in this study, rather that of the blind or partially sighted person. With such a focus, I needed to tell the story of the experience of the client and not be *the expert'* on their lived experience,

rather be the gatherer of information to interpret their stories. In this regard I wanted to explore the phenomenon of how this particular group within the constructivist paradigm make sense of their experience.

Choice of methodology

In choosing the methodology for this research, I was influenced by the manner in which previous research involving clients who are blind or partially sighted had been carried out. A study and review of the involvement of people who are blind and partially sighted in research by Duckett and Pratt (2007) found a demand for their inclusion in research and for research that had a beneficial impact on their lives. However, Duckett and Pratt (2007) also found a substantial lack of any form of this research in the academic social science literature on blindness and partial sightedness. This lends further support for the importance of my piece of research.

With this perspective in mind, I wanted my choice of methodology to have the participants as the main focus of the research and have them actively involved in the research that will hopefully have a beneficial impact on their lives. I chose a qualitative design in which initial curiosities for research often come from real-world observations, emerging from the interplay of the researcher's direct experience, tacit theories, interests in practice and growing scholarly interests (Marshall and Rossman, 2010).

The chosen methodology of IPA is rooted in my aim to examine the experience and perception of each participant interviewed. The aim of IPA is to explore in detail the processes through which participants make sense of their own experiences, by looking at the respondents' account of the processes they have been through and seeking to utilise an assumed existing universal inclination towards self-reflection (Chapman and Smith, 2002).

IPA methodology recognises the interpretative role played by myself as both the interviewer and the researcher. The participant is the *expert* on the topic, thus in some instances the interview moves completely away from the schedule and instead follows a course set by them (Smith *et al.*, 2012). With this in mind the main exploratory questions within the semi-structured interviews were:

- What is the experience like of being a blind or partially sighted client with a sighted therapist?
- Can you describe what the experience of the difference of sight was like within the therapy?
- How did you conceptualise the verbal and non-verbal aspects of your therapy?

In psychological research the majority of research relating to people who are blind or partially sighted comes from the previously discussed medical model and understandings of sight with the emphasis of the research being on diagnosis, treatment and rehabilitation. This type of research is usually conducted by sighted '*experts*' speaking about people who are blind or partially sighted (Bolt, 2005). I was conscious whilst conducting my research of holding a very different position to this type of research and researcher mentioned.

Early philosophical thought as mentioned in the review of related literature, gave great importance to the use of sight as a means of making sense of the world and the human experience. Philosophical thought in the twentieth century moved away from this dominance of sight and took a 'linguistic turn.' In the analytical schools of Bertrand Russell and Ludwig Wittgenstein and in the continental schools of Edmund Husserl and Martin Heidegger, the authority of vision held by early philosophers as the archetype of knowledge, truth and reality was overthrown and replaced by a paradigm in which language is given a determinative role within phenomenological philosophy and method. Given that this research involves participants who are blind or partially sighted, the phenomenological philosophy of Husserl and Heidegger felt for me naturally to fit this research.

As Descartes considered, phenomenology challenged the reductionist idea that all knowledge was held in the mind, separate from the body. Phenomenology studies appearances as opposed to reality (Moran and Mooney, 2002). Franz Brentano (1874) considered that phenomena are what occur in the mind and are acts of consciousness and their contents. Phenomena are whatever we are conscious of, such as events, people and ourselves as we experience these. From this standpoint theories about knowledge begin with how we observe, reason about and seek to explain phenomena or appearances we encounter.

Edmund Husserl (1859-1938) the founder of phenomenology characterised knowledge as a way of seeing rather than a set of doctrines. This avoids the traditional philosophical ideas of constructing knowledge from an empirical or rational foundation. It takes an unprejudiced

look that is not tainted by scientific or cultural attitudes and pays close attention to the evidence that presents itself to our grasp or intuition (Moran and Mooney, 2002). Phenomenology then holds that knowledge production is not contained in the realm of the mind; rather it is only one part of a larger system in operation. Knowledge is understood and arrived at from the position of being conscious and being fully engaged at the fundamental level of human experience in and of the world. It is produced through the manner in which things and meanings show themselves or come to be self-evident for us.

Reinforcing this phenomenological position, Heidegger in *Being and Time* (1962) uses the phrase *"being in the world"* to refer to the way we are simultaneously making and being made by the world we live in. In this sense we are inseparable from the world. We find out about the world by engagement and not just by observation. This phenomenological philosophy aligns itself to this research and my trying to make sense of the lived experience of the blind and partially sighted participants to extract the knowledge that they could provide.

In this phenomenological sense both the client and I are bound up in making sense of the same experience. Myself being the sighted therapist and being *'blind'* as to how these clients experience therapy with a sighted therapist. As Heidegger (1962) mentions, we are both (client and I) inseparable from the world and our engagement with it. Phenomenology challenges the natural scientific notion of the objective observer by asserting that we can never get outside of life in order to observe it, we are always participant observers (ibid.).

Phenomenological methods of research are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives, and therefore challenging structural or normative assumptions (Moran and Mooney, 2002). Adding an interpretive dimension to phenomenological research enables it to be used as the basis for practical theory. It also allows it to inform, support or challenge policy and action (Hycner, 1985). Given that I was interviewing blind and partially sighted clients and seeking to inform practical theory of working with this population as sighted therapists, a phenomenological methodological approach was a clear choice.

Within IPA, interpretative work can be judged appropriate as long as it serves to "draw out" or "disclose" the meaning of the experience (Larkin *et al.,* 2006). As a post-positivist researcher, I was not seeking to uncover 'absolute truth' from interviewing my participants, rather to provide 'adequate contextualisation' in order to provide insight into the experience of the blind and partially sighted participants (Smith and Osborn, 2003).

On a methodological level, an IPA study typically involves a highly intensive and detailed analysis of the accounts produced by a comparatively small number of participants. These verbatim accounts are generally captured via semi-structured interviews, focus groups, or diaries, and the analysis then proceeds such that patterns of meaning are developed, and then reported in a thematic form (Larkin *et al.,* 2006).

IPA was preferable over other choices available such as grounded theory, given this research involved a small sample size of nine participants. The goal of grounded theory is to develop an explanatory theory of basic social processes, studied in the environments in which they take place. Within this approach knowledge of social realities is achieved through careful observation of behaviour and speech practices (Glaser and Strauss, 1967). With the blind and partially sighted participants that I interviewed I was solely interested in this particular population, not seeking to establish theories to a broader population.

I appreciate that there are other approaches as phenomenological research overlaps with other essentially qualitative approaches including ethnography, hermeneutics and symbolic interactionism. Pure phenomenological research seeks essentially to describe rather than explain, and to start from a perspective free from hypotheses or preconceptions (Husserl, 1970).

More recent humanist and feminist researchers refute the possibility of starting without preconceptions or bias and emphasise the importance of making clear how interpretations and meanings have been placed on findings. They also make the researcher visible in the 'frame' of the research as an interested and subjective actor rather than a detached and impartial observer (Stanley and Wise 1993). In consideration of this aspect, I next discuss how I position myself in the research and hold the frame mentioned here.

Positioning myself in the research

Given my research is entitled 'The Blind Leading the Blind,' the choice of using IPA appealed to me as I felt very *'blind'* working with my clients. I was curious as a sighted counselling psychologist of the challenges and role played by the difference of sight within the room and also themes of ability and disability.

It was important as both counselling psychologist and researcher to try and make sense of the lived experience of blind and partially sighted clients, so that I could try and make sense of my own lived experience of being the sighted therapist in this shared experience.

While the focus of this research is about the experience of the blind and partially sighted client having therapy with a sighted therapist it has been co-constructed with myself as the researcher as part of the double hermeneutic of IPA. IPA requires a combination of phenomenological and hermeneutical insights. The phenomenological aspect required me as researcher to get as close as possible to the personal experience of the blind and partially sighted participants. In the hermeneutic aspect, this inevitably becomes an interpretative endeavour for both myself as researcher and also the participant. Without the phenomenology there would be nothing to interpret; without the hermeneutics, the phenomenology would not be seen (Smith *et al.,* 2012).

With my phenomenological perspective in mind, my choice of methodology of IPA is rooted in the interpretation of the phenomenology of the blind and partially sighted clients that I interviewed having therapy with a sighted therapist. Holding this position in conducting the research, IPA operates a double hermeneutic as analysis always involves interpretation. The phenomenon is ready to show itself, but it is up to the researcher to facilitate and interpret that phenomenon. Therefore both participant and I are bound up in the research.

In holding this double hermeneutic and phenomenological approach using IPA within this research, I am not looking to entirely bracket myself off. Holding this reflexive position within this research, Etherington (2004) speaks about three dimensions. These are personal, methodological and epistemological. Personal reflexivity acknowledges that the researcher's position on an issue has the potential to affect their conclusion about it. Methodological reflexivity acknowledges how the researcher shapes their own conclusions and epistemological reflexivity involves an acknowledgement that the method itself shapes the conclusions.

Given that I am a sighted counselling psychologist who has worked with clients who are blind and partially sighted and that I was interviewing clients who are blind and partially sighted about their experience of having therapy with a sighted therapist, it was important that I *'suspend'* or *'bracket'* my own assumptions and bias on the subject. Bracketing is a methodological device of phenomenological inquiry that requires deliberate putting aside one's own belief about the phenomenon under investigation or what one already knows

about the subject prior to, and throughout the phenomenological investigation (Freeman, 2011).

Giorgi (1997) stated that only the researchers (and not the participants) should engage in the bracketing, because it is the participants' lived experience the researcher is trying to understand. Wall *et al.*, (2004) suggest that using a reflexive diary is helpful to develop bracketing skills and facilitate decision making during the progress of a phenomenological investigation. To bring reflexivity into consciousness, a reflexive diary is used to write down thoughts, feelings and perceptions. It allows researchers to re-examine their positions when issues are raised that might affect the research process.

My own reflexive diary was used during this research to ensure that I was aware of *'bracketing'* as much as I could my own bias and assumptions on this experience of the participants that I interviewed. However I hold to the position that it is never fully possible to do this. As Heidegger maintained, our consciousness can *"never be completely uninvolved with or separated from the world,"* (LeVasseur, 2003, p. 414). My bracketing was therefore as much as I could personally perceive, but it was not *absolute* as Heidegger observes.

My choice of the phenomenological approach inherent in IPA also aligned with the critical-realist position that I hold. Critical realism is concerned with the philosophy of perception. It is realist and critical for two reasons: objects in the world, and in particular social objects, exist whether the observer or researcher is able to know them or not; and secondly, knowledge of these objects is always fallible (Scott, 2007). As knowledge is always fallible, ontology is concerned with the nature of reality and what there is to know about the world. Key ontological questions concern whether or not there is a social reality that exists independently of human conceptions and interpretations and, closely related to this, whether there is a shared social reality or only multiple, context-specific ones (Ritchie *et al.,* 2013).

The reduction of thought, language, belief, custom, or experience implicitly reproduces a certain ontology, a certain understanding of the world which sustains that reduction. It also argues for the necessity of ontology. The pursuit of ontology is the attempt to understand and say something about 'the things themselves' and not simply about our beliefs, experiences, or our current knowledge and understanding of those things (Scott, 2007).

Critical realism stands in contrast to idealism, as proposed by Kant. Idealism is the category of philosophical systems that claim reality is dependent upon the mind rather than independent of it. Extreme versions of idealism deny that any world exists outside of our

minds. Narrower versions of idealism claim that our understanding of reality reflects the workings of our mind first and foremost and that the properties of objects have no standing independent of the minds perceiving them (Royce, 2010).

I held the critical realist position within this research, in listening to the stories of the participants that I interviewed and how both participant and I made sense of their lived experience. This was important because any attempts at describing the experience of the participants that I interviewed needs to take account of the transitive nature of knowledge.

Selection and recruitment of participants

In recruiting participants, I contacted support services for blind and partially sighted people in the UK. This led to the initial pilot interview. I then used snowball sampling (Noy, 2008), to try and recruit additional participants. This involved contacting further support services, such as Action for Blind People for assistance. This led to the recruitment of six additional participants. Finally I asked work colleagues if they knew of any blind and partially sighted clients who had therapy in the past two years with a sighted therapist. This led to the final two participants being identified.

Participants were drawn from across the entire UK. One interview took place face to face and the other eight were by telephone due to geographical constraints. Participants were given an information sheet prior to the interview, citing ethical considerations, requesting consent and explaining the withdrawal process. These are discussed in separate sections to follow.

The key criteria for participation in the research was for the person to be registered as blind or partially sighted and to have had psychological therapy with a sighted therapist in the past two years. I emailed and also spoke with all participants by telephone and gave them further information about the research and the commitment required. After the pilot interview, the next eight participants to fit the criteria were invited to take part and all agreed.

The nine interviews, including the pilot, were conducted over a six month period. All participants recruited went ahead with the interview and none withdrew. After consenting to take part in the project, all participants were sent an information sheet by email. Participants were asked if they had speech recognition software and assistive software on their

computers and they all did. As part of the information sheet, verbal consent was requested to participate in the research prior to the interview. This consent was again reiterated at the start of each interview and confidentiality explained.

Description of participants and researcher

I interviewed a diverse range of participants. The research was conducted with seven females and two males, between the ages of 22 and 75. The eye conditions reported by participants included: age related macular degeneration, retinitis pigmentosa, glaucoma and retinal detachment. Two of the participants had been blind since birth and all other participants had acquired conditions throughout their life.

Six of the participants were in paid employment, one was retired, one unemployed and the other was a full-time mother. Participants were drawn from England and Scotland. They also reported different cultural identities including white British, Asian and Spanish (see Appendix 1 for a brief overview of participants' information).

Research Design:

In designing the research, it was important that I select participants based on the criteria of their being blind or partially sighted and having had therapy with a sighted therapist in the past two years. In order to help reach the right demographic, I initially made contact with the RNIB and spoke with the head of the Sight Loss Counselling Team about the research and possible recruitment of participants. Although they could not help with the recruitment of participants they did give me the contact details for Action for Blind People, which is an organisation associated with the RNIB that offers counselling to people who are blind and partially sighted in various locations around England. I made telephone contact with these services and spoke with the heads of service about my research and possible participant recruitment. I then emailed through the information sheet regarding the research (see Appendix 2).

These initial conversations were very helpful in explaining my research and yielded six participants who took part in the research. The heads of the service contacted clients that they knew and asked them if they would be interested in being interviewed for the research.

They gave the clients my contact details, both by email and telephone, so it was left entirely up to the clients to contact me should they wish to do so.

Initial communication with these clients who contacted me was by email, as they emailed me stating their interest in the research and about possibly taking part. I returned contact by email to the clients and asked their permission to have a telephone conversation and answer any questions that they may have. I then set up the initial telephone call and had a conversation with them about my rationale for the research, how long the interview would take, answer any further questions that they may have had and discussed consent and ethics should they agree to take part. I was conscious of the research by Duckett and Pratt (2007) who stated that blind and partially sighted people demanded inclusion in research and for research that had a beneficial impact on their lives. This initial telephone call with potential participants was to help make the rationale for the research explicit and facilitate their inclusion in it.

After this initial telephone call and their consent to participating in the research, I asked how they would like to receive the information sheet; this could be sent by post, email or be provided in braille. Once sent, I requested that they contact me if they have any questions about the research and if they were happy to progress to being interviewed. In the correspondence back from participants granting me permission to interview them, I then emailed back to arrange a time that was suitable for them to be interviewed and this was scheduled at their convenience. All six interviews then took place over the telephone at the agreed time the participant requested. Participants were made aware at the start of the interview that I would be recording the call and that there were no other people in the room with me. I also reinforced confidentiality and that they could withdraw at any time.

The other two telephone interviews and the one face to face interview took place due to snowball sampling by asking fellow colleagues if they knew of any clients or colleagues that would be suitable to taking part in the research. This yielded three additional participants who were suitable. Again the same procedure was followed with them as with the other telephone interviews, that of initial contact by email, followed by arrangement of the telephone interview at a convenient time. One interview took place face to face. This interview was conducted in a private office at a convenient location and time for the participant.

The table below shows individual participant demographics:

No of participants: 9

Name:	Age:	Location:	Ethnicity:
Nora	49	South West	Asian British
Pat	51	South East	Asian British
Erica	35	South East	White British
George	55	South west	White British
Barbara	75	South west	White British
Diane	47	South East	Black British
Alison	22	North England	Spanish
Jerry	31	South East	White British
Kelsey	33	North England	White British

Data collection: interview preparation and procedure

The interviews were guided by semi-structured questions which facilitated the foundation for the questions and prompts developed before the interviews took place. These were based upon speaking with a member of my team in the NHS who is blind or partially sighted and also with professionals who work with adults who are blind and partially sighted. The questions of the semi-structured interviews fell under the following four themes (see Appendix 3 for list of specific questions):

- Being a blind or partially sighted client
- The experience of the therapy
- Verbal communication
- Non-verbal communication

At the start of the research, I chose to use telephone interviews with the participants as opposed to face to face interviews. Telephone interviews are largely neglected in the qualitative research literature and, when discussed, are often depicted as a less attractive alternative to face-to-face interviewing. The absence of visual cues via telephone is thought to result in loss of contextual and non-verbal data and to compromise rapport, probing, and

interpretation of responses. Yet, telephones may allow respondents to feel relaxed and able to disclose sensitive information, and evidence is lacking that they produce lower quality data (Novick, 2008).

Reported disadvantages of using telephone interviewing include a lack of telephone coverage for some participants, the absence of visual cues and the potential for distraction of participants by activities in their environments. Another reported disadvantage is that telephone interviews must be kept short compared to face-to-face interviews, thereby reducing in-depth discussion. Yet, little evidence is presented for this claim, and research reports that telephone interviews lasting 1.5–2 hours, had little participant fatigue. Some practical suggestions offered for conducting telephone interviews include establishing contact or rapport in person prior to conducting telephone interviews and using a prepared script to introduce the study at the beginning of the first telephone interview (Carr and Worth, 2001).

Given that my participants were blind and partially sighted, the use of telephone interviewing created the sense of an even position for both myself as a sighted researcher and the blind and partially sighted participants as neither of us had visual contact within the interview. This allowed the focus to be on what was said. The use of telephone interviewing also allowed me to access participants in different geographical locations across the country at a time and location convenient for them.

Following the interview I made detailed verbatim notes and also took my own observational field notes. With regard to *bracketing*, I also recorded my own processes and emerging awareness in my reflective journal to help me appreciate any potential bias and assumption that was residing with me. Bias and recall were considered by the use of some of the suggestions proposed by Guba and Lincoln (1989), such as iterative questioning in data collection dialogues and peer scrutiny of the project. This is dealt with in greater detail in the validity and trustworthy section to follow.

I ensured their consent to participate was informed and clearly understood along each step of the research process. All participants gave verbal consent to taking part in the research. I asked how they would like the information sheet sent to them. The information sheet contained detailed information regarding the research and confirmed oral consent, confidentiality and how to withdraw from the research. All participants were offered the information sheet to be posted, emailed or sent in braille (see Appendix 2). All participants asked for it to be emailed as they had assistive software to read the information sheet to them, none requested it in braille or by post. The participants also confirmed oral consent

again prior to the interview taking place and understood that they could withdraw from the research at any time and to withdraw consent for any written or audio material to be used.

Participants were given confirmation of confidentiality throughout the research process. In all aspects of the research process, their anonymity will be maintained. Transcripts were securely stored in a locked filing cabinet in my office without identifying information about the participants. Participants were also offered the chance to take part in a debrief session.

Pilot study

The pilot study was a helpful experience that helped paved the way for the subsequent interviews. A pilot can be a pre-testing or trying out of a particular research instrument. The recorded advantages of conducting a pilot study is that it might give advance warning about where the research project could fail, where research protocols may not be followed or whether proposed methods or instruments are inappropriate or too complicated (Van Teijlingen and Hundley, 2002).

The pilot study aided me in finding a flow to the interview process. My pilot interview was beneficial in building rapport with sybsequent participants over the telephone. It felt like an even playing field for both of us as we were reliant on the use of the voice and not sight in the interview process. This helped me as interviewers appreciate what the experiences maybe like for the participants in speaking with someone that you can't see.

As a counselling psychologist I am familiar with using active listening in my professional role. The pilot study helped me appreciate how important it was to use this in the interview process. Active listening has been described as a multistep process, including making empathetic comments, asking appropriate questions, and paraphrasing and summarizing for the purposes of verification. The goal in active listening is to develop a clear understanding of the speaker's concern and also to clearly communicate the listener's interest in the speaker's message (Cramer, 1998).

The pilot study further highlighted the need to guide the participant so that the interview did not deviate from the research aims and goals. This was a challenge at times as inevitably the story would digress and it was necessary to bring the research back into focus. I also appreciated the use of my prompts from the pilot interview in sustaining the interview and moving it along. Prompts are as important as the questions themselves in semi structured

interviews. They do two things, they keep people talking and they rescue you when responses become difficult (Leech, 2002).

Analysis process

Using IPA in the analytical process, I was aware that I was not just being *descriptive* in terms of the data from the interviews, rather I was *analysing* it. IPA goes beyond description due to its phenomenological origins, as it focuses upon sense-making activities and our involvement in the world. The researcher and interpreter in IPA is also offering an interpretative account of what it means for the participant to have such concerns within their particular context (Larkin *et al.,* 2006).

This analytical process took me from transforming the data that I collected from all nine interviews to the actual themes and meta-themes. IPA aims to do this by a set of common processes and principles of moving from the particular to the shared, from descriptive to interpretative with a commitment to understanding the participant's point of view and a psychological focus on personal meaning-making in particular contexts. This route through the data is not a linear one, rather it is a creative one and the end result is always an account of how the analyst thinks the participant is thinking. This is the double hermeneutic in IPA (Reid *et al.*, 2005).

I was aided through the analytical process by taking initial hand-written notes as well as using Word to help with the collation and storage of the data (see Appendix 4). The first stage of the analytical process was to transform the recorded data into a written transcript for further exploration of meaningful units and coding. After each interview was completed, each recording was transformed into a verbatim transcript. This process was done using the help of a professional transcriber, my own listening of the interview and immersing myself in the original data from the interview. I then re-listened to the interview and went through the script again, using this iterative process of transcription.

From the initial reading to re-reading the transcription, I moved from listening to the interview on the voice recorder to just engaging with the transcript. In doing so I recorded my notes and observations on the transcript, all the while keeping the interviewee as the focus of the analysis. I explored the semantic content and the language used on an exploratory level.

This involved looking at the language used, thinking about the context of their lived experience and identifying more abstract concepts to make sense of the patterns of meaning

in the accounts. This also involved looking at metaphors, emotions and possible emerging themes within the data. I used my research journal to note down any personal observations about myself and my own process as I engaged with the data.

The next stage was to transfer the data into Excel spreadsheets by breaking the text down into numbered lines in Excel. I began transferring my initial annotations of the transcripts into Excel (performed by hand, see Appendix 5 for example sample). This began the start of the cyclical process of analysis and engagement with the text. Each interviewee had their own spreadsheet and each new phrase or sentence from the interview corresponded to a line number. All initial annotations corresponded with the interviewee in question and was linked to the line number where the initial comment was made. This allowed the initial data to transform from meaning units into possible codes.

The iterative process of engaging with the text to develop emerging themes was the next step in the analysis. As I began the coding process to establish the emerging themes from the interviews, I wanted the research to move from descriptive to interpretative analysis. I had, as Larkin *et al.* (2006) mentioned, the dilemma familiar to IPA researchers, finding the point where description ends and interpretation begins and also balancing the representation against interpretation and contextualisation.

To assist with this I kept the title of my research question and philosophical position by my side. I also kept a reminder of the hermeneutic cycle, therefore any interpretation involves a circularity of understanding of my participant's interpretation of the phenomenon in question and then my interpretation of their interpretation (Tappan, 1997).

The next step of interpretation involved going through each interview and abstracting the emerging themes that were contained within the data of the interview (see Appendix 6 for coding column breakdown example). It was important that the naming of themes given to events, objects, actions and interactions with the data reflect the context of the respondent's words. I sought to position myself within the data, and move to a higher level of abstraction and named themes based on asking questions about the nature of what is going on in the data and how the incident compares with other similar incidents in the data (Fade, 2004).

In concluding this iterative process, I had a set of themes for each participant with a clear line back to the coding and supportive data. Having completed this process for each case, I created a pivot table for each participant giving a frequency of theme information (see Appendix 7). Krueger and Casey (2000) advocate the use of either a long table or a computer-based approach for cutting, pasting, sorting, arranging and rearranging data through comparing and contrasting the relevant information.

To assist with the organising of the themes, I created a table in Excel of all 86 themes generated across the nine participants and this identified four overall meta-themes for the group. Smith (2004) suggests that researchers imagine a magnet with some of the themes pulling others in and helping to make sense of them. The pulling together of the themes in this manner gave a sense of cohesion and clarity to the research question.

I noted the frequency with which themes appeared by creating an overall frequency table and a top themes table (see Appendix 8 and 9). Through these different techniques in the analytical process, it is hoped that the richness and quality of the original data is gleaned in subsequent findings and discussion.

Validity and trustworthiness

In considering quality, trustworthiness and validity within qualitative research Yardley (2000) argues that as the purpose of qualitative research is to produce just one of many possible interpretations, reliability maybe an inappropriate criteria against which to measure qualitative research. This approach is consistent with IPA's recognition of the interactive and active role of the researcher within the research. Therefore the goal of validity in IPA is not to produce *"a singular account"* of the data gathered; rather it is to ensure the credibility of the themes produced (Brocki and Wearden, 2006).

Yardley (2008) developed a set of four core principles relevant to qualitative research to help ensure validity and trustworthiness. These include (1) sensitivity to context, (2) commitment to rigour, (3) coherence and transparency and (4) impact and importance. In conducting this research I sought to adhere to these four core principles and demonstrate them to maintain validity.

With sensitivity to context, I was aware of the perspective and position of the people that I interviewed and ensured that they felt comfortable taking part in the research. The interview was set up at a time and place convenient for them. I was very conscious throughout the whole interview process of having the participants as the main focus and that they were the '*expert*' in the research interview and not myself.

In my commitment to rigour, I purposely recruited people who represented an adequate range of views relevant to the research topic. This included both male and female to have a differing gender perspective. Participants also had to have had psychological therapy within the past two years, so that some accurate recollection of the experience could be recalled.

Maintaining coherence and transparency, I have given an accurate description of how the data was collected, coded, relevant themes identified and supporting evidence in the appendices. Ensuring coherence and validity was not the sole domain of myself as the researcher. An additional colleague and one participant also checked the coded themes.

Finally, with impact and importance, I sought within the findings and also discussion to explain the phenomenon under investigation and give a holistic perspective. I also suggest further ways that the research can be used to benefit blind and partially clients and sighted therapist who may work with them.

I used these four general guiding principles for conducting qualitative research to help focus on ensuring the research was valid and trustworthy. However, in line with my philosophical perspective and epistemological position, I sought to expand on this area of validity further to clarify the work I did and the subsequent conclusions reached.

Guba and Lincoln (1989) view validity as a positivist notion and propose to substitute this for the concept of authenticity in the research. Expanding on the validity and trustworthiness of the research that I conducted, I agreed with this proposed position. Guba and Lincoln (1989) substituted reliability and validity with the parallel concept of trustworthiness, containing four aspects: credibility, transferability, dependability, and confirmability. I sought to follow these four aspects.

Guba and Lincoln (1989) further suggest, in maintaining credibility within research, that the researcher uses prolonged engagement. This involves spending sufficient time in the field to learn or understand the culture, social setting, or phenomenon of interest. This involves observing various aspects of a setting, speaking with a range of people, and developing relationships and rapport with members of the culture.

At the start of my research I met with the head of the RNIB emotional support service to talk about my research and also get information on studies they have done in this area. I also made contact with other researchers around the UK who have conducted research with blind and partially sighted clients to be informed of what it's like conducting research with this client group. Given that I had previously had blind and partially sighted clients, I was also familiar with the phenomenon of interest and the setting involved.

The second aspect of transferability involves a type of external validity by means of 'thick description.' Thick description refers to the detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context (Holloway, 1997). I sought to do this in the research by the iterative process of coding and abstracting the compiled data and showing sensitivity to the data and

transparency by the use of verbatim extracts to support the arguments that are made in the research. Thick description stands in contract to 'thin description', which is interpretation made at a superficial level as opposed to the more detailed level that exposes the phenomenon in question.

Thirdly, dependability involves showing that the findings are consistent and transparent. This involves creating an audit trail, having an independent researcher examine both the process and product of the research study. The purpose is to evaluate the accuracy and evaluate whether or not the findings, interpretations and conclusions are supported by the data. A colleague looked through the collected data from the research and gave feedback. I also had a friend who is not a counselling psychologist or mental health professional look at the findings and give his feedback as a lay person.

The benefit of external auditing is that it can provide important feedback that can lead to additional data gathering and the development of stronger and better articulated findings. However, given that this is a phenomenological study, external auditing relies on the assumption that there is a fixed truth or reality that can be accounted for by a researcher and confirmed by an outside auditor. From an interpretive perspective, understanding is co-created and there is no objective truth or reality to which the results of a study can be compared (Cresswell, 1998).

Finally, the last aspect of confirmability considers the extent to which the findings of a study are shaped by the respondents and not by researcher bias, motivation, or interest. This highlights my reflexive position as researcher. With this in mind, I was conscious of what Malterud (2001) cautions:

> *"A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions,"* (Malterud, 2001, p.483).

To monitor this I kept a reflexive journal and made regular entries during the research process. In these entries, I recorded methodological decisions and the reasons for them and reflected upon what was happening in terms of my own values and interests.

By following these steps throughout the research, my hope is that the research will resonate with the reader and also do justice to the interviewees. In speaking with colleagues, peers and other researchers in the field of blindness and partial sightedness, the project has been greatly received and there was a sense that this was an important area for consideration that needed addressing.

Ethical considerations

This study was undertaken within the context of the ethical guidelines of the academic institution I attend. An Ethics Form was submitted and approved by The Metanoia Institute/Middlesex University Ethics Committee. As a Chartered Counselling Psychologist and an Associate Fellow of The British Psychological Society (BPS), I am also informed by the ethical and professionals standards that I hold as part of this organisation. I am also a Registered Practitioner Psychologist with the Health Care and Professionals Council (HCPC) and adhere to the professional standards of conduct set out by them. Holding these professional frames in mind when conducting this research ensured I kept ethical considerations paramount.

I ensured all participants were fully informed before taking part in the interview of the purpose of the study. This was achieved by initial informal telephone conversations with all participants prior to the interview and also sending through an information sheet in the method of their choosing (email, post or braille). I arranged the telephone interviews to take place at a time that suited them and also allowed time at the end of each interview for de-briefing to ask me about the interview and research. If further support was needed, a referral for counselling was possible to the RNIB Emotional Support Service or Listening in Action support service. In writing up the research I assured confidentiality of participants by ensuring their anonymity and changing their names in the research.

I was very conscious of what Dale (2008b) spoke of when conducting research with people who are blind and partially sighted. She stressed how important it was to tell their stories to audiences in ways which moved them from a position of *'being invisible'* to that of having a voice that was listened to. In doing so, this helped participants feel connected with positions of strength, rather than feeling '*talked about'* by '*experts'* which left them feeling disabled and powerless. I hope in some way that I have achieved this with this research I have conducted.

<u>Findings</u>

Overview

This research afforded me the opportunity to interview blind and partially sighted participants who gave their time to tell me of their experience of having psychological therapy with a sighted therapist. As a result, I obtained a wealth of data which lets their voices be heard in this findings section.

Being a researcher-practitioner and interviewer on this project has caused me to reflect on my own position of being a sighted person and also being as sighted counselling psychologist who works with clients who are blind and partially sighted. Some of these points are referred to within the findings and also within the discussion section.

Overall the data from the nine participants revealed four meta–themes which expound the experience of being a blind and partially sighted client having therapy with a sighted therapist.

Table 1: Meta-themes

1	**Struggles between the two worlds**
2	**Bringing the 'elephant' into the therapy room**
3	**Non-verbal communication**
4	**Verbal communication and the power of the therapeutic relationship.**

These meta-themes were developed as a result of analysing the data and looking for connections across the interviews. The following table considers the themes across all nine interviews with four meta-themes that add clarity and depth to the phenomenon.

I discuss each of the four themes in turn pointing out the ways in which participants represent unique idiosyncratic instances but also shared higher order qualities.

Table 2: List of all themes, segmented by meta-theme and listed alphabetically

1. Struggles between the two worlds
Dependency on the sighted world
Difference of sight a gap that can't be filled
Eye contact is the springboard for conversation
Hard to describe what it's like to live with sight loss
Inability to control sight loss so need to control everything else
Lack of sight internalised as lack of identity
'Mind the gap' between sight and sight loss
My blindness or partial sightedness shouts
Necessity to let you know my needs
Never fully accept not being able to make eye contact
Nothing holistic about body language and eye contact
Overriding nature of being blind or partially sighted
Power dynamic of sight implicit in every relationship
Powerless to challenge society's position on sight loss
Sight loss and personal identity
Society can enable or disable you
Society is labelling me as disabled
Struggle between needing assistance and asking for it
Two perfect eyes are judging your one bad eye
Visibility of disability leads you vulnerable
You just want to fit in really, you don't want to stand out
You wanted to be seen as normal
2. Bringing the 'elephant' into the therapy room
'As if' quality forgotten
Ask, don't make assumptions
Avoidance on part of the therapist
Being listened to shows empathy and comfort
Expectation on part of therapist for working together
Felt unseen due to being blind or partially sighted
Frustration of inability to return to gaze
Holistic and not fixed in their ways
I could tell she was lost
I just wanted to have a connection
If I was fully sighted perhaps they wouldn't do that
Machine like nature of sighted therapist
Narcissism of can you see me?
Need to feel understood by therapist
Need to listen without judgement

Need to reassure therapist that I was capable
No consideration given to my being blind or partially sighted
Powerlessness of not being able to reciprocate gaze
Pressure to put sighted therapist at ease
She treated me like a unique person
Therapist made me feel more self-conscious of my disability
Therapist needs to talk about what's real
Therapist own responsibility to say they don't understand
Therapy bias ableist position starts from
Therapy should start with a blank slate
Trying to work out the move to the 'dance'
Blindness or partial sightedness is the 'elephant' in the room
Vulnerability in the room due to difference of sight
Willingness of therapist to carry my baggage
3. Non-verbal communication
Does yawning mean she's bored?
Insecurity creeps up in the silence
Natural use of touch
Physical position of therapist in the room
Silence can feel punishing
Silence harder to deal with at beginning of therapy
Thanking the therapist through touch
The comfort of touch
The instinctual nature of touch
Touch, a different medium of communication
Touch compensates for lack of sight
Touch is an acknowledgement of your pain
Touch is reaching out to me to let me know they're there
Touch shows empathy and compassion
Wall of silence was not inviting
What's actually happening in the silence?
Yawning is ugly
4. Verbal communication and the power of the therapeutic relationship
Building trust without sight
Chair closer shows enthusiasm and interest
Distant sat from facilitated emotional distance
More in tune with voice due to being blind or partially sighted
Much more to it than eye contact
Non-verbal communication goes beyond a senses thing
Not what is said, but how it's said
Power of the connection in the moment
Sensitivity to changes in the voice
Therapist disclosure without eye contact
Therapist reliance on communication empathy through face and eye contact
Tone of voice used for deeper communication

| Use of the voice for atunement and mirroring |
| Verbalise the warm and empathy by use of the voice |
| Voice helps to build the relationship |

Beneath each meta-theme I have taken a number of themes from this list to act as sub-headings to guide the reader through the analysis. Both meta-themes and themes are understood and elucidated by direct quotes from the transcripts. Please note, in the extracts (…) indicates omitted text.

1) Struggles between the two worlds

Overview

Common to all participants interviewed was the sense of difference, exclusion and sometimes anger at trying to live as a blind or partially sighted person in a sighted world. Participants voiced how they longed for the '*normality*' of the sighted world and desired to feel a part of that world and not excluded. This included their desire to be viewed as a 'normal' person and not as a person who has a visual disability.

There was a sense of a reluctant acceptance that they will never fully feel a part of the sighted world and of having to deal with "*the elephant in the room*," which is their blindness or partial sightednesss (J: 14). This need to adjust to the sighted world and feelings of *abnormality* due to their blindness or partial sightedness also came into their relationships with the sighted therapists that they had psychological treatment with.

For all participants there was a sense of inhabiting a world within a world. There was a broad range of attitudes and emotions expressed about living between these two worlds from the theme such as *society is labelling me as disabled* where the influence of sighted society was felt as punishing and debilitating to the comparative more balanced position of the theme *society can enable or disable you.* Also expressed was the sense of frustration and powerlessness to change the position of society when it comes to how it treats people who are blind and partially sighted with the theme *"The main thing is you just want to fit in really, you don't want to stand out."* (G: 30).

For some participants there was the view that dependency on the sighted world was something that needed to be reluctantly accepted as a feature of living as a blind or partially sighted person. There was an acceptance of the assumed roles of dependency of both the sighted and non-sighted persons inhabiting the sighted world. George further recalls, *"I think the sighted person does have a certain amount of power. You just become so dependent, even crossing the street, you're so dependent on the goodwill of other people, because half the time crossings aren't working, that kind of thing. So there's a bit of a power thing, obviously it's a natural development. You have to become dependent. And possibly the sighted person has had to take on this role, whether they like it or not."* (G: 72).

This meta-theme provides a context into their world and the reality of living with sight loss in a sighted world. I feel this theme is very important to provide insight for sighted professionals into the lived experience of blind and partially sighted people.

Below are three sub-themes to help capture the experience of living as a blind or partially person in the sighted world.

(1) (i) Sight loss and personal identity

The first sub-theme looks at the impact that living with blindness and partial sightedness has on the personal identity of participants. Some participants in this research were born blind and some had acquired either blindness or partial sightedness in adulthood. Regardless, all participants had a sense that their visual disability became an identifying part of who they are and that this identity also manifested itself in how they interact with sighted society and how they feel sighted society interacts with them. Nora mentioned, *"My visual impairment feels like the overriding factor in most of my life decisions and it seems that maybe because that's the first thing that people engage with, when they don't know me that well."* (N: 51)

Another participant expressed that living as a blind or partially sighted person reduces your identity and thought processes down to the visual disability and that this becomes the decisive factor in living your life. Kelsey expressed it this way, *"When you have the visual impairment, you link everything to it, the reason that you feel like this is because of that, you don't really look past it. 'That's the reason I did that today' or 'that's the reason I feel like that' you sort of shut yourself down to the visual impairment rather than thinking, well actually there's more to this going on here."* (K: 30). The pervasive nature of not having sight

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shrinks the identity of the person and becomes overriding in its impact on the life of the person.

The pathological nature of disability linked to the medical model of disability as discussed earlier was observed by Pat who expressed this when she says, *"So there's something faulty about not being seen I think. That's the human response. That if somebody won't look at you there's something wrong. So by that very nature, having a human impairment makes you wrong in some way."* (P: 88). This is observed as almost a natural order of things in the sighted world, that if you can't reciprocate sight, then you don't really fit into or belong in this sighted world. The visual disability becomes pathological and the fault of the person who has it.

The effect of blindness and partial sightedness on personal identity is seen as almost assuming a life of its own and shouts at sighted society. Nora expresses how she experiences this, *"Yes. Yes I think it does. I think that it seems to be the loudest part of me, through whatever that is. I know for starters, the way I wield my cane its like 'I'm coming' 'I'm coming' and I'm blind.' That's how it is."* (N: 54). The difference of being a blind or partially sighted person is seen as 'shouting' at the sighted world that it is there and that it needs to be heard and not ignored and that the presence of a person with their cane signifies a need for acknowledgement of that.

The impact being a blind or partially sighted person on the personal identity of that person is a personal and by extension also a societal challenge. For the participants in this research juggling these two positions is a challenge for them as they struggle to live between these two worlds of sight and no sight. There is the burden of feeling personally responsible for having the visual disability in the first place and also the daily battle to live with the loss of a sense that can feel consuming in its effect.

(1) (ii) Mind the gap between sight and sight loss

The next theme relates to the sense of enormity of bridging the gap between living in the physical sighted world and the lived personal world of being blind or partially sighted.

Although literally living in the same physical shared world, there is a sense that the sighted world and the world of a person who is blind or partially sighted are separate. This is borne out by the statement from Diane, *"I think it can be very difficult to understand what it's like to be visually impaired, and what the world is like when you can't really see things and how you move around and everything."* (D: 10). The lived experience of being blind or partially sighted in a sighted world is appreciated as something that is hard to understand for sighted people.

The relationship with the physical world that both sighted and blind and partially sighted people inhabit is different. The world is experienced differently and moving about and interacting with that world is hard to describe from the perspective of the blind or partially sighted person to someone who is sighted. The use of the word *'world'* describes the enormity and all-encompassing sense of living with blindness or partial sightedness.

Nora elaborates on the effect of this when she says, *"I think that sometimes there is a gap, for me anyway, when I'm visually impaired and someone is sighted that there is a gap, there is a gulf that almost can't be filled because that person doesn't know what it's like trying to look through my eyes, literally they don't know what that's like."* (N: 30).

There is a sense of the impossibility of understanding what it is like to live in the world of being blind or partially sighted as in a very literal sense the world is seen through different eyes. For the sighted person these are eyes that experience the world in a visual sense and for the blind or partially sighted person, the eyes can't perceive the world in the same manner. Both are looking at the world through different eyes in both a literal and symbolic way.

There is also acknowledgement of being disadvantaged when it comes to expectations on a social level and the gap that exists when there is no allowance made for the person who is blind or partially sighted. This is described well in the quote by George, *"You have one blind person in a group of sighted people. Often somebody might expect a reply; you might have someone just give a look, thinking the blind person will pick up on this look. Or you might say what do you think? And look at the person, and of course that's automatically their cue*

to join in. But those with visual impairment, they just don't know it's happened, unless someone kicks them in the shins." (G: 38). I was struck by the use of the language *'kicks them in the shins.'* The blind or partially sighted person in a sighted conversation needs to be '*kicked*' into the conversation.

George speaks of how he is metaphorically made painfully aware of the gap that exists between him and the sighted world and how he does not fit into the existing communication styles of the sighted world. This metaphor is violent in its nature and may indicate again the oppressive experience of blind and partially sighted people living in a sighted world. Instead of accommodating blind and partially sighted people, the sighted world is violently oppressive and demonstrates this by the way it interacts with them.

Living as a person who is blind or partially sighted within this sighted world is experienced as something that can have a positive or negative impact on the blind or partially sighted individual. This is seen in the statement by Diane, *"It's a world that can be either enabling or disabling, as well as your own internal world and how you cope with your disability or how you respond to it."* (D: 16). The sighted world for the blind or partially sighted person can enable them to live in this world in either a beneficial or harmful way. This relates to the societal model of disability as discussed earlier which sees disability as a social concept that sighted society adopts and then this is felt in an enabling or disabling way by the blind or partially sighted person.

The use of the word *'disability'* itself is experienced as a personal struggle in dealing with the difference of sight. Disability is understood not in a personally labelling manner; rather it is experienced on a relational level living in the sighted world as a blind or partially sighted person.

Jerry discusses this experience when he mentions, *"For me I use that word in terms of, I'm more comfortable seeing myself as a person with a disability. For me that word means I suppose, in some ways, it acknowledges my difference between someone with full sight and someone like me. It also acknowledges that although I put on a brave face, I find it hard and struggle to do the same things a person with full vision does. Through that process I experience my own vulnerability and some awkwardness around my disability which I'm growing more accepting and comfortable with. So when I use the word disability or disabled I mean it in a relational context rather than labelling myself that way."* (J: 20).

This interaction with the sighted world is observed as a process that highlights the difference of sight and in this process the struggle of living in this sighted world leaves the person feeling vulnerable and *disabled.* There is the external struggle of moving around in this visual world and how a *brave face* is needed to defend against the reality that this is a *real* personal struggle. This external struggle is also facilitating a personal, internal struggle of feeling *disabled* in living with the identity and reality of sight loss and the acceptance of this.

(1) (iii) 'You wanted to be seen as normal.' (G: 27)

The previous two sub-themes considered the impact on personal identity that blindness and partial sightedness has on the participants and also the gap that is felt of trying to live within a sighted world and how this gap is experienced. The final sub-theme considers the emotional impact and the desire to be seen as *normal* and find an acceptable and comfortable place to try and fit into this sighted world.

This world of the visual is something that is perceived as *'normal'* and that being blind or partially sighted within this normal sighted world leaves you open to negative judgements, and feelings of disablement and marginalisation. This desire for the feeling of normality is seen in the statement by George, *"Yeah, you didn't want to give into it. You wanted to be still part of the sighted world. You wanted to be seen as being normal."* (G: 27).

This desire to '*fit into'* the sighted world is something that facilitates resistance in the acceptance of sight loss and the feelings of marginalisation and *abnormality* that this creates. This also leaves a desire of not wanting to stand out and draw attention to yourself. George concludes, *"The main thing is, you just want to fit in really. You don't want to stand out."* (G: 30).

Living with blindness or partial sightedness in the sighted world may include having obvious physical indicators of this condition. These include white canes, wearing sunglasses when it's not sunny and reliance on a guide dog. Although these are necessary to help the person navigate the sighted world, they are also perceived as unwanted symbols that leave you vulnerable. George explains, *"You just want to be able to walk along the street without it being obvious you have a visual impairment. Things like a white stick, or blind dog or sunglasses or that type of thing. In this sort of world we're around now, if you have a weakness or disability you're vulnerable."* (G: 29).

There is a desire to blend into the sighted world and not stand out as being blind or partially sighted. Even the visual aids that offer assistance to the blind or partially sighted person are viewed negatively as they attract unwanted attention to the person and leaved them feeling vulnerable within this sighted world.

This vulnerability due to the difference of sight is also observed as adopting a lower position in this sighted society and of having a more powerful position if you have sight. Kelsey comments on this experience when she says, *"The more I lose, the more I feel people who are fully sighted are gaining something above me. They've got something over me. They've got one up on me kind of. Especially if they're looking into your eyes, with their two perfect eyes that can see everything through a microscope. It's a little belittling sometimes, even though it's not meant to be obviously. It does feel like their two perfect eyes is judging your bad one eye."* (K: 120).

There is also the sense of being scrutinised as if *"through a microscope"* which exaggerates the sense of judgement that is felt. Also in the sighted world, the only acceptable way to exist is to have *"two perfect eyes"* and these *perfect* eyes judge negatively the *'bad'* eye that the blind or partially sighted person has. The loss of sight is experienced as a wider loss of position in sighted society.

There is a personal battle between trying to achieve acceptance and sustain that acceptance. Nora talks about this personal struggle when she says, *"Part of me wants to step outside myself and say well why? Why do you feel as if there's a power dynamic here? Your experience is just as valid even if you're not seeing in the same way as someone else you know, it's just about you're sight being different to that person's sight and sometimes I can really reach that place but I can't sustain it because society won't allow that to happen."* (N: 78). This challenge between the personal acceptances of one's sight loss exerts pressure to retain this acceptance. In a sighted society, the challenge is to hold this position of acceptance and not feel disempowered by sighted society. Again this holds to the social model of disability as enabling or disabling.

Finally in concluding this meta-theme, George speaks of the personal attitude that he's adopted toward living as a blind or partially sighted person in the sighted world, he forcibly says, *"I've gone around apologizing to the world for being blind, and I have to stop doing this."* (G: 70). His quote exemplifies the pathologising effect of the medical model of disability making the disabled person feel responsible for their disability and so must apologise to the rest of abled society for this. As George says, this needs to stop.

2) Bringing the 'elephant' into the therapy room

Overview

The second meta-theme focuses on the experience of participants when they entered psychological therapy with a sighted therapist. This theme relates to the initial stages of therapy and the experience of coming to therapy and *starting off* with a sighted therapist. All participants had experienced therapy with a sighted therapist. This theme, considers what the initial experience of meeting the therapist was like and the early stages of building the therapeutic relationship.

I will not focus on the actual techniques and tools the therapists used whilst the therapy was in progress as they will be discussed in later themes. This theme will consider the experience of participants as they entered therapy and began to enter another aspect of the sighted world, that of having psychological therapy with a sighted therapist.

This next sub-theme will consider how these struggles also entered the therapy room as participants started working with a sighted therapist, linked to the previous theme of the struggles of living as a blind or partially sighted person in a sighted world. What is captured is the experience of *"the dance"* (N: 138), the dance between the sighted therapist and the blind or partially sighted client in navigating between the two worlds, the therapist within the world of the blind and partially sighted client and the blind or partially sighted client in the world of the sighted therapist. In the movements of this dance, adjustment is required to find a place where both therapist and client are dancing in step with each other to facilitate a working therapeutic relationship.

(2) (i) 'The elephant'

This metaphorical idiom was used by two participants to express the obvious reality when it came to entering the therapy room with a sighted therapist. Nora talks about two elephants that walk into the room, *"I walk in with the blind dog, and I and the dog are the elephants in the room."* (P: 83). Here, there is a personal reference to both client and their guide dog being the elephant in the room. The presence of the client with their dog is something that

cannot be ignored and it is obvious that the client is blind or partially sighted. As there is no avoiding that reality.

This metaphor being represented by *"the elephant"* is further brought out by Jerry who expressed it this way, *"For me it's like my visual impairment at times is like the elephant in the room and if I don't bring it into the room and if I don't bring it into the relationship, or I don't acknowledge it, it's like it's something that's not acknowledged. I suppose I also wanted to, I suppose it's something that I always have to adjust or adapt to, so I thought it was quite important to start talking about it with my therapist."* (J: 14).

There is a sense of constant adaptation and adjustment when living as a blind or partially sighted person in the sighted world. There is also a necessity to talk with the sighted therapist about this *'elephant'* and work with the reality of it in the room. This is further described by Nora as a vital way that client and therapist can start to build the connection or therapeutic relationship between them, *"So in terms of making a connection with somebody, it's not just about the tone of voice but whether they are prepared to talk about what's real, that you're a person with a visual impairment, and how best can you communicate in the environment you're in or the situation you're in."* (P: 63). In other words the therapist needs to face reality and talk about, and not avoid, the difference of sight or the *"elephant in the room."*

Further highlighted by Erica is the role that the client has in educating the sighted therapist about how the *"elephant"* personally affects them, she says, *"I don't think all of the responsibility should be with the therapist actually. I think some, the responsibility should be with the client themselves to articulate what they want and articulate the problem clearly, because everyone's sight problem is different.'* (E: 82). There is an acceptance that the client can help the therapist manage *"the elephant in the room"* by informing the therapist of how their sight loss impacts on them thus helping the therapist work effectively with the unique needs of the client.

(2) (ii) The room

When trying to position the "*elephant in the room*" attention needs to be given to the room itself and how the room makes provision for accommodating the *elephant.* In making the sighted therapist aware of the individual needs of the client, some participants commented on how the set-up of the room helped to manage the '*elephant.*'

This is observed in the comment by Erica, *"Actually with one particular therapist they did ask about the lighting because my condition is very much effected by light. Actually they didn't actually know that but it was quite a good question whether the light was ok and stuff and to be honest, it was just a lamp, and I couldn't see much anyway, so I said it was ok, even if they'd put on the light I wouldn't have been able to see well anyway, but it was nice that they asked about that."* (E: 4). The therapist willingness to talk about the *'elephant'* and how best to handle it was greatly appreciated by the client and accommodated a useful discussion of how best to manipulate the room to accommodate the client's individual needs.

This is further expressed by Pat, *"I simply think that it's about asking and not making assumptions. Whether that's 'would you like an arm?', 'there's a table next to you', 'there's a glass of water on the table', 'the lavatories' down the corridor'. It's about information but not just giving it, saying it, but asking what would be helpful, and then allowing that person whether it's me or someone else. What's helpful for me might be irrelevant to somebody else."* (P: 70). Again tackling *"the elephant in the room,"* involves the sighted therapist actually asking the client what would be helpful, then tailoring the room according to the specific needs of the client.

When addressing this subject, Jerry describes a behaviour about his sighted therapist and the effect of her handling the *"elephant in the room"* and attending to his individual needs. He recalls, *"I suppose, and this is something minor, she does guide me to the therapy room, and I don't necessarily need her to do that, but it feels like it's something she may enjoy doing for me. Like it's, like she almost takes responsibility getting me from reception to the room, and is concerned about me walking into something. It feels like, with her, more something, something she's willing to take responsibility for, getting me from point A to point B, and she usually offers to carry my bag as well, because I have a cup of water and my cane as well, so it feels like she's accepting that I need, that I'd like the extra help, to get from point A to point B."* (J: 64).

The description which Jerry initially details is minor, but the meaning and effect on him is not. His sighted therapist, in guiding him silently into the room and ensuring he is safe, has a significant meaning to him. Although she does not need to do it, nor does he need her to do it, she is taking some responsibility for his safety. The result is a feeling of acceptance on his part that he has unique needs and she recognises these and goes about addressing them. Finally, the impact of the sighted therapist being consistent in handling *"the elephant in the room"* is expressed in the words of Kelsey, *"She would always set her room up for when I came. So after the first meeting she obviously asked me what the lighting was like for me, would you prefer me to do this, or prefer me to do that, so the next time I came and each time after, she made sure the harsh lighting was off, if it was a sunny day the blinds were closed and the soft, gentle light was on. Everything was in the same place for me every time I came in, nothing had been swapped around, which would have caused me an accident coming in."* (K: 100). This again shows the obvious nature of the sighted therapist being conscious of the individual needs of the client with sight loss and after initially amending the room to facilitate her needs, keeps the room consistent to ensure the client is safe.

 "The elephant in the room" need not become something that blocks the sighted therapist and the blind or partially client from working together. By both managing the difference of sight in the room in an educative and practical manner, the therapist can become aware of the unique needs of the client and the client can feel safe with the therapist accommodating those. This may require conversations on the part of the sighted therapist they have never have had before and also making adjustments to accommodate the client.

(2) (iii) The dance

The start of a therapeutic relationship involves the client and therapist meeting each other and trying to build an alliance that both can work with. The therapeutic relationship is something that the therapist does not do *to* the client, rather it is done *with* the client. As with dancing, a person can dance alone or can dance with a partner. When coupled, each partner work out the moves to the dance to produce something enjoyable for both.

This metaphor of dance to describe the start of building a therapeutic relationship is described by Nora, *"It was like, trying to work out the moves to the dance. She wanted to know what side I wanted her to be on and how I wanted her to assist and she was really open with me. She said 'the person that assessed you has given me some information' but*

she said 'I want to hear it from you' and she has just been really honest and open right from the start really." (N: 138).

The start of building this therapeutic relationship is also about building trust. In so doing, there is a need to make adjustments in the dance steps at the beginning to help facilitate this trust. This is seen in the comment by Erica, *"Things that might come up in the initial meeting are talking through a contract, you know the usual things …. I found that the initial meeting obviously is about kind of about establishing a relationship and building trust and things, and I think it's quite difficult in a way not being able to fully see your therapist."* (E: 4).

The careful consideration of the sighted therapist at the initial meeting in trying to understand the needs of the client helped to build the trust and start the steps to the dance of building a therapeutic relationship in motion. In this manner the steps to the dance are adjusted for both so that the dance can continue and build.

The client being met by the sighted therapist as another unique client, is helpful. Nora further adds, *"She's always just met me as I am and who I am and I've found that helpful and it has felt really accepting, I've felt really accepted by her."* (N: 140) The blind or partially sighted person is met by the sighted therapist just as they are and in so doing, this facilitates a feeling of acceptance by the client. This stands in contrast to the gap felt by sighted society in general.

There was a need to meet the blind or partially sighted person as just another client and not assume that they have come to therapy to talk about their visual impairment. This is seen in the comment by Erica, *"Therapy should still bring an open mind anyway, and irrespective of whether they want, whether the clients coming and wanting to talk about it (their sight loss) or not, they should start with a blank slate anyway."* (E: 108).

The sighted therapist should start with a blank slate and not assume that the blind or partially sighted client has come along to therapy to talk about their blindness or partial sightedness. The agenda belongs to the client and not the therapist. This again helps to equalise the power in the room and not facilitate the power imbalance that can be felt in sighted society in general.

Erica elaborates, *"I didn't think that they were focusing on that (sight loss) all the time, and they didn't make an assumption about me wanting to focus on that. They just took me as a whole person rather than just someone with a sight issue. I didn't feel categorized."* (E: 104).

The sighted therapist not having an agenda or assuming that the client with sight loss wanted to focus on that the whole time in therapy was helpful in the client feeling they were being treated holistically rather than in a reductionist way of focusing on just one obvious thing. This reinforces the importance of the social and not the medical model of disability.

Erica also talks about how helpful it is not to assume that the client is there to talk about his or her sight loss. She also links this to not feeling categorised into a particular sub-group, rather there is a sense of the whole person being treated and not a reductionist position on the part of the sighted therapist. This is useful in not pathologising the client as in the medical model and reducing them to a category of people who have a particular condition.

(2) (iv) "She was being a bit of a machine somehow." (A: 45)

This sub-theme looks at the experience of a number of participants who have had psychological therapy with a number of different sighted therapists and explore how bringing "the elephant into the room" can prove a very difficult dance for both client and sighted therapist to navigate.

The theme is taken from a quote by Alison regarding her first experience of having psychological therapy with a sighted therapist. She recalls*, "She was missing a bit of empathy somehow. I understand a counsellor's not there to be your friend, but it's good to show a bit of concern, not concern, but you could tell she was being like a machine somehow, and I didn't feel understood in anyway."* (A: 45).

The therapist was experienced as machine-like in her approach. She was keeping an emotional distance from the client and this was experienced in a negative manner. It gave a sense the therapist wasn't showing any empathy or concern for Alison as a blind or partially sighted patient. There is a sense that the sighted therapist sitting opposite the blind client was non-human and a machine.

The experience of Nora exemplifies the pitfalls some sighted therapists can fall into in dealing with all clients in the same general manner, facilitating the feeling one is being dealt with by a machine. *"I've come across therapists who have just really understood what to do and what to offer and how to offer it, but I've also come across therapists that you know, have thought it's okay to give me a pen and paper and deal with some business in that format, and all of these have been therapists that have known that I am completely blind at*

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the outset. You know, it hasn't been a situation where they haven't known." (N: 5). The behaviour of this sighted therapist in avoiding *"the elephant in the room"* and approaching the client as Nora mentions in a *"business"* format, implies that when it comes to working with all clients, the dance moves stay the same.

The reality of this approach is it created an immediate rupture to the therapeutic relationship as Nora continues to relate how she reacted to this sighted therapist, *"I immediately wanted them to have their pen and paper back and I wanted to leave and that's what I did …. it was an immediate reaction for me because I just thought I don't know how I can get on with you, if you're not going to understand this about me."* (N: 7, 11). The manner in which the sighted therapist dealt with Nora at the start of this treatment resulted in a strong, immediate feeling of not being understood by the sighted therapist, which led to a powerful emotional reaction of rejecting the sighted therapist and leaving the treatment.

This *machine-like*, business format of applying therapy in the same manner with the same dance steps was also experienced by Kelsey, *"It wasn't personal. It felt like I was just another client, just another person. It wasn't tailored to me. It wasn't about me, it was just another person coming through the door."* (K: 16) The generic nature of some sighted therapists, was experienced as just another client coming through the door and gave no consideration to the individual, particular needs that they may have. It was *one dance fits all.*

Sadly, the *machine-like* nature of some of the sighted therapists seemed to reflect and mirror the experience of a number of participants when they were dealing with other medical professionals in eye hospitals around the country. Barbara relates her interaction with certain medical doctors, *"Yes because it was just like a machine you know? And they just looked at your eye, said what they wanted to say, increase the dose of any medicine you were taking and then next appointment."* (B: 59).

The impact of dealing with certain medical staff is further elaborated by Barbara. In one such instance Barbara commented, *"In the eye hospital, that's all they talk about, they just see you as a walking eye, you know? The consultants and the doctors just want to look at your eye and say well off you go. But I never felt any real support from them."* (B: 55). Barbara also goes on to relate*, "Even when they were breaking bad news to me, you know, that the eye had gone forever and they couldn't get it back. And, they just said it, you know, it was an everyday occurrence to them, but not to me." (*B: 57).

The manner in which the medical staff communicated was experienced as one of being emotionally distant and routine. There was no sense of this being personable. The client was being treated by a mechanical, emotion free machine with no consideration for the feelings of the client.

Kelsey spoke of a similar experience, *"It's different when you're going to a clinic, or going to see a specialist. You're at their power, you're at their mercy to what they're going to hear today and you sort of, even though it's about you, you feel powerless in that chair you're like 'ok, thank you thank you' at the news. It might be dreadful news, but at the time you don't feel that you can communicate back to them in anyway because it's a normal routine for them."* (K: 110).

Even when medical professionals are giving bad news, there maybe no sense of support from them leaving the client feeling powerless to communicate with them. Sadly this general approach of treating clients seems to rub off on some sighted therapists and in their dealings with clients who are blind or partially sighted. It is deemed as '*business as usual'* with no consideration of the individual needs of the client and tailoring the psychological treatment to the needs accordingly.

(2) (v) The sighted therapist inside and outside the room

The final sub-theme in this meta-theme looks at the interplay between the physical and emotional positioning of the sighted therapist both inside and outside the therapy room. A number of participants spoke about how the '*elephant'* was initially brought into the therapy room. This actually began outside the room when the sighted therapist was making contact with the client regarding the start of treatment. This is contrasted of the effect on the blind or partially client to attending a clinic where this is not the case. For some sighted counselling psychologists and therapists, this maybe a unique way of working.

Alison, speaking about the difference when she was about to start psychological treatment with her sighted therapist and attending another clinic for medical eye appointments, relates, *"The first contact you make with someone, you can always realise what they are like and what it's going to be like. When I contacted the first therapist she was very efficient with me. You know 'sit down, tell me'. C was well 'hi, how are you?' She met me at the station. She showed me the route to where I had to go. Three times she showed me. Three times she*

met me at station and told me how to go to the place. She'd make sure I was comfortable on my own, making that route with a guide dog, and just that, you know, and that first approach and making sure I was comfortable with that, that was so important.' (A: 54) The therapist in working with the client came out of her room and maybe her comfort zone to ensure that the client was cared for.

Alison contrasts this with attending a regular hospital appointment, *"With the NHS I always had to find the clinic. I always feel lost, and get lost in a massive hospital. She never made an effort to show me what was the route is like, or I'm going to show you the first three times, as much as you need it. And that's very important because you're already very self-conscious and aware of your disability and you're there lost having to ask for help. Everything becomes big and big and big and you find yourself in another clinic crying 'I don't know where I am'. So it's bad, really bad."* (A: 54).

The first contact with the client is seen as important in establishing a working alliance with the blind or partially sighted client. The therapist actually going out of her way to meet the client outside the therapy room, not once, but three times, is an indicator of her interest in working in a different way with this client and also assisting with her individual needs. Again, this is contrasted to the more general approach that some medial professional adopt and the negative impact that this has on the blind or partially sighted client and as Alison reports, can leave them feeling vulnerable and emotionally distressed.

The benefits of the availability of the therapist to meet the client outside the room is also reiterated by Kelsey, *"My therapist actually came and met me at the bus and walked me to her office, and she was actually fantastic. She talked the whole way, she'd done guide dog training, so she knew exactly what to tell me and how to announce a situation. She put me at ease already because you have to get personal being guided by someone you don't know. You know you're holding on to them, it's more personal than you would with a stranger obviously, but she put me at ease straight away. She was so friendly and so open it was hard not to like her."* (K: 8).

Nora also commented on the therapist's behaviour in meeting the client and how this was interpreted, she comments, *"She was just really natural about meeting me in reception, about helping me get to the therapy room, just really natural about it and I think, that's what happened is that she's just thought 'Oh, this is just a need that this particular client has. Fine.' It just hasn't been made into a great big deal."* (N: 131). There is a sense here that the sighted therapist knew how to behave toward a blind or partially sighted client. This was

understood by the client as the therapist having a natural approach to the individual unique needs of the client and treating these as such.

Three of the participants also commented on the actual physical position of the sighted therapist in the room and the impact this had on the therapeutic relationship. Where the therapist actually placed themselves in the room represented different meanings to the clients.

Pat recalls, *"I went to see him, he did something which made me think I don't think I want to work with you. He sat right across the room from me, quite a long way away and he invited me to sit down in a chair where I don't think I could even make out his outline and it was just he hadn't asked me where I wanted to sit and what would work for me in that room put me off. Looking back on that, it put me off."* (P: 61). The actual physical distance the sighted therapist sat from the client facilitated an emotional distance. Again there was no consideration for the needs of the client with sight loss and how this would be interpreted.

This was also experienced by Erica who recalls, *"I had a therapist once, I couldn't really see her that well, she was actually sitting quite far away from me, so I think positioning is quite important as well."* (E: 19). Again the position of the therapist in the room is an important factor to be kept in mind as it has an impact on the client.

The opposite experience is related when the sighted therapist sat closer to the client with sight loss, in contrast to the therapist sitting far away from the client. This is recalled in the experience of Nora, *"When I'm really emotional about something and that might be that I'm really upset or it might be that I'm really ecstatic about something, whichever it is, she'll actually pull her chair a bit closer to mine and I actually really appreciate that, because she's wanting to get involved, there's enthusiasm and interest in what's happening for me at that time."* (N: 96).

The physical movement of the sighted therapist in pulling her chair closer to the client when she was in a heightened or distressed emotional state was seen as a symbolic movement of wanting to get emotionally closer to the client and showing an enthusiasm for the client in the moment.

Creative sighted therapists are managing the difference of sight within the therapeutic relationship which allows the blind or partially sighted client to feel the sighted therapist is emotionally close to them and facilitating a close therapeutic relationship. This helps to

ensure that the *"elephant in the room"* is dealt with. The steps to the dance between client and therapist start outside the therapy room and continue inside. This helps the client feel they are being considered and cared for by a warm, empathetic human and not an emotionless machine.

3) Non-verbal communication

Overview

The third main strand in the findings is what occurred after the *'elephant'* had entered the therapy room*,* particularly the use of non-verbal communication. Encapsulated in this theme is the use of touch and silence that the sighted therapist used with the blind and partially sighted client. Six of the nine participants spoke about the use of touch. When it came to the interpretation of silence used by the therapist in the therapeutic alliance, six participants spoke about the impact it had on them.

An interesting sub-theme that emerged was yawning, how this was seen as non-verbal communication in the therapy room and how this was interpreted by the clients. Yawning was mentioned by three participants and was not something that I had thought about when discussing non-verbal communication with the participants.

What this theme showed, as in the previous theme, is that when dealing with blind or partially sighted clients, sighted therapists need to be adaptable and more aware of the needs of this particular client group. Also they may need to challenge their own ways of working and therapeutic techniques in order to build a therapeutic relationship with blind or partially sighted clients. This may require learning *new ways to dance.*

(3) (i) "You're yawning, it's not nice." (A: 69)

This sub-theme is taken from a direct quote from Alison when she was describing when she visited her first sighted therapist and she yawned in the therapy room with her*. "I remember, some therapists yawn! That first therapist, she would be yawning, and I found that so*

terrible. Ok, you might be tired but here I am emptying my heart and you're yawning, it's not nice. Very, very ugly". (A: 69). For Alison, the therapist yawning was interpreted as a terrible thing to do and *"ugly."*

There is a sense that Alison is trying to understand the therapist maybe tired, but in the absence of eye sight to interpret this differently, the therapist yawning has a negative interpretation. It is viewed as disrespectful to Alison that she is emotionally vulnerable and yawning is viewed as disinterest in the emotional content from the blind or partially sighted therapist.

The interpretation of yawning was also picked up by George when he relates, *"It's a very friendly voice she has. A soft and friendly voice. There's no, you never get the feeling from her voice that she's holding back or yawning or looking at her watch, that sort of thing, 'is this nearly finished?', there's nothing like that you pick up on."* (G: 63). Here again yawning is interpreted as something negative and links again with the sighted therapist showing disinterest in what the client has to say and being inattentive. The absence of yawning in the room is seen as a positive thing that facilitates a sense of the therapist being engaged with the client and not being disinterested.

The third participant who spoke about her sighted therapist yawning was Erica. Again when she was describing the sighted therapist yawning, there was a negative connotation attached to it. She relates, *"I could hear her yawning away constantly…constant! So I was thinking god, one or two yawns, but constantly yawning, I was thinking… I don't mind that, but as long as she isn't completely bored at the same time. It's just really hard to tell."* (E: 20).

As Erica relates, she had a certain tolerance and acceptance of the therapist maybe needing to yawn. But the constant yawning by the sighted therapist again had a negative impact on her and thinking was her sighted therapist bored in the session? Also Erica speaks of how hard it is to tell if the sighted therapist was bored or not, as she did not have to use of sight to make a different interpretation.

Erica goes on to relate the impact that the therapist yawning had on her*, "It had crossed my mind, if I was fully sighted, perhaps they wouldn't do that. Perhaps they would not, sort of, in a way, as I said earlier perhaps my own insecurities might be creeping in such as they're just taking advantage of the fact I can't see…. It fleeted through my mind but yeah obviously they*

might be aware, we can't see them so they wouldn't need to pay too much attention to their expression and things, their own expressions." (E: 22, 23).

The interpretation of yawning in the room is taken further here, that the sighted therapist maybe taking advantage of the blind or partially sighted client and were a sighted client sat in front of them, they would behave differently. This again feeds into the first theme of struggles between the two worlds and the continual challenges that blind and partially sighted clients experience in living within the sighted world. In the absence of eye contact to offer an alternative explanation as to what maybe going on, yawning is seen as negative non-verbal communication that sighted therapists need to be aware of.

(3) (ii) Touch

The topic of touch and its use came up in six of the nine interviews in conducting this research. The use of touch by the sighted therapist with blind and partially sighted clients is something that was interpreted as just an alternative form of communication by all six participants who mentioned it. It was also interpreted in a positive and not a negative way by all.

In discussing the way her therapist communicates with her, Nora comments about touch, *"The other thing that she does is that she isn't afraid to be tactile and to touch me and to ask me if that's ok and how it feels and it's sometimes brief and sometimes we sit and hold hands and it feels really safe and it also feels like she's really understood that she's communicating with me just the same, it's just through a different medium."* (N: 97).

Nora comments that the sighted therapist is not afraid to touch her, so the touch is done respectfully as the sighted therapist asks her if it's all right. The effect of this is not that Nora feels at risk or vulnerable with her therapist, rather it facilitates a feeling of safety and understanding.

Nora goes on to further expand on the use of touch, *"It feels like somebody is reaching out to me to let me know they're there. It feels like somebody is wanting to make contact and wanting to understand what it's like being in my role and it actually feels like quite a special moment actually because I think these moments are rare in life, whether in intimate relationships these moments are few and far between really."* (N: 99).

I found the language used here to describe the use of touch to be powerful in its intent. There is a real sense of a human connection in the touch, a feeling that a rare special moment has occurred. The touch acknowledges that the sighted therapist is present in the darkness of the room. This is experienced as a wanting on the part of the therapist to be alongside the client and empathise with them.

Barbara also spoke about the use of touch with her sighted therapist and the impact this had on her. She relates, *"Yes, but that's what you need. You need some sort of physical closeness, to really feel that they really understand how frightened you are."* (B: 45). Touch here is seen as a *necessity* in the therapeutic relationship. Talking alone is not enough to facilitate physical closeness.

Touch is also seen as an acknowledgement of how frightened the client is. Barbara goes on to describe why the touch is so important, *"Yes, I feel that when you've lost sight, even only in one eye, that you need the touching. It gives you something, well a hand is substantial, and just to be sitting opposite is not. It's more clinical."* (B: 47). Barbara here makes the distinction between the meaning of touch as opposed to having a therapist just sit opposite you. Touch humanises the experience for the client.

Just sitting opposite the client is too clinical and feeds into the experience of some participants in the previous sub-theme, (2) (ii) *'She was being a bit of a machine somehow.'* The sighted therapist here is showing her humanity and expressing that in the room. Barbara goes on to relate how the touch occurred, *"It just happened. I didn't say 'please hold my hand' and she didn't say 'would you mind if I hold your hand' it just happened, as were talking, and that was feeling supportive."* (B: 51). Again this feeds into the experience that Nora had regarding touch, which happened organically and naturally. What Barbara describes is a spontaneous act of humanity on the part of the sighted therapist to show in a very physical and explicit way that she was there to show her support.

In expanding on the use of touch in a positive way in her therapy, Erica also relates, *"I think touch can be quite useful sometimes, I know that therapists are a bit scared of that, but especially with someone who can't see that well, if you are say balling your eyes out for someone just to reach over and touch your arm. That says a lot actually for me."* (E: 59).

Strong language is again used about the power of touch. There is an acknowledgement of the fear some therapists have about the use of touch, but for someone who has sight loss,

this touch is necessary. For Erica touch *speaks* to her and says much, reiterating the powerful language that is expressed in this non-verbal communication.

Erica goes on to speak about how touch impacted on her, *"It feels like they're, they're feeling your pain, they're recognising it, they're acknowledging it, and they are not going to run away. They're there. It just feels like they're there and there not sort of shocked, well they might be shocked by."* (E: 62). Touch is felt as an acknowledgement of the emotional pain that the client with sight loss is experiencing. It also provides a sense of comfort that the sighted therapist can contain the emotion that the client is experiencing and is going to be a permanent, presence in the darkness. The power of touch is experienced as something extremely beneficial for the blind or partially sighted client.

The subtlety of touch and its use in the room is brought out by Pat. She observed, *"I liked her and also she gave me a little pat on the shoulder when I left, early on in the therapy. And it was very nice and reassuring of her, because I think I was probably upset and she gave me a little pat and saw me out of the door and I felt that she got me. She responded very naturally, which is what I liked about her."* (P: 40). The use of touch is seen as an instinctual behaviour on the part of the sighted therapist. In the absence of eye contact, the use of touch here was reassuring and interpreted on the part of the client that the sighted therapist *got her* and the use of touch was a physical acknowledgement of that.

Touch here is a powerful expression of non-verbal communication in the message that it gives to the blind or partially sighted client. Pat expands, *"I think she understood that I couldn't probably see any compassion or empathy in her face so instinctively she gave me a little pat. It was very subtle."* (P: 43). The subtle use of touch here was seen as a compensatory behaviour on the part of the sighted therapist to convey compassion and empathy that can't be conveyed by the use of sight. There is a sense that the subtle nature of this type of non-verbal communication speaks just as much as eye contact does in the message it can convey amongst sighted people.

Kelsey spoke about touch from the perspective of being both the receiver of touch and also the giver. In speaking about her sighted therapist touching her, she relates, *"Obviously everybody reads into touch differently, so some can be quite offended, but if you initiate that, and you're open to it, I think for visually impaired people it's very important. It's a way of reaching out, a way of communicating to somebody, a way of supporting somebody as well."* (K: 58). The use of touch here is a positive experience and one that is deemed as important

for clients who do not have the use of the sense of sight. Touch is seen as an alternative type of non-verbal communication in the absence of eye contact.

Kelsey also talks about the personal meaning that contact has for when she touches her sighted therapist. She recounts, *"I think the way I do it with C, it's my way of showing her, C said herself, that in the hugs in which I'm giving her, I'm showing her the thanks for what she's opening up to find me, which is what I wanted through therapy, to find who I was again and to become the woman I needed to be, and that's what those hugs meant and C told me she sensed that relief of this is me and I'm here to stay."* (K: 52).

This passage describes the powerful, intimate communication that touch has between therapist and client. It conveys a gratitude on the part of the client for finding her in literal and symbolic darkness and the sense of relief on the part of the client that the therapist helped her find herself again through the therapy. It also gave the message that the therapist is contained and present in her therapeutic relationship with the client.

The final participant to talk about touch was Jerry. His experience of touch with his sighted therapist is both humorous and touching and provides a different perspective on the use of touch in the therapy room and how this is used a means of non-verbal communication. He recalls, *"I couldn't see what she had on her feet and she described them to me, and she let me feel the bottom of her trainer because it was wedged and I didn't know what that was like, and she let me touch her. Which felt like again, it's little things like that about me using my other senses to think what she might be wearing, or what she's like, but little touches like that makes me feel like it's ok to feel her trainers that's she's got on."* (J: 35).

The creative use of touch on the part of the sighted therapist allowed Jerry to feel that she was comfortable in using touch as an important means of non-verbal communication and in doing gave him permission to use the other senses available to him, such as touch to compensate when the sense of sight is not available to him.

All six blind and partially sighted participants who spoke about the use of touch by their sighted therapist spoke about it in a positive manner. In terms of touch as a means of non-verbal communication it spoke of support, gratitude, presence, kindness and wedged shoes. In working with blind and partially sighted clients, touch is seen as something very valuable as it serves to communicate so much in the darkness of the therapy room.

(3) (iii) "The wall of silence." (P: 9)

The final sub-theme in this meta-theme discusses how blind and partially sighted patients experienced the use of silence by the sighted therapist in their psychological therapy. This sub-theme is also taken by a comment from Pat about how silence felt to her in the therapy room. In conducting these interviews, six participants spoke about the use of silence in their therapy and what was happening for them in the silence. Similar to what participants said about the use of touch, I found that what they said about silence also challenged my own position on the use of silence and the impact that this may have on the client.

The sighted therapist's silence with a blind and partially sighted person may be used in the same manner as with someone who is sighted. There may not be any adaptation in the use of silence with a blind and partially sighted client. What is observed is the sighted therapist working in the same fashion with a blind or partially sighted client as they would with a sighted client. The therapeutic '*dance'* stays the same and no new moves are introduced.

Nora gives insight into how she perceives silence in therapy and what happens for her in the silence, *"They'll be a moment of silence and I'll say 'I want to tell you what's happening. I want to tell you what's happening for me right now. What I want to tell you is you're sat there looking at me and I'm sat here in my own thoughts, wondering about you looking at me."* (N: 81).

The silence used by the therapist is facilitating an internal dialogue with the client. The client wonders about the therapist looking at her. There is also a tone of anger regarding what the silence is doing for the client and that it is causing her to have a strong emotional reaction toward the therapist. The silence is not silent at all. This form of non-verbal communication it is actually filled with cognitive and emotional processes for the client, which unless verbalised, is not understood by the sighted therapist.

When Erica talks about silence in her therapy, she speaks about it being a difficult place for her. She states, *"Well, sometimes, they might remain quiet and I might wonder why. For all I know they might look completely bored or not! They might look completely interested. It's really hard to know and I think my own insecurities have crept up now and again, not just in the assessment, in other sessions, whether that is the case, or whether they're interested, because they haven't verbalized that."* (E: 6).

In the silence, insecurities of the client come up with regard to what is happening in the room, as sight cannot be used to fill in the gaps. The lack of any other sense in the room, such as sight or sound, leaves the client feeling vulnerable and questioning what is happening.

Erica concludes it would be helpful to adopt a balanced use of silence for good effect in the room, "*I think silence is still important to have in many ways, because you know it helps me process what's just been talked about. I've been trying to think about my experience, and I think that might be the only thing I could identify that might be a barrier. At the same time I do think silence is important too, so it's getting that balancing act for the therapist pointing things out.*" (E: 11). The use of silence needs to be balanced so as not to create a barrier in the room, or *wall* between the blind or partially sighted client and the sighted therapist.

Pat goes on to relate the effect of silence on her, *"But at the time I remember I was met with a wall of silence and it didn't feel like a particularly inviting space in which to speak and I do remember feeling incredibly anxious, probably because I couldn't read his face."* (P: 9). The use of the metaphor *"wall of silence"* infers the silence is something of a blockage in the therapy room and facilitates the space feeling uninviting for the blind or partially sighted client.

The resulting emotion that this creates is *anxiety* in the client as they try and navigate this wall. Due to sight not being available to the client, the space may seem uninviting and uncomfortable. The blind or partially sighted client is left feeling anxious about what is happening and also feeling vulnerable.

When Jerry talks about silence, he relates the emotional impact that silence in the room has on him. He observes, *"But I suppose when she is in the moments when she is silent, I get a bit antsy because I can't see she what she's doing, or what facial expressions might be going on her face. So I get antsy and anxious when that happens, so I feel like thankfully there's not a lot of silence in the room, otherwise it might feel like it's too intense for me."* (J: 72). Silence creates anxiety in Jerry as he can't use any other senses to understand or interpret what might be happening. He also mentions if there was a lot of silence in the room the experience would feel too emotionally intense and difficult to manage.

Jerry goes on to describe the silence in more detail. He adds, *"It's just the fact I can't see what she might be thinking about, what emotions might be going across her face, whether I've said something for example, and I don't feel like she's judged me in the past, but if she*

was just sitting there saying nothing what so ever." (J: 74). In this statement Jerry links the presence of silence to possible judgement on the part of the sighted therapist toward him.

Jerry cannot see her facial expressions, due to the lack of sight. The silence leaves him nothing to go on in terms of reference to what might be happening in the room between him and his therapist. Also in terms of understanding how his words may have fallen with his therapist, the silence leaves him questioning what he has said and whether these words are met with understanding or judgement.

Regarding non-verbal communication, yawning, silence and touch were significant to the participants. They are not simply actions and behaviours which are without meaning, rather they are laden with content in what they communicate to the blind or partially sighted client.

I conclude this section with a final quote from Jerry. He talks about living with sight loss and not having eye contact as a form of communication available to him when in therapy and in his life in general and sums up the experience and his feelings toward it. He states, *"There's so much depth lost because I can't see what she's doing or how she might be responding physically. Like I said, it's frustrating for me, because it feels like there's a whole different level of communication that's completely shut off, and I'm unable to see her facial expressions. I can vaguely make out her body language, and I imagine that sort of communications makes up your 90% of expression, so it's frustrating. Say if she's responding to me in a certain way, and she's reflecting back anger or sadness or acceptance of what I've said, on one level I can sense that through her speaking or the tone of her voice yet there's another. Yeah it's frustrating, and I feel some anger about it, but then I've had to deal with that over the duration of my life." (J: 37, 38).*

4) Verbal communication and the power of the therapeutic relationship

The final meta-theme that arose from the findings related to the use of verbal communication by the sighted therapist, illustrating the nuances and flexibility of the voice and how that is used in the room. The use of the voice by the sighted therapist is something that all participants spoke about in their experience of therapy.

The communication between therapist and client went beyond the physical words that were said and took into account the pace, the tone and also the mirroring of the therapist's voice to the client's, in examining the use of the voice. Pat and George spoke about the use of language and how words used by the therapist can leave the client feeling frustrated and alienated.

What was also evident was the reliance on the use of voice on the part of the blind and partially sighted clients. As sight was missing, voice became a powerful means of communication. The degree of skill that the therapist had in using voice in the room had various positive and negative experiences. Voice was also perceived as a therapeutic tool that could be skilfully used and trained to effectively work with blind and partially sighted clients.

Three of the participants spoke about a moment or a connection between client and therapist that transcended all five senses and that was hard to define in terms of the communication that occurred. It was a moment powerfully felt by the blind or partially sighted clients and perceived as something very rare and special. This connection took place in the absence of eye contact between the client and therapist and suggests that this special connection was not defined by any particular sense and hard to put into words. The use of voice and the power of the therapeutic relationship are discussed below using five themes taken from the text as sub-headings to guide the analysis.

(4) (i) The use of voice

This sub-theme considers the use of the therapist's voice in the room. A number of participants spoke about voice and how they interpreted its use. How the voice is used is very important and can communicate a lot more than just the words themselves that are spoken. The necessity of using voice properly is brought out by Kelsey, *"It's not what you say, it's how you say it. Just if you close your eyes and listen to someone talk you can take it completely differently, then if you're opening your eyes and watching how the face is reading it to you."* (K: 94)

Kelsey highlights a powerful difference. Eye contact can influence how words are interpreted and that lack of eye contact can facilitate a completely different meaning to the words spoken. Unable to see or read the face that is saying the words leaves the blind or partially sighted client left with only voice and the words to work with and making them more powerful in their effect.

The nature of how the voice is used in the room and what constitutes a helpful voice is discussed further by Pat, *"Also the other thing I wanted to say about the first therapist I had, I didn't like her voice. Because voice is very important as well. The tambour, tone, and accent. If you can't see, so you're listening to people. You get so much information from the tone of their voice, and I didn't like her voice actually. She had a …. I can't remember it well. I remember just not liking it."* (P: 49).

Pat discusses that she didn't like the voice that her therapist had. She dissects the voice, not just into sound, but the tone, accent and also the tambour. She speaks about the voice on a deeper level than just words and sound. Rather it is something with particular parts. She also clarifies that when you can't see, that you are listening all the time. Therefore the voice takes on a different position in the sense of how it is related to in the absence of sight.

The use of the voice in therapy with blind and partially sighted clients is described by George as a tool that the therapist can skilfully use in the room, *"It's a nice pleasant, easy, relaxed kind of voice. I struggle to put it any other way. It's a very easy voice, but you kind of tell there's a drawing intensity, a tool to try and get you talking."* (G: 64). The voice can be used by the therapist to draw in the client to get them talking. In this instance it was relaxed and helpful and as a substitute for eye contact replaces the gaze from another person and thus can draw you in.

Erica talks about the use of the voice in an additional way, how the tone of the voice is important in the room. She adds, *"Yes. The tone of the voice of course. That's going back to the verbal isn't it? Yes the tone of the voice is important, you can definitely pick up on things by that and I think that maybe when you're not fully sighted you're more in tune with that. So I think that is very important."* (E: 74). There is acknowledgement that when sight is missing in the communication between two people, the voice substitutes for the lack of eye contact. Attunement to the voice is something that occurs in the absence of eye contact between two people.

Erica concluded that in the absence of eye contact voice is more important as that becomes the main sense that is relied upon in room. She observes*, "Well if they're sounding quite flat, or their pitch goes up, they're sounding more interested. So pitch and I guess the fastness, the speed of the voice can make a difference. To me if they're quite fast it might sound like they're rushing you through something. But anyone might pick up on that possibly, but maybe I'm just more sensitive to that, because that's what I rely on more, hearing the voice, more so than seeing someone's features and stuff."* (E: 78).

This section has emphasised the role of voice in the room and the need to be aware of its use by the sighted therapist as important for the client. Voice is a powerful tool as a sense in the room that communicates more than words to the blind or partially sighted client.

(4) (ii) Verbalising emotions

The second sub-theme considers how the sighted therapist used the voice to verbalise and name emotions. When sight is missing in the room, the sighted therapist can't rely on the power of the eyes or the face to convey emotion.

In discussing this further, Erica expresses it well when she talks about the natural ability that the sighted therapist would have in being able to communicate their emotions. She relates, *"Obviously a sighted therapist, naturally would express themselves through their body language and facial expressions, they wouldn't necessarily have to think about verbalizing that every minute, it wouldn't come naturally to them, and I absolutely don't blame people for that …. it's a bit of a difficulty in a way, because I think especially when you're trying to build up that trust if it isn't verbalized, if their warmth and empathy isn't verbalized."* (E: 7).

Erica acknowledges that the sighted therapist would not naturally verbalise their emotions as sight would do that for them. There is an acceptance this is a natural process for sighted people. However, she highlights the need to verbalise warmth and empathy in the room as it can't be taken for granted that the blind or partially client will pick up on this. She also suggests that this is an important factor in building up trust between client and therapist.

Alison also talks about the sighted therapist not taking for granted the use of gestures and expressions, as again these will not be picked up on by the client. She relates, *"Give a lot of voice feedback to make sure you are listening. If you're nodding with your head, just say 'huh-huh' or something, or if you gesture, any gesture you make, make sure that's being described verbally. You don't have to say 'I'm nodding with my head now' or 'I'm making a surprised face' but you have to show that surprise, or that agreement. You have to show it verbally."* (A: 122).

The natural use of the body to communicate maybe lost on a client who cannot see. Alison mentions that head-nodding to show agreement or other gestures are missed by the client if they are not verbalised. She also, by her use of the word *"have to"* twice in this section, shows this is a necessity for the client.

Erica also speaks about the need for the therapist to be more vocal in the session to help verbalise the emotion that is not being interpreted through sight. She says, *"By, them, making small sounds like 'oh' you know or saying 'I feel sad listening to you talking about that' or sort of just verbalising their emotions in some way."* (E: 50). Erica talks about the sounds a sighted therapist will make in the room and verbalising the emotion this sound is expressing is helpful. The therapist actually needs to use an emotional language that is available to the client and Erica talks about naming the emotion that is expressed, such as using the word *"sad."*

Kelsey also talks about how her therapist verbalised in a symbolic sense how she was emotionally responding to what was happening for her in the room, *"In the some of the gasps that she did, the twitching, the moving she was doing. I know from what I was saying that is going to affect whomever I'm saying it to and she would communicate to me very clearly 'oh, that's just caught me in the chest' and so on."* (K: 74).

The therapist's use of language here to convey to the client the impact of what they have said is communicated verbally by means of the symbolism of *"catching her in the chest."* The

verbal communication was clear and named the emotion the therapist felt. Without the use of sight and body language to communicate emotion and empathy, the voice, words used and the creative use of both, helps the blind or partially sighted client *see* the emotion that the therapist is conveying.

(4) (iii) Attunement and mirroring

The third sub-theme in this meta-theme relates to sighted therapists' use of voice to mirror and attune to the voice of the client. Nora comments on this, *"Yes sometimes she'll say something really quite quietly and other times she might say something quite loud and I think sometimes she does a really amazing job of matching my energy and my emotional place at any given time so I think there's times, I think kind of what happens partly is when I'm quite fragile and uncertain about something she's, she can, she will tread carefully but when I'm really banging on about something that's pissed me off, she's really good at mirroring that and I think maybe there's a parallel there about , you know many therapists talk about mirroring someone's body language for example, I think she's very good at mirroring my emotional energy and my voice actually."* (N: 108).

Nora talks in detail about how her sighted therapist mirrors her emotional energy and her voice. The sighted therapist is careful to observe the emotional energy in the room and the voice to demonstrate that she is tracking what is happening in the session and so build congruence and rapport between the two of them. All this is happening without the presence of sight.

Jerry also talks about the experience that he had with his sighted therapist and how she also used her voice to match his and show this attunement. He relates, *"When she uses her voice, the word attunement comes to mind, like she's tuning into the sense of what I'm expressing and expressing that back to me, and to use that through the tone of her voice, and then there's the words which will also accompany, which is important but I think it's the tone of her voice is where the deeper communication is."* (J: 54). Jerry uses the word attunement to demonstrate his therapist *"tuning into"* what he is saying and this is communicated through the tone of her voice. He expresses that to him this is where the deeper communication lies, rather than in the words that are being expressed.

Kelsey also talks about this mirroring that took place with her therapist and how this was experienced. She relates, *"She had a lovely voice and the tempo changed which tells me that she's listening. So she'd change with me, if I was getting a bit giddy about something, a bit crazed, not the word, or a bit manic about something 'wah,wah,wah,' and going off on one, you know, she would soften that down for me. Or if something genuinely excited me or I'd be passion about something, she'd give me that passion back in her voice…her tone changed with me."* (K: 90). The mirroring of the voice by her therapist conveyed that she was listening. She was saying a great deal without actually saying anything. The changes in the tempo helped to build the rapport between client and therapist; it also showed that the sighted therapist was congruent with the client.

The skilful use of the voice in this sub-theme shows the impact this has on clients who are blind and partially sighted. The voice is a powerful tool for the client in helping them feel listened and show the sighted therapist is adjusting to the emotional changes of the client and adapting the session accordingly. This adaptation to the client's emotional state and adjustment is conveying more than just words, rather it is conveying that the therapist is tracking the client within the session and assisting them in the changing emotional places they find themselves. The sighted therapist who relies upon sight and eye contact would miss the opportunity to work effectively with the client and manage their needs.

(4) (iv) "Can you see me?" (P: 71)

The fourth sub-theme in this meta-theme relates to the use of words and language. It is taken from a comment by Pat when talking about the use of words and expressions and the impact these have on clients who are blind or partially sighted. Many of the words that are used in language relate *seeing* to knowledge, which ties in with the early philosophical perspective psychology had of how sight was necessary for meaning making and knowledge.

Expressions such as *"I see what you mean,"* or "*I can see what you're saying,"* integrate vision and sight into understanding something and giving it meaning and clarity. Both George and Nora speak about this use of language and how it can impact on the blind and partially sighted client. It also highlights how sighted therapists may need to be more cautious about their use of words and language when working therapeutically with this client group.

George speaks about how the use of language can be biased toward sight, he relates, "*It's the same with learning, the resources aren't there, everything is visual, you know there's expressions like 'I can see what you're saying' or 'I can see what you mean', that's where these sayings come from I mean. The whole explanation is by demonstration and it's difficult for the visually impaired or the blind.*" (G: 35). The bias of sight in linking knowledge to seeing is alienating in its use to a blind or partially sighted person. The powerful position that the visual sense plays in associating seeing with knowledge and understanding is a difficult association for those who do not have sight and hence using these expressions is not helpful.

Pat talks about certain expressions that can sometimes be used by the sighted therapist and society in general and how she hears and interprets these, when discussing the use of words and language within therapy, "*I think the other thing that I have to say, I have to say happens not just in therapy but all the time if you are visually impaired, sighted people say all the time, 'can you see me?' and I find that an annoying question because then it's all about them. I find that thing of 'can you see me?' annoying and that really comes up quite a lot for more people with a visual impairment. That's probably a very common response.*" (P: 70).

This statement by Pat again shows the power of the language that is used by sighted people and how this is perceived by those with sight loss. As Pat mentions, the statement *'can you see me?'* is narcissistic and elevates the sighted person into a position of making it all about them. The emotional response to this is annoyance.

Pat expands on the use of these words when she says, *"The question of 'can you see me?' immediately puts the visually impaired person at a disadvantage because they have to say 'well not really' or 'I can see you're outline.' It immediately conveys a lack and I think that's why it's such an annoying question."* (P: 77). The use of this terminology as Pat mentions puts the blind or partially sighted person in an inferior position and again she is annoyed by the question as it conveys that lack of sight personalises into lack of person.

She goes on to describe some more about how she experiences this by saying, "*…immediately it brings up the difference, 'can you see me?', 'No I can't' because the next part of the question which is left unsaid is 'because I can see you'. What's this going to be like? You see it never goes there. That's why it's an unhelpful question. If it was to be 'well ok you can't see me but I can see you, so I wonder what that's going to be like for you,' might be more helpful." (*P: 79).

This may explain why the use of this question of '*can you see me?*'' is such a problematic one. As Pat mentions, it immediately infers the difference between the sighted and non-sighted person. However, the part that is left unsaid of *'I can see you,'* leaves the person with sight loss having to almost defend and explain their position of not being able to see. Pat suggests a more helpful response that could be used to bring both sighted and non-sighted person into the shared experience, rather than just focusing on the person with sight loss.

Pat also talks about an expression that is often heard and that has a major negative emotional impact. She mentions *"Whereas the question of 'how much can you see?' or 'can you see me?' that's another one 'how much can you see?' that's just unquantifiable isn't it? It's a ludicrous question, which I often want to say, but politeness prevents one."* (P: 81). Again in the use of words and language, this is totally alienating and as Pat mentions unquantifiable. She highlights the ridiculousness of the question, *"how much can you see?"* as something that is not worth responding to.

This sub-theme highlights how words and language can have a biased slant toward the sighted population and can feel alienating for the blind or partially sighted person. This serves as a reminder to sighted therapists to be cautious about their use of language when working with people who are blind and partially sighted. Language can leave them having to explain and justify their position in a sighted world, causing them to feel disabled and disadvantaged.

(4) (v) 'But it's not all about eye contact is it?' (A: 96)

The final sub-theme in this meta-theme relates to the experience that a number of participants spoke about, which is having a connection with their sighted therapist that went beyond eye contact and the other senses. This sub-theme is a quote from Alison when she talks about the connection that can be made between two people who do not share the same sense of sight. In speaking on this, Alison says, *"There's much more to it than eye contact. Eye contact is part of it, but not the most important part at all."* (A: 98).

Alison acknowledges that eye contact plays a part in producing a connection between two people, but as she clearly states it is not the most important thing in building this connection. This infers something else must be more important to help establish the connection between

two people. This sub-theme tries to identify and explain what this other important part may be. It concludes that the power of the therapeutic relationship is something that can have a significant, positive impact on the therapy experience for the blind or partially sighted patient.

Alison goes on to talk about how these connections are possible with people who are in her personal life. In discussing the other thing that helps make connections and relationships without eye contact, she relates, *"Eye contact can also be something which is substituted by other things surely. I've never had a problem with my friends, or with my family or with my relationships, so that can be replaced."* (A: 114).

Alison explains in her life outside the therapy room eye contact can be substituted by other things and that existing relationships between her and family and friends are well established without the use of eye contact. Surely a sighted therapist has the ability to do the same?

Nora relates the positive experience she is having with her sighted therapist and the power of the deep connection they have made with each other. She says *"You know I feel as though I really experienced her heart, her soul, her mind, what she stands for, and the essence of who she might be and what her views might be and you know she doesn't often disclose all that much but her therapy style definitely communicates a lot to me about her."* (N: 123). Nora here is describing the powerful impact that the sighted therapist is having on her. Although she is not disclosing a lot verbally, her therapy style is disclosing a lot about who she is and the connection that is made on a deeper level that goes beyond sight and words.

An experience Jerry had with his sighted therapist to try and describe the powerful connection in the therapeutic relationship that can take place, concludes this sub-theme. The language that he uses and his description put into words the hard to describe moments when human connections transcend all the senses. He beautifully recalls, *"I remember one time I'd said something like, I can't remember the exact words I'd used, but I expressed something personal towards her and she responded back by going like 'ahhh'. I feel a little bit embarrassed saying that over the phone. It's difficult to describe out of context but it's almost like, it's almost in those moments the feeling I get of being a little boy and I've just given my mum a birthday card, and I've put a lot of effort into putting it together and I've given it to her and she's put it up and felt really pleased or touched by what I've kind of bought to her, and she uses her voice, and that's the sort of thing I get from her, it's a really meaningful contact in those moments."* (J: 48, 49).

The experience spoken of here is something that transcends the senses to create a powerful emotional connection between sighted therapist and the blind or partially sighted client. It transcends visual, verbal and auditory senses and is a powerful connection in the moment that is experienced. In those intimate moments between therapist and client something bigger than both of them is happening in an organic, holistic and powerful way. There is a true therapeutic human connection that is experienced and in this connection the two people meet as people, not as a sighted person and someone without sight. In this moment, both are equal.

Summary

The findings of the interviews highlighted several areas for consideration for sighted therapists who work with blind and partially sighted clients. The inhabited sighted world can be disabling or ableing to them. This can be pervasive and the sole identity of the blind and partially sighted person becomes their disability, disregarding any other aspects of who they are. This in turn can leave them feeling stigmatised and marginalised.

There is the need for sighted therapist to acknowledge the *'elephant in the room'* which is the difference of sight. This requires the sighted therapist to adapt their stance and behaviour within the therapeutic relationship to accommodate the difference of sight and benefit the client.

The use of non-verbal communication needs to be given careful consideration. Silence and touch were discussed in relation to the impact that they can have on the blind and partially sighted client both in a positive and negative way. Verbal communication was also highlighted in the use of voice and language and the importance of being aware of how their use influences the therapeutic relationship.

Discussion

Overview

When conducting this research, I interviewed nine participants to learn about their experience of having psychological therapy with a sighted therapist. As the interpretative researcher, I sought by means of analysis and verbatim quotes to record their voices. From recording, translating, coding and analysis I have kept my focus on hearing those voices to tell the story of their experiences. I have focused on connections between the interviews at the theme and meta-theme level to have the experience and phenomenon investigated from that perspective.

One of the key drivers behind this research and its contribution to counselling psychology and therapeutic practice was to explore the experience of blind and partially sighted clients who have had psychological therapy with a sighted therapist. From the interpretative phenomenological analytic approach, I believe that this research provides a client perspective on this experience that has not been previously seen in a study of this size.

The first meta-theme, *Struggles between the two worlds*, highlighted the lived experience of blind and partially sighted people living in a sighted world and the struggles they have. These struggles are both personal in terms of the impact they have on identity and also general in trying to navigate and find a place in a world of sight and sighted people. This sighted world can be experienced as enabling or disabling and there was also a desire for the '*normality*' of the sighted world.

The second meta-theme*, Bringing the 'elephant' into the therapy room,* was rich in metaphor and focused on the experience of participants when they entered psychological therapy with a sighted therapist. This theme related to the early stages of therapy and the experience of coming to therapy and *'starting of'* with a sighted therapist. This also highlighted the *'dance'* that occurs at the start of therapy as both therapist and client try to adjust to the difference of sight in the room. It also exposed therapist behaviour inside and outside the room and how this was beneficial or not.

The final two meta-themes, *Non-verbal communication* and *Verbal communication and the power of the therapeutic relationship*, reflected on the meaning given to touch, yawning and

silence and therefore non-verbal communication. In the absence of sight as a means of making interpretation, non-verbal communication was important in what it communicated to the client.

The verbal communication was described in great detail as being more than just words. The voice was a therapeutic tool in itself, so tone, pitch and pace all held meaning and communication to the client. The power of the therapeutic relationship between client and therapist was highlighted as something that can occur without the necessity of sight.

I was mindful of the goal of quantitative research as discussed by Zhang and Wildemuth (2009), in conducting the research and the subsequent discussion that it has produced:

> *"The goal is to identify important themes or categories within a body of content, and to provide a rich description of the social reality created by those themes/categories as they are lived out in a particular setting. Through careful data preparation, coding, and interpretation, the results of qualitative content analysis can support the development of new theories and models, as well as validating existing theories and providing thick descriptions of particular settings or phenomena." (*Zhang and Wildemuth, 2009, p.319)

This discussion section has five main functions: (1) it highlights some implications from the findings and makes recommendations for counselling psychologists and other mental health professionals who may have blind or partially sighted people as clients (2) it seeks to outline the main ways that this piece of research adds to previous research and helps raise awareness of the issues of working as a sighted counselling psychologist with blind or partially sighted clients, (3) presents a reflective learning piece on my experience as a research-practitioner, (4) examines some of the limitations of this investigation and (5) aims to highlight areas for future research.

"It's still trapped in an ableist discourse." (N: 19)

This quote was taken from the interview with Nora. The '*it's'* she mentions was in reference to the discourse and practice of psychotherapy and counselling which in her view operates from a position of ability. Those that have full use of all their senses and abilities can have full access to it. As previously mentioned, *ableism* is one of a set of universalising social

practices that ignore differences in individuals and groups. This drive to unify difference constructs those, whose difference is not valued or construed as deviance, as 'other' or lacking anything in common with the normal (Young, 1990).

Nora highlights for her that psychotherapy and counselling is *trapped* in this ableist discourse, indicating that it is stuck there with what seems no way out. In this section of the discussion, I explore ways that the profession of counselling psychology can move from this trapped discursive *ableist* position and move forward to one that is inclusive of clients who are blind and partially sighted.

Commenting on the work that a counselling psychologist does, I quote the British Psychological Society (BPS):

> *"Counselling psychologists focus on working with a tailored psychological formulation to improve psychological functioning and well-being, working collaboratively with people across a diverse range of disciplines."* (BPS, 2014)

The goal of counselling psychology is to improve psychological functioning and work collaboratively with a wide range of disciplines. The key word in this description is *tailored.* As was discussed in the findings, sighted therapists who do not *tailor* their way of working to adjust to the needs of their blind and partially sighted clients actually can do more harm than good. The findings agree with Humes *et al.,* (1989) who suggested that therapists have not facilitated the personal growth and development of their clients with disabilities, including sight related ones. They concluded:

> *"The literature includes many testimonies of persons with disabilities…who have achieved successful careers despite roadblocks they perceived to have been imposed by counsellors,"* (Humes *et al.*, 1989, p.145).

My research highlights potential '*roadblocks'* that sighted therapists may place in the way of their blind and partially sighted clients. These include: not adapting the room for their personal needs, treating them as if they were *actually* sighted and also careless use of language. As the BPS suggests, working as effective and professional counselling psychologists requires that we *tailor* how we work to the benefit of the clients who come and see us. As my research has discovered, this very much needs to be extended when working with blind and partially sighted clients to ensure that as sighted counselling psychologists that we are not placing '*roadblocks'* in the way of this client group. Future recommendations

in this regard are made further on in the discussion, under the heading of *Conclusion and future directions.*

Research into disability in general within counselling psychology is sparse and research into the practice of working with blind and partially sighted clients even more so. The little research that has been conducted has been done by researchers who are themselves blind or partially sighted. This fact may also be indicative of the *ableist* position that Nora spoke about. Research into working with blind and partially sighted clients is not undertaken by sighted counselling psychologists as the *ableist* position ignores difference and so this is overlooked in the field of research within counselling psychology.

As I am a sighted counselling psychologist with no history of sight loss, I was conscious of being aware of, and seeking to challenge, this *ableist* position that Nora mentions. As has been previously discussed, counselling psychology and some of the therapies which are used when working with clients such as Gestalt and EMDR, do not take into account clients who are blind and partially sighted. Counselling psychology as a profession has been very helpful in addressing certain cultural differences, but not all.

Over the past 35 years counselling psychologists in the USA and UK have taken leadership in promoting the need for multicultural competence among psychologists who work with different cultural populations and how to manage that (Constantine and Sue, 2005). This has been beneficial in assisting counselling psychologists to understand and work with cultural difference.

Cross-cultural psychology is well embedded in the field of psychology. Brunel University, London offers an M.Sc in Cross-Cultural Psychology (Brunel, 2015) and numerous books and articles have been written on the subject, such as Gerstein *et al.,* (2009) *International Handbook of Cross-Cultural Counselling: Cultural Assumptions and Practices Worldwide.* Yet counselling psychology as a profession does not seem to be addressing the needs of a large population of people who are different in other ways. Even though almost two million people in the UK live with sight loss and this figure is predicted to increase by 22% by 2020 and double to almost four million people by the year 2050 (RNIB, 2009), research and training on the part of counselling psychology as a profession on working with clients that are blind or partially sighted is not addressing this growing population.

This ableist position was observed in the findings of this research, as seen in the quote by Kelsey, *"It wasn't personal. It felt like I was just another client, just another person. It wasn't*

tailored to me. It wasn't about me; it was just another person coming through the door." (K: 16). Counselling psychology needs to change its position. It needs to treat blind and partially sighted clients not as just another person coming through the door. The difference of sight within the room needs to be accommodated and respected.

My experience of conducting this research concurred with what Dale (2008b) also wrote about in her research with blind and partially people. Both participants in her paper discussed how the medical model of sight loss had silenced and isolated them. Their being able to tell their stories and be listened to, enabled them to feel connected with positions of strength, in contrast to when they were '*talked about by experts'* which left them feeling disabled and powerless. This again reinforced the need to personally question attitudes about disability, as shall be discussed in the following section.

All participants within the research thanked me at the end of each interview for listening to them and also highlighted how important being a part of the research was to them. They wanted their voice to be heard and for this research to reach out to the wider community of mental health professionals about ways of working with blind and partially people.

"They just took me as a whole person rather than just someone with a sight issue. I didn't feel categorized" (E: 104)

The above quote is from the interview with Erica when she spoke about the difference of how she experienced her therapy with a sighted therapist in comparison to appointments with other medical professionals she visited in specialist eye hospitals. She speaks of being treated in a holistic fashion by the sighted therapist and not reduced to just an eye problem.

Erica also describes how being treated in this manner meant that she did not feel categorized. The findings within this research, in particular the meta-theme *(1) Struggles between the two worlds*, highlighted the personal struggle of living as a blind or partially sighted person in a sighted world. This struggle had an impact on the personal identity of the person and also the position that they felt they occupied in sighted society, as Diane recalls, *"It's a world that can be either enabling or disabling." (*D: 16).

The medical model places people with disabilities into stigmatising categories such as Erica described previously, therefore allowing others to view them in a category, such as 'the

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blind,' 'the deaf,' 'the mentally ill.' (Nagi, 1969), as has been previously discussed. The medical model shows a lack of attention to the individual and their environment. It observes the disability as existing totally with the individual. Accordingly, the individual with the *'problem'* of the disability should also be responsible for the solution (Kiesler, 1999).

This medical model of disability reinforces seeing disability and sight loss as pathological and does not take into account any of the other *abilities* the person may have. It views the person who is blind or partially sighted as *disabled* and so the focus and approach is not to view the person as *enabled* and in possession of abilities and skills that allow a blind or partially sighted person to feel enabled within sighted society. The struggle that participants mention of living between the two worlds highlights this medical model in action. It is reductionist in its approach.

In challenging this medical model for counselling psychology, Smart and Smart (2006) discuss the implications for the psychological professions when dealing with models of disability. In their paper, they list twelve potential implications for the psychology profession to be mindful of when dealing with clients who are disabled. Among these they discuss that therapist's need to be aware of their own countertransference toward the disability of client as that may prevent the therapist from fully understanding the client and negatively affect the therapeutic relationship. The attitude of the sighted therapist toward disability and working with it can have a positive or negative impact on the therapeutic relationship, as was considered in the findings. Sighted therapists who were willing to focus on the needs of their client and accommodate those had a positive impact on their blind and partially sighted clients. This stands in stark contrast to the *machine-like* nature of other medical professions that they dealt with.

Smart and Smart (2006) further mention that the power differential between the therapist and the client with a disability should be addressed. They caution that the power imbalance in the therapeutic setting may reflect the broader world in which the client functions. This was again highlighted in the findings as something that sighted therapists need to be aware of when working with blind and partially sighted clients. They may replicate in the therapy room the broader experience that the client maybe experiencing in the sighted world.

Sighted counselling psychologists would do well to consider models of disability and be aware of the medical and social models, as they have implications into how disability is interpreted and how the person with the disability is treated. Within my research, I positioned

myself within the social model of disability and listening to the participants in the interviews; this is the model that they felt was *enabling* and not *disabling.*

The core definition of the British Social Model of Disability comes in the UPIAS document *Fundamental Principles of Disability*, an edited version of which is reprinted by Oliver (1996):

> *"In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society."* (Oliver, 1996, p. 22).

This statement echoes what Diane and other participants in this research also concluded.

Participants in this research spoke of their treatment by the medical profession at specialist eye hospitals they attended. On this, Barbara says, *"In the eye hospital, that's all they talk about, they just see you as a walking eye, you know? The consultants and the doctors just want to look at your eye and say well off you go. But I never felt any real support from them."* (B: 55). The medical model of disability is evident here, reducing the person down to the condition and disability that they have. No consideration is given to the rest of the person that is able and available to the person. As Barbara mentions, this gives little support to the client.

She further clarifies the difference between the interaction with the medical staff and the sighted therapist that she saw, *"Well I thought she (the therapist) saw me as a human being first of all. And that cut through a lot of the clinical efficiency of the doctors and they never, held my hand, even when they were breaking bad news to me, you know, that the eye had gone forever and they couldn't get it back. And um, they just said it, you know, it was an everyday occurrence to them but not to me. Whereas L was more personal and said it must hurt to give up these things that you've enjoyed for years, and she saw some of my work and thought it was superb, because I was really good at it, both the knitting and the embroidery and so she said you must feel a sense of loss if you've lost that and that made a difference, it made me feel more human." (*B: 57).

For counselling psychologists and other mental health professionals who may work with blind or partially sighted clients, holding the position of the social model of disability and not the medical model of disability is very important. As Barbara mentions, her sighted therapist treated her in a holistic manner. She saw her as a human being first and did not reduce her

to an eye condition. This was exemplified in her acknowledging the emotional loss Barbara experienced of not being able to do things that she enjoyed before she lost her sight.

Given counselling psychology as a specialism can help to assist people manage emotional difficulties they have been, or are going through in their lives, it is important when working with blind and partially sighted people that they are treated and viewed in a holistic manner and are met as a person first and foremost. There should be no assumption on the part of the sighted therapist that the blind or partially sighted person is there to talk about their sight loss.

Erica speaks about the position that the sighted therapist should hold when engaging in therapeutic work, *"Because therapy should still bring an open mind anyway, irrespective of whether they want, whether the clients coming and wanting to talk about it (sight loss) or not they should start with a blank slate anyway."* (E: 108).

A "*blank slate"* position allows the sighted therapist to begin where the client is and not where the sighted therapist assumes or imagines. This requires the sighted therapist to acknowledge the *'elephant in the room',* the difference of sight. They should challenge their own attitude toward disability.

Finally, Pat's conclusion articulates well the position a sighted therapist should take when working with a blind or partially sighted client. She says, "*You know therapists get set up as being all knowing, all seeing and they're not. They can only be alongside in my view but we were experts on ourselves. To me, therapy's just a thinking space really, and it's inviting the therapist and client to think together really. It seems to me the purpose of therapy. So that in itself you don't make assumptions."* (P: 94).

The need to acknowledge 'the elephant in the room'

The second meta-theme, described how the sighted therapist needs to address the *'elephant in the room'* which is the reality of having a blind or partially sighted client in the room with them. '*Elephant in the room*' is an English metaphorical idiom for an obvious truth that is either being ignored or going unaddressed. The idiomatic expression also applies to an obvious problem or risk no one wants to discuss (Cambridge University Press, 2009).

This explanation of the expression speaks about an obvious reality that is being *deliberately* ignored and also an obvious problem that no one wants to discuss. Given that there is so little research conducted by counselling psychology in the field of disability and also working with clients who are blind or partially sighted, counselling psychology maybe ignoring *'the elephant in the room'* that is obviously there. No one is talking about it or conducting research into this area.

It became apparent from the findings, that there was a responsibility on both the part of the sighted therapist and also the blind or partially sighted client to talk about *'the elephant in the room.'* Some sighted therapists did not want to acknowledge the '*elephant in the room'* and just continued with the blind or partially sighted person as they would a sighted person, even brazenly handing them written material to fill out.

Nora gives an explanation as to why a sighted therapist might behave this way. "*They forget the 'as if' quality. I think that is what happens. They really step into imagining what it would be like for them if they were blind and I think when most people do that, whether they're therapists or not, move into a really frightened place. And I have seen that happen to therapists that have worked with me." (N: 36).* Nora perceives what happened to the sighted therapist, *"There was something about her being scared if she had to live with being blind or also there was a fear of the unknown, that what I could possibly say that's going to be substantial or meaningful to this client when I can see and they can't.*" (N: 40).

There is a word of caution here for sighted therapists when working with blind or partially sighted clients, especially if they have not worked with them before and also have not received any training or read any information on working with this client group. This is in line with what Harsh (1994) discussed. Therapists need to acquire knowledge about the various types of blindness and partial sightedness; the impact these impairments have on daily functioning; and the interactions of these impairments with societal demands to become more effective in working with this population. In addition, therapists need to explore their attitudes about blindness and partial sightedness. Harsh (1994) also mentions that historically blindness has been one of the most feared disabilities.

Goodley and Lawthom (2013) talk about Scotomaphobia, which is a fear of blindness. This phobic anxiety is a fear of going blind and having to live as a blind or partially sighted person. This personal fear may be activated on the part of the sighted therapist when dealing with a blind or partially sighted person. When doing so, as understood from a psychoanalytic perspective, sighted therapists who have not considered their own attitudes

to disability or sight loss, may unconsciously go to a defensive place to help them contain their own fear of losing their sight.

Drawing on the psychoanalytic writings of Lacan, Goodley *et al.,* (2012) suggest that disabled bodies and minds expose the ontological insecurities of the non-disabled psyche, body and culture. A sighted therapist may have their own unconscious *ableist* insecurities exposed when they are working with blind and partially sighted clients. The emergence of those insecurities may cause the sighted therapist to disavow them and in return disavow '*the elephant in the room'* which is the blind or partially sighted client. Disavowal captures those moments of cultural catharsis, anxiety, paranoia and uncertainty on the part of the non-disabled towards the phenomenon of disability (ibid.).

Psychoanalytic theory may also help offer insight as to why a sighted therapist may disavow the difference of sight in the room. Commenting on this Wilton (2003) talks about the complex origins of *aesthetic anxieties* that surround disability within ableist culture, and the way in which these emotions are implicated in the geographic exclusion of *different* bodies. In particular, psychoanalysis helps to demonstrate the illusory nature of the *able-body* as a key source of oppression (ibid.).

Sighted therapists need to be aware of their own potential insecurities and attitudes toward disability in general and sight loss. This research found there is a need for the sighted therapist to be open and not disavow the client in the room.

Finally, Pat gives insight into the attitude that needs to exist when working as a sighted therapist with a blind or partially sighted client when she says*, "So in terms of making a connection with somebody, it's whether they are prepared to talk about what's real, that you're a person with a visual impairment, and how best can you communicate in the environment you're in or the situation you're in." (*P: 63). Not just the sighted therapist, but also the field of counselling psychology, needs to talk about '*what's real'* when working with clients who are blind or partially sighted. In so doing, it can avoid disavowal and talk about '*the elephant in the room.'* My goal with this research is that it will talk about *'what's real'* and assist in bringing greater awareness to this subject.

The sound of silence

The findings spoke about certain aspects of psychological therapy between sighted therapist and the blind or partially sighted client. Participants spoke about the contrasting experience of silence and voice in the room. The observations of silence as a means of non-verbal communication illustrates how its use impacts on the therapeutic relationship between sighted therapist and the blind or partially sighted client.

Describing this therapeutic relationship, Green (2010) describes it this way:

> *"Thus you need to acknowledge that you cannot counsel someone who is not, on some level open to it or willing to engage with you in the therapeutic relationship. In other words counselling is not something you do to someone, it is something you do with them, as partners in the enterprise,"* (Green, 2010, p.14).

Both client and therapist are seen as partners in the relationship. The therapeutic relationship is something that the therapist does not do *to* the client; rather it is done *with* the client. In working within this partnership, awareness of the use of silence and the voice is helpful in building or not building this therapeutic relationship.

Silence is something that historically within psychological therapy is a tool to use in working with clients. The use of silence is seen as something that can be beneficial in working with uncovering material that is in the mind of the client. *"Language is situated between the cry and the silence. Silence often makes heard the cry of psychic pain and behind the cry the call of silence is like comfort,"* (Green, 1977, p.148). The use of silence can be seen to make possible the expression of emotional pain that the client is in.

One study (Hill *et al.,* 2003) surveyed eighty one therapists about their use of silence and their general attitude towards it. It showed therapists used silence primarily to facilitate reflection, encourage responsibility, facilitate expression of feelings, not interrupt session flow, and convey empathy. During silence therapists observed the client thought about the therapy and conveyed interest. In general, therapists indicated that they would not use silence with very disturbed clients. Therapists learned about using silence mostly through clinical experience.

Silence is seen as a heavily used therapeutic tool, used to facilitate a number of different purposes. Interestingly, it cites therapists use it to show empathy, facilitate reflection and facilitate expression of feelings. These no doubt are positive motives and rationale for the use of silence to help build the therapeutic relationship. Yet in the findings of my research, no participant spoke of silence as being a positive experience. All struggled in the silence and found it a very difficult space for to be in.

Pat expressed why she found silence such a difficult space to be in with the sighted therapist. She comments, *"But at the time I remember I was met with a wall of silence and it didn't feel like a particularly inviting space in which to speak and I do remember feeling incredibly anxious, probably because I couldn't read his face."* (P: 9).

Silence must be used differently when working with blind and partially sighted clients. Walking into a therapist office and being met with silence places an initial wall for the blind or partially sighted person to navigate. It is not a comfortable or supportive space to walk into; rather the environment is anxiety provoking. Not being able to read the face of the therapist and use that as a means of interpreting the silence, leaves the client *in the dark.*

For blind and partially sighted clients, sitting in silence in a sighted therapist's office may feel like a form of temporary sensory deprivation and therefore elicit negative psychological effects on the client, such as paranoia. An example of this is seen in the interview with Nora when she spoke about silence, *"They'll be a moment of silence and I'll say 'I want to tell you what's happening. I want to tell you what's happening for me right now. What I want to tell you is you're sat there looking at me and I'm sat here in my own thoughts, wondering about you looking at me."* (N: 80).

Alison also recalls a similar experience in the silence, *"If there's no reason for the silence, then I'm uncomfortable, because I'm wondering what's going on? If, for example, the therapist asks me a question and I take a while to respond because I'm thinking it's ok. If I ask the question and the therapist doesn't say anything, then I want to know what's going on. That is strange. Or if I've answered, and the therapist doesn't say anything because he's thinking or whatever, that's not cool either, because you're thinking what have I done wrong?"* (A: 126).

The sighted therapist has the use of the sense of sight in which to interpret the environment whereas the blind or partially sighted client does not. Therefore the experience of silence is different for both. Sighted therapists who work with blind and partially sighted clients need to

be aware the use of silence can be anxiety-provoking for the client as it can be an ineffective therapeutic tool and hinder rather than help. As Jerry commented in his interview, *"I feel like thankfully there's not a lot of silence in the room, otherwise it might feel like it's too intense for me."* (J: 72). Sighted therapists do well to remember that the silence maybe a very intense experience for the blind or partially sighted client and adjust their therapeutic approach accordingly. The traditional view of the benefits of silence may need to be re-addressed so that it does not become another '*roadblock.*'

"You need the touching." (B: 47)

This sub-heading is a quote from the interview with Barbara, when she was describing the use of touch on the part of her sighted therapist. For Barbara, within the therapeutic space as a blind or partially sighted person, the use of touch was considered necessary. Touch and its use within therapy between sighted therapist and the blind or partially sighted therapist was commented on in a very positive light within the findings. Yet touch is something that traditionally within counselling psychology and psychotherapy is to be either avoided altogether or used with caution.

Historically the use of touch in psychotherapy and counselling is prohibited. This is seen in the quote *"Physical contact with the patient is absolutely a taboo (since it may) mobilize sexual feelings in the patient and the therapist,"* (Wolberg 1972, p.606). Much controversy and opposition to touch in psychotherapy is based on the concept of the *'slippery slope.'*

The opinion is that an innocent touch of a hand or pat on the back may move toward a sexual relationship. Boundaries are crossed, the client exploited and the therapeutic relationship violated. Small boundary crossings lead to bigger boundary crossings. This fear can strongly influence therapists to avoid the use of touch (McGuirk, 2012).

One study published in 2004 examined the use of touch among psychologists (Stenzel and Rupert, 2004). A sample of 470 practicing psychologists responded to a survey regarding touch in adult individual psychotherapy. Results reflected a high degree of caution regarding physical contact with clients. Close to 90% of respondents never or rarely offered touch to clients during a session. The handshake, a socially stereotyped form of touch most likely to occur during greeting or parting, was the only form of touch that occurred with some frequency. Therapist and client gender, theoretical orientation, and touch experience of the

therapist were related to the use of touch. Touch was typically not discussed with clients when it occurred.

This study exemplifies that touch is something that psychologists do not use in their work. Yet, the blind and partially clients in this research found it hugely beneficial in their therapy. It was used as a powerful form of non-verbal communication that held a variety of meanings for the participants.

Touch to *all* humans maybe a powerful sense and something that is inherent in *all* our experience of life. It is often referred to as the *"mother of all senses"* as it is the first sense to develop in the embryo (Montagu, 1971). All other senses, sight, sound, taste, and smell form after it. Within three weeks of conception, we have developed a primitive nervous system which links skin cells to our rudimentary brain. The tactile system is the earliest sensory system to become functional (in the embryo) and may be the last to fade (Fosshage, 2009).

Touch is considered our first language. Long before we can see an image, smell an odour, taste a flavour or hear a sound, we experience others and ourselves through touch. It is our only reciprocal sense. Yet this fundamental sense is something that is not being used by most psychologists as a means of non-verbal communication when the sense of sight is missing.

Zur and Nordmarken (2011) discuss that due to the absence of attention to touch in most training programmes, clinical supervision and outcome research and testing, most therapists do not think critically about incorporating the use of touch into treatment plans. Additionally, the possible negative consequences of never touching our clients must be taken into consideration. They suggest that a professional, responsible solution would be for all therapists to receive education and training that will allow the powerful therapeutic aspects of touch to be used responsibly and discriminatively in the care of their clients.

Given that blind and partially sighted clients do not have the use of the sense of sight within the therapeutic space, touch as a sense and a means of non-verbal communication becomes an important means of communication in therapy. When working with blind and partially sighted clients, sighted counselling psychologists may need to challenge themselves and their views on touch within their therapeutic work. This maybe a fundamentally different way of working and attitude. However as has been expressed by the participants in this research, touch is not a *want* on the part of the blind or partially sighted client, rather it is a *need*. Sighted counselling psychologists and the field of counselling

psychology in general should consider that need when working with this client population and be prepared to meet that need by further training.

"Eye contact can also be something which is substituted by other things surely." (A: 114)

The final theme in this section is taken from a quote from Alison. She was born blind and speaks about the reality that lack of eye contact can be substituted by other things or other senses. The meta-theme *'Verbal communication and the power of the therapeutic relationship',* discussed the powerful use of the voice on the part of the sighted therapist for the blind or partially sighted client. Voice was held to be a therapeutic tool within therapy and when skilfully used communicated many things to the client.

The field of counselling psychology and mental health in general places emphasis on the role of eye contact both on the part of the client and therapist (Darrow and Johnson, 2009). Within some of the research, increased therapist eye contact has been found to be related to more positive perceptions of the therapist in terms of rapport, respect, empathy and genuineness. These are all very positive attributes, yet sight needs to be available to the client to receive them.

Eye contact on the part of the therapist is a central issue in research on intimate interactions between therapist and client. Although a variety of nonverbal behaviours have been studied in social interaction research, eye contact seems to be particularly important in communicating responsiveness. In line with this eye contact is frequently cited as a behaviour that communicates emotional responsiveness, involvement and interest (Burgoon *et al.*, 1984). High levels of eye contact are thought to convey a responsive attitude, whereas lower levels of eye contact are associated with an unresponsive attitude on the part of the therapist (Barak *et al.,* 1982). Research has indicated that therapist eye contact has a substantial effect on the positive ratings of the therapist by the client (Hall *et al.,* 1995).

Not only is eye contact on the part of the therapist viewed as a significant non-verbal communicator in counselling psychology and psychotherapy, eye contact on the part of the client is also viewed as significant. Eye contact between therapist and client has been discussed in relation to being a central aspect and therapeutic tool of psychological treatment. Eye contact can create distress between therapist and patient and also create an

atmosphere where the patient feels embarrassed to disclose something and make them feel self-conscious (Gabbard, 2010).

Counselling psychology and psychotherapy view this non-verbal communication as an important factor in both aiding the therapist to assist the client and also for the therapist to assess the client and the emotional state that they may be experiencing. However, again consideration is not given to the client group where eye contact is not possible due to the lack of sight.

With blind or partially sighted clients, the sighted therapist can't convey all the positive attributes mentioned previously that good eye contact affords. Also the sighted therapist can't use the client's eye contact as an informative therapeutic tool. Because of this, for both sighted therapist and blind or partially sighted client, a substitute tool is required, as Alison mentioned, *"Eye contact can also be something which is substituted by other things surely."* (A: 114).

Within the findings, the use of voice on the part of the therapist is something that was a possible substitution for the lack of eye contact. The use of voice on the part of the sighted therapist was not just about the talking; rather the voice was perceived as a powerful tool that conveyed detailed information to the blind or partially sighted client. The words, tone, pitch and mirroring of voice were deemed to build all the positive qualities that, as mentioned previously, eye contact facilitates.

Counselling psychology and psychotherapy all come under the collective banner of *'talking therapies.'* The NHS UK website, specifically writes about talking therapy and its benefits. It mentions that talking therapies can help all sorts of people in many different situations and cites research shows that talking therapies work just as well whether you're old or young, male or female, white or black, gay or straight, rich or poor. It states that talking therapy is for anyone who's going through a bad time or who has emotional problems they can't sort out on their own and that you may be able to get talking therapy on the NHS in your area (NHS, 2015).

Adding to this, The British Association of Counselling and Psychotherapy (BACP) states that:

> *"Counselling and psychotherapy are umbrella terms that cover a range of talking*
> *therapies. They are delivered by trained practitioners who work with people over a*

> *short or long term to help them bring about effective change or enhance their wellbeing."* (BACP, 2015).

While such therapy emphasises *talking,* there is minimal focus on *how* to talk and use the tool that produces speech, *the voice.*

As participants in this research revealed when the sense of sight is missing additional senses become substitutes, particularly voice. *Talking therapy* suggest that words and communicating with a mental health professional will possibly help the person who is enduring emotional distress. Yet as this research shows, it is not just *talking*. There is far more than that involved in *talking therapy.* When sight is not present in the room, voice becomes a vehicle to convey emotion, empathy, presence, attunement and mirroring of affective states. Actual talking and physical speech is only one part of it.

For sighted counselling psychologists who's profession it is to engage in talking therapies*,* the use of their voice with blind and partially clients is very important. The voice is a substitute for the lack of sight and eye contact in the room and becomes an important therapeutic tool.

Being mindful of engaging with the power of voice, what is said and how that is said is important when working with blind and partially sighted clients. This type of *talking therapy* with blind or partially sighted clients can be the beneficial type that the NHS website discusses. It may help put the *talking* into talking therapies properly and highlight the actual therapeutic benefits of talking which is so much more than the words that are said.

Are the blind leading the blind?

The Cambridge Dictionary states that the expression, '*the blind leading the blind'* is used to describe a situation where a person who knows nothing is getting advice and help from another person who knows almost nothing (Cambridge University Press, 2011).

The title of this research is *'The Blind Leading the Blind;' A Phenomenological Study into the Experience of Blind and Partially Sighted Clients with a Sighted Therapist*. Inherent in the title is the consideration of the word *blind* in both a metaphorical and physical sense.

Metaphorically *blind* sighted counselling psychologists are leading blind or partially sighted clients through therapy. This was my own personal experience when I, as a sighted counselling psychologist, started working with blind and partially sighted clients. I felt metaphorically *blind* in working with this client group as I did not have any previous experience or training of working with blind and partially sighted clients. Thus this research in part was borne out of my own personal experience.

This research considered the difference of sight between therapist and client. All nine participants had the same shared experience of having psychological therapy with a sighted therapist. No participants in this group that I interviewed had psychological therapy with a blind or partially sighted therapist.

Research examining therapy for blind and partially sighted clients has been conducted by therapists themselves who are blind and partially sighted (Harsh, 1994) (Thurston, 2010) (Thurston *et al.,* 2013). One of these papers (Thurston *et al.,* 2013) considered the depth of understanding that could be offered by the sighted therapist when it came to working therapeutically with blind and partially sighted clients. It concluded a shared lived experience by both client and therapist was important in offering a depth of understanding. This particular research begged the question within its conclusion as to whether a therapist with no vision problems could offer such a sufficient depth of understanding for blind or partially sighted clients.

The findings of my research suggest that the difference of sight does bring along some challenges for both the client and the sighted therapist. The initial working out of *'the dance'* as discussed under the meta-theme *'Bringing the elephant into the therapy room,'* considered adjustments that may need to be made within the therapeutic alliance as the difference of sight is managed in the room. Adjustment was possible and can facilitate a good working relationship between sighted therapist and blind or partially sighted client.

The personal qualities of the sighted therapist and the skill that they used in the room with the blind or partially sighted client gave a depth of understanding between both that allowed them to work successfully together. In giving consideration to how it is possible for a sighted therapist to do this when they have no actual lived experience of their client's condition, the concept of *unconditional positive regard* as proposed by Carl Rogers may help.

In 1957, Rogers defined unconditional positive regard in this way:

> *"It involves as much feeling of acceptance for the client's expression of negative, bad, painful, fearful, defensive, abnormal feelings as for his expression of good, positive, mature, confident, social feelings, as much acceptance of ways in which he is inconsistent as of ways in which he is consistent. It means caring for the client, but not in a possessive way or in such a way as simply to satisfy the therapist's own needs. It means a caring for the client as a separate person, with permission to have his own feelings, his own experience."* (Kirschenbaum and Henderson, 1990, p.225).

This unconditional positive regard facilitates and allows both therapist and client to be separate and in this separation the client has permission to have their own feelings and experiences. Previous research between blind and partially sighted therapists focused on what was similar between therapist and client and not on what was different and separate. In my research, the difference of sight between therapist and client and the separation that this brought into the therapeutic relationship was contained and facilitated due in part to the *unconditional positive regard* displayed on the part of the sighted therapist toward the blind or partially sighted client. This allowed for the difference of sight to be contained and assimilated into the therapeutic alliance and not become a divisive factor. It's not a case of the *blind leading the blind*, rather it's the separate person leading the separate person to work together as two individuals with their own experiences.

Borg (2005) published a paper after supervising a blind therapist who had a blind client, the difference of sight as a factor. One of the matters arising from this paper is that the client's choice of choosing a blind therapist reflected a belief that the therapist would be able to recognize something deep and hidden in her, as if only another blind person could recognize the unreachable.

This *fantasy* of having therapy with a blind or partially sighted therapist was also observed within this research. Erica talks about the assumption that she has when she thinks about therapy with a blind or partially sighted therapist, *"I think it's bit of an assumption of mine that they might be more used to communicating how they're feeling without using their expressions and body languages. It's not necessarily the case, so I suppose no, it wouldn't matter to me whether they're sighted, whether they're non-sighted, as long as we can get along and I can feel fully comfortable talking to them, we have a connection and they can empathise. They're the main things.*" (E: 39). The assumption that the therapy would be

more meaningful when the therapist has a shared experience is challenged by the reality that the meaningful focus is having a connection, feeling comfortable and also empathising.

Pat also talks about another factor which may come into play when both client and therapist are blind or partially sighted, in considering the merit of working with a blind or partially sighted therapist. She reflects *"It never would have occurred to me that I would find a therapist who couldn't see. I'm even wondering now whether I would have opted for that even. I might have thought 'oh no, I couldn't possibly see someone who was blind' at that point, because I was so uncomfortable with it myself."* (P: 35).

This exemplifies the part of the experience in the paper by Borg (2005). In his paper, the client's experience of knowing or understanding her therapist was based on an important, but *fantasised*, identification. In addition to their symbiotic collusion, it seemed as though therapist and client were experiencing complex cross-identifications, in which they recognized disavowed and dissociated aspects of themselves in each other. Pat in her reflection talks about her own discomfort with her sight loss and that it would have been too uncomfortable for her to sit with a therapist who was blind or partially sighted. The similarity of experience is not viewed as a comforting or positive thing, rather the opposite.

Sighted counselling psychologists and other mental health professionals can greatly assist blind and partially sighted clients when they work with them and it does not have to be a case of '*the blind leading the blind.'* In concluding this section, I finish with a quote from Nora when she talks about her experience of therapy with her sighted therapist. I feel this sums up the attitude and stance sighted counselling psychologists should adopt. She says, *"Yes, she meets me as me. That's what she's about and that's all she wants to know about*." (N: 127).

"If there were only one truth, you couldn't paint a hundred canvasses on the same thing," (Pablo Picasso, 1966).

Picasso recognises there is not one absolute truth waiting to be discovered, rather there are many different versions of truth. The nine participants that I interviewed in this research gave me their version of their *truth* of being a blind or partially sighted person having psychological therapy with a sighted therapist.

I was very much aware in conducting this research that I was not the '*expert'* on living as a blind or partially sighted person. I have no lived experience of this and although I have worked with blind and partially sighted clients as a counselling psychologist, I have never asked what the experience of having therapy with me as a sighted counselling psychologist was like. This was an interesting and challenging reflexive position for me to hold to move from practitioner to researcher.

Holding this reflexive position, I sought to be a researcher whom Bruner (1986) described as one who *"appears not as an individual creative scholar, a knowing subject that discovers, but more as a material body through whom a narrative structure unfolds."* (Bruner, 1986, p.150) I want the body of my material and research to reveal the narrative of the clients that I interviewed as part of this research.

The job as a qualitative researcher is to make sense of the stories and experiences of the people we interview in a meaningful way with a view to learning more about humankind and, often, to effect change, whether that be in terms of influencing policy and practice or enhancing understanding at an individual or institutional level (Shaw, 2010). In holding my reflexive position, I wanted to be a researcher with this focus. I was not in a practitioner role of working therapeutically with the people I interviewed; rather I was a researcher who wanted to learn more about their story with a view to benefitting myself and others who work with blind and partially sighted people.

Reflexivity can be defined as both a central component of being human and also as the ability to reflect on and consider intersubjective dynamics between researcher and data (Finlay and Gough, 2003). This required me to develop the personal-professional self-awareness that underlies reflexivity. Part of this dynamic involved me as researcher listening to the narratives of interviews and thinking of my own position as a sighted person in the sighted world.

As I listened to the interviews, it made me consider what Gadamer (1975) explained as a position of personal-professional self-awareness that underlies reflexivity in terms of horizons. We each have our own presuppositions, beliefs, and ideas which make up our own horizon of understanding. When we meet another person, if our two horizons overlap then we will be able to make ourselves understood and in turn understand the other person. For Gadamer, this fusion of horizons is effected by first making ourselves more transparent.

This fusion of horizons, involved my past experience of being a practitioner in this area, but not a researcher. This was a very different position for me to occupy. As a researcher, I was not the practitioner and my position was not one of a client-therapist relationship rather it was a researcher-participant relationship. This was a new position for me and I needed to be mindful of seeing my identity in this research as curious researcher of the participants. They were not my clients and I was not their psychologist.

Finlay and Gough (2003) consider the process which takes place as researcher and participant interact when conducting the research. They say:

> *"Our understanding of 'other-ness' arises through a process of making ourselves more transparent. Without examining ourselves we run the risk of letting our unelucidated prejudices dominate our research. New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process, between the self-interpreted co-constructions of both participant and researcher."* (Finlay and Gough, 2003, p.108).

When I was listening to the accounts of the participants that I interviewed about living in a sighted world as a blind or partially sighted person, I found myself considering my own position as a sighted person in this world. My reflexive position was two-fold, not just as being a sighted counselling psychologist working as a sighted researcher. It was also as a sighted person getting an insight into the world I lived in, from a completely different perspective that I had no experience of.

My research impacted me on both a personal and practitioner level as a sighted person and sighted counselling psychologist. As I listened to the participants I felt their anger and frustration at the way they were treated by the sighted world and also sighted therapists. It made me reflect on my own clinical work with blind and partially sighted people. Was I informed and sensitive enough to their daily struggle of living in a sighted world, a world that I took for granted? It also gave me an insight into the daily lives of blind and partially sighted people before they visit me and how my position as a sighted therapist could help facilitate a different experience from the marginalisation they experience in the sighted world. It made me very mindful too of not assuming that the disability of sight is the sole focus of their coming to see me, as that would be reductionist and reinforce the medical, and not social, model of disability. I seek to see ability and not disability in my interactions.

With my professional work as a sighted counselling psychologist with bind and partially sighted people, this research has changed the way I work with my clients. I ensure that I ask my clients about the light in the room, where I am positioned in the room and are they comfortable in my office. I also am more conscious of using touch when necessary, to convey my physical presence and do not feel this is therapeutically damaging. I am careful with my use of silence also, mindful that this can be an anxiety-provoking experience for my blind and partially sighted clients. This research has helped me tailor how I work with my blind and partially sighted clients and made me mindful that I do not work the same way with them as my sighted clients. This research has helped me on a professional level feel less 'blind' in working with blind and partially sighted clients.

On a personal level, this research impacted on my position of being a sighted person in a sighted world. At the end of several of the interviews, I found myself feeling both sad and guilty at some of the stories that I had listened to. My sadness came from thinking about the overwhelming sense of loss that some of the participants felt from losing their sight. I was moved by the effect this had on the lives of themselves and their families, and how they coped with this on a daily basis. I also felt guilty that I could see and never had any sight problems. My guilt was of living as a sighted person in the sighted world they longed for and having something they don't possess. I found myself wanting to apologise on behalf of sighted people when they told me stories of being treated unkindly and being made to feel disabled.

In the aftermath of the research, I found that I was far more mindful of the presence of blind and partially sighted people in my sighted world. I became more sensitive to their presence in my environment and not just when they were my clients. In my daily life, both as a sighted counselling psychologist and sighted person, I was conscious of being enabling and not disabling. I found myself holding the position that participants said was helpful, which was not assuming but asking if they needed any help and also if they did, what this help might be.

On the personal front, it is also about seeing the person as a whole person not reducing their identity to that of their disability. I also found myself being very careful of my use of the word disability, aware that this is something that is defined by the blind and partially sighted person and not me. Holding this position toward blind and partially sighted people, I also hold my own guilt of being sighted and how I experience this sighted world that blind and partially sighted people occupy. In so doing, I am careful that I do not add to the disabling

experience that blind and partially sighted have when interacting with sighted people in this sighted world.

I am thankful that this research afforded me this insight into a world that I have no lived experience of and that on a personal and professional level it has made me question and reflect on my position as a sighted person, which is not something I have previously done.

As Finley and Gough (2003) mentioned, conducting this research made me look at how transparent I am in terms of my own awareness of disability and of my attitudes and assumptions. It made me question whether I am *abling* or *disabling* in how I operate in the sighted world toward blind and partially sighted people. This research made me question not just my role in the therapy room, but also outside it and how I interact with blind and partially sighted people in both environments and identities.

Limitations of this research

This research sought to investigate the experience of blind and partially sighted clients having psychological therapy with sighted therapists. I appreciate that this research has limitations within its focus, design and findings and that further research may wish to consider some of these limitations. I discuss these within this section.

The research did not define which kind of therapy participants had with their sighted therapist. The focus of which therapeutic modality was used was not assessed or investigated. Instead, a broader view of just psychological therapy was used. The remit of this study was not to specifically ask which type of therapeutic approach was used, such as person-centred or psychodynamic. The specific therapeutic approach used by the sighted therapist may have yielded different responses. A future study could consider therapy modality as a focus, such as whether there would be a difference between person-centred and psychodynamic approaches.

In conducting this research I did not specify sight loss conditions and when these were acquired. As a result, participants included those who had been blind or partially sighted from birth and also those who acquired their sight loss later on in adult life. It also did not consider adults who had lost their sight through trauma or accident. A more specific focus on this may have yielded different responses from participants. Making such a differentiation,

may have yielded different responses in areas such as personal identity and disability and also adjustment to sight loss.

All interviews except one were conducted by telephone. Given the geographic locations of participants, it was not possible to conduct the interviews face to face. Face to face interviews between myself and the participants may have been an interesting dynamic to observe for me as researcher in holding my own reflexivity. It may also have yielded different responses in interview content due to my physical presence. Themes such as yawning, touch and silence may have been influenced by my physical presence.

This research did not have an equal gender split. There were seven women and two men that took part. There was no real consideration given to gender differences within the interviews and responses. An equal gender split of four men and four women, may have produced different themes and outcomes such as the gender based differences in responses to interview questions.

The methodological choice of IPA influenced the approach and also focus of the findings. An alternative methodological approach such as grounded theory may have generated a theory that explains how aspects of the experience under investigation occur. As IPA is interested in individual experience and not generating a theory, an alternative approach may have produced different results and proposed new theoretical ways of thinking.

This research did not look at the reasons for participants seeking therapy in the first place. No consideration was given as to whether this was for issues related to their sight loss or another reason. A study considering the rationale for therapy in the first place may have helped consider some salient points with regard to why blind and partially clients may seek out therapy.

Finally, this study interviewed all participants only once and used this sole interview as the raw data. The research could have gone deeper in asking participants in a second interview about the themes drawn from the first initial interview and then generated additional themes from both interviews. Having a second interview may have generated a more detailed analysis. Themes were corroborated by another psychologist and also by my supervisor.

Conclusion and future directions

My intention was that this research goes some way to achieving what Olkin (2003) states, *"Disability studies and psychology can join hands, but they haven't yet."* (Olkin, 2003, p.303). Although this was not a study into disability, my hope is that this research will go some way to joining counselling psychology with the subject of working with clients who are blind and partially sighted.

Given the framework this research is embedded in, no claims to generalising are made. Rather it was grounded in a detailed explanation of the experience of the nine participants. Using IPA I explored in detail the processes through which participants made sense of their own experiences. By looking at the respondents' account of the processes they have been through and seeking to utilise an assumed existing universal inclination towards self-reflection (Chapman and Smith, 2002). The self-reflection of the participants highlighted implications and areas for consideration for sighted counselling psychologists and other mental health professionals to be mindful of when working with clients who are blind or partially sighted.

I would argue the findings from this research challenge assumed and traditional ways of working with clients and expose some of the limitations of counselling psychology when it comes to working differently with a client group that does not have the sense of sight available to them. It discusses a new way of looking at disability and working creatively with clients who have specific, individual needs. Consistent with the participant's experience and subjective phenomenology, their voice is expressed in challenging ways of working with blind and partially sighted clients.

Supported by the verbatim quotations from the interviews examining the experience of participants, I have drawn up seven key implications and recommendations as reflection points for counselling psychologists and other mental health professionals.

These are:

(A) As a piece of work using IPA research, this research recommends both on a training level at university and also on a professional level within services, that psychological practitioners receive training in working with clients who are blind and partially sighted. Universities with counselling psychology training programmes can consider including

disability awareness as part of the training they offer trainees on their courses to ensure a tailored approach and not a generalist one is provided for blind and partially sighted clients.

(B) This research recommends that counselling psychologists and other mental health professionals reflect on their own attitude toward disability to ensure they do not place unnecessary roadblocks within the psychological therapy with blind and partially sighted clients. The social model of disability that is individualistic and not reductionist is preferable in facilitating and focusing on ability and not disability with this client group.

(C) This research highlights an awareness of the possible power dynamics which the difference of sight can create and that some medical practitioners facilitate. A collaborative, non-assuming and open position to ensure any potential power dynamics are dealt with, is suggested as aiding a good working alliance and providing a tailored approach. Again, this requires awareness of working therapeutically with blind people and partially sighted people. Dale (2008) 'Different Horizons: Information and resources for counsellors working with clients who are blind and partially sighted,' which is available from the RNIB online is helpful for sighted therapists to make themselves aware of how they may tailor their approach to the benefit of their blind and partially sighted clients.

(D) This research has implications for counselling psychology as a profession to consider alternative, creative ways of working with this client group. The research challenges the traditional ways of working therapeutically with touch, silence and the use of eye contact as a therapeutic tool. Consideration of differing client groups, what they may need on an individual basis and not what has traditionally been expounded by counselling psychology can help facilitate a truly therapeutic experience for blind and partially sighted clients.

(E) This research recommends counselling psychologists and other mental health professionals consider their use of verbal and non-verbal communication with this client group and its importance, paying careful attention to how the spoken word is used and interpreted. When working with blind and partially sighted people the use of voice and the spoken can work as a substitute for the sense of sight. This can be a powerful tool that enables or disables the blind or partially sighted client.

(F) This research has implications for counselling psychology researchers to try and help increase research into working with disability and how to work alongside clients groups with specific disabilities in a manner that enables and not disables. Specific research with working with blind and partially sighted clients would be helpful to expand on the current

limited research available, also that this research is inclusive and of practical aid to blind and partially sighted people. This could help to reduce the blindness of sighted therapists working with this group and highlight additional ways to assist this client group.

(G) This research also suggests implications for NHS and charitable services such as the RNIB in meeting the emotional needs of this client group. Sighted therapists can help meet this demand for emotional support services and help increase the availability of such so that this is not just administered by blind and partially sighted therapists or in specialist services. The physically blind do not need to lead the physically blind in providing emotional support, sighted therapists can help in taking this lead too.

This process of planning, conducting and documenting this research has been a tremendous experience and challenge for me. I felt very honoured as a sighted person to be allowed access to a world I knew very little about. My hope is that my voice within this research facilitates the voice of those I interviewed and will go some way in having their stories heard and listened to by those in the profession. This will hopefully narrow the gap between living in the sighted world as a blind or partially sighted person and facilitate *ability* and not *disability*.

I conclude with a quote from Helen Keller, the American author, political activist and lecturer who was the first deafblind person to earn a Bachelor of Arts degree. Her quote emphasises the importance of seeing physical disability as *different ability*, something not totally disabling a person. She writes:

> "*Because I cannot see or hear, the thoughtless suppose life must be a blank to me. They do not understand that things have other precious values besides colour and sound. It never occurs to them to FEEL the flower, and they do not know what they miss – the exquisite shape of leaf and stem and bud. I do not suppose light suggests to them the radiating, life-giving warmth of the sun. True, I cannot see the stars scattered like gold-dust in the heavens, but other stars just as bright shine in my soul.*" (Keller, 2000, p.2).

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Appendices

Appendix 1

Participant Statistics:

No of participants: 9

Name:	Age:	Location:	Ethnicity:
Nora	49	South West	Asian British
Pat	51	South East	Asian British
Erica	35	South East	White British
George	55	South west	White British
Barbara	75	South west	White British
Diane	47	South East	Black British
Alison	22	North England	Spanish
Jerry	31	South East	White British
Kelsey	33	North England	White British

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Mark Rackley
Doctorate in Counselling Psychology and
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Doctoral Conversion Programme

'The Blind Leading the Blind;' A Phenomenological
Study into the Experience of Blind and Partially
Sighted Clients with a Sighted Therapist.

A psychological research study to capture, in their own voice, the experience of blind and partially sighted clients with a sighted therapist

You are being invited to take part in a research study. Before you decide it's important for you to understand why the research is being done and what it will involve. Please take time to consider the following information carefully and discuss it with others if you wish. Please ask if anything is not clear or where you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to give an accurate picture of a blind and partially sighted client's experience of having

psychological therapy with a sighted therapist. As part of the DCPsych at Middlesex University in conjunction with the Metanoia Institute, it is hoped that this research will help inform psychological services and eye departments. By volunteering to take part you will help to guide and improve knowledge for such services in the future.

Why have I been chosen?

You have been invited to take part as you have volunteered to be contacted regarding the research. The aim is to recruit at least eight clients who are blind or partially sighted who have experienced psychological therapy with a sighted therapist.

Do I have to take part?

It's up to you to decide whether or not you take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form, and given a copy. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I decide to take part?

If you decide to take part your information will be given to a research interviewer. He will then be in touch with you to arrange a suitable time for a one-off interview. This interview will last approximately one hour and will be at a time convenient to you. You will be asked questions about your experience of having psychological therapy with a sighted therapist. The interview will be recorded.

Following the interview there will be an opportunity to find out more about how the research, or receive further information on services in the field of visual impairment counselling.

What are the possible disadvantages and risks of taking part?

It is possible that the interview may bring back some of the details and feelings of the information that you discussed whilst you were in therapy. Should you experience feelings that you wish to explore following the interview, the research team will be able to put you in touch within the counselling field for a debrief session.

What are the possible benefits of taking part?

We hope that participating in this study will help you. However this cannot be guaranteed. The information we get from this study may help future clients with visual impairment gain better services in the psychological therapies. It is hoped that the research will give a voice to clients who are blind and partially sighted, to inform psychological and support services in the future.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information from you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be treated with full confidentiality, collected and stored in accordance with the Data Protection Act 1998. If excerpts from your interview were to be published, this would be done in such a way that you could not be identified.

What will happen to the results of the research study?

It is intended that this research be published as part of a postgraduate dissertation, with copies help at Metanoia Institute and Middlesex University. The findings will also be available to the RNIB Emotional Support Service.

Who has reviewed the study?

This study has been reviewed by the Metanoia Research Ethics Committee.

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A copy of this information sheet and the consent form are yours to keep.

Thank you for taking part in this study.

Notes for research interviewer:

- Do not enter 'expert' mode, the interview has to be participant led!
- Stay close to their experience and watch for my own assumptions!
- Listen for metaphor and emotional vocabulary.
- Want to hear their voice, so listen accordingly!
- Use suggested prompts to help clarify and expand the interview.
- Go beneath the surface to extract the phenomenon!

Interview Schedule:

A. **What is the experience like of being a blind and partially sighted client with a sighted therapist? (15 Mins)**

1. Could you please describe the initial meeting?
2. Could you please describe your overall experience of the therapy?
3. Could you please describe the relationship between you and your therapist?

B. **What was important to you about your therapist when coming to therapy? (10 Mins)**

1. Could you describe any influencing factors in choosing your therapist?
2. How did the therapist having sight or not affect your decision in your choice of therapist?

C. **Can you describe what the experience of the difference of sight was like within the therapy? (20 Mins)**

1. How did you feel understood by the therapist?
2. What are your thoughts about the difference of sight between the two of you?

D. **How did you conceptualise the verbal, non-verbal aspects of your therapy? (15 Mins)**

1. How would you describe what the therapist did that showed you felt understood?
2. What was it like for you to know that the therapist had sight and did this effect how you interacted with them within the therapy?
3. What if anything do you feel the therapist could have done that would have made the therapy experience different for you?

E3: I've seen a few different therapists, but I think they all have similarities in terms of the initial meeting and my experience is sort of as a non-sighted person with a sighted therapist – and they're all sighted therapists.

R: So you've only had therapy with sighted people?

E3: Yes I have, and usually, things that might come up in the initial meeting are talking through a contract, you know the usual things, but obviously showing me to a chair and offering water.. actually with one particular therapist they did ask about the lighting because my condition is very much effected by light, actually they didn't actually know that but it was quite a good question whether the light was ok and stuff and to be honest, it was just a lamp, and I couldn't see much anyway, so I said it was ok, even if they'd put on the light I wouldn't have been able to see well anyway, but it was nice that they asked about that, and um, I found that the initial meeting obviously is about kind of about establishing a relationship and building trust and things, and I think it's quite difficult in a way not being able to fully see your therapist but it hasn't ever been an issue for me, I haven't ever sought out a non-sighted therapist, because I've anticipated too much discomfort, so I've never sought out a non-sighted therapist but I think that it has, I have wondered in the initial assessment and any subsequent sessions about what expression they might have, and I've always second guessed that.

R: When you say you 'second guessed that' what do you find you're second guessing?

E3: Well, sometimes, they might remain quiet and I might wonder why. For all I know they might look completely bored or not! They might look completely interested. It's really hard to know and I think my own insecurities have crept up now and again, not just in the assessment, in other sessions, whether that is the case, or whether they're interested, because they haven't verbalized that.

Obviously a sighted therapist, naturally would express themselves through their body language and facial expressions, they wouldn't necessarily have to think about verbalizing that every minute, it wouldn't come naturally to them, and I absolutely don't blame people for that, but I, it's a bit of a difficulty in a way, because I think especially when you're trying to build up that trust if it isn't verbalized, if their warmth and empathy isn't verbalized.

R: Sounds like that theirs a bit of a gap there. In the silence you're wondering what's going on? Would it be helpful if the therapist said in the silence, this is what I'm feeling right now this is what I'm experiencing?

E3: Definitely. More immediacy, more being congruent and saying how they feel verbally, or how they're perceiving me, yes generally just being more verbal would be helpful.

R: If they were to be more verbal, what would you like to them say, or what would be helpful to be able to hear from them in that moment?

E3: Oh god, I don't know, that's a difficult question, because it depends on what the situation is. You know, just things, like I'm sitting here wondering blablabla or I'm sitting here, I am interested in what you're saying, I'm pondering on something that you've said. Just to, I don't know, I think silence is still important to have, in many ways because you know it helps me process what' just been talked about. I've been trying to think about my experience, and I think that might be the only thing I could identify that might be a barrier. At the same time I do think silence is important too, so it's getting that balancing act for the therapist pointing things out.

Also I've noticed in assessment some therapist might take notes and stuff and obviously you do hear the scribbling and things like that and I think for anyone sighted or not, that can be a bit off putting and you kind of wonder what are they writing down. Knowing when they're

writing and not writing is a bit difficult when you've not got much sight and if their waiting for you to talk, waiting for you to say something… when they're still scribbling and you can't hear them, so I guess that's hard to identify. Just sort of saying, I'm just taking some notes, I'm just jotting down the last line here and I'll come back to what you're saying.

R: Would that be helpful, what you were saying there, about the sighted therapist giving you a description of what they're doing?

E3: In a way, without it becoming too intrusive, I don't know, it's the same of going to see an audio described TV programme, or a theatre performance and it can be a bit annoying. Obviously being a bit more verbal without having a commentary of what they're doing, I'm just going to get a tissue, or I'm just filling up my glass of water. Sometimes it is nice to know.

R: Does that help you to fill in the gaps, if the sighted therapist were to be a more active?

E3: I think so. I think it would.

R: So do you think that would make a difference to the experience in the room, if that were to happen?

E3: Yeah.. yeah.. I think it would. I think it would.

I had a therapist once, I couldn't really see her that well, she was actually sitting quite far away from me (so I think positioning is quite important as well).

I could hear her yawning away constantly…constant! So I was thinking god, one or two yawns, but constantly yawning, I was thinking… I don't mind that, but as long as she isn't completely bored at the same time. It's just really hard to tell.

R: What's that like? I'm quite struck by that. Her yawning away, we can all be tired of course but when you're in a therapy session, you're quite conscious of being present, and a yawn can be interpreted as boredom, or up with kids, or whatever, but for you, not being able to see the sighted therapist and hear that, that yawning coming towards you, what's that experience like E when you're not able to see the therapist?

E3: It has crossed my mind, if I was fully sighted, perhaps they wouldn't do that. Perhaps they would not, sort of, in a way, as I said earlier perhaps my own insecurities might be creeping in such as they're just taking advantage of the face I can't see. I could be saying something, because I did hear the same therapist, I wouldn't say snigger, but laugh at something, kind of under her breath, but she could be smiling at things that I'm saying, but I would just not be aware of that, and as I say there's mind reading going on there to a certain extent but there is that… there could be that thought. It wasn't a big thing. It fleeted through my mind but yeah obviously they might be aware, we can't see them so they wouldn't need to pay too much attention to their expression and things, their own expressions.

R: And was that you're sense, that sometimes that happened, the difference in sight, maybe for you, that you experience it, that there was the sense that the therapist was yawning, or sniggering under her breath, or whatever, that there was facial expressions there, maybe things that they did, that they wouldn't do with a sighted person?

E3: Only with that therapist. It only crossed my mind with that therapist. Actually that therapist was a fairly recent one, and I only saw her for one session anyway, and that was a hypnotist actually. It was a little while ago actually, but other than that, prior to that, all the other therapists I've seen, it did not cross my mind. It even didn't cross my mind about the difference between myself not being fully sighted and them being sighted. It just didn't at all. But I think that I was aware of it unconsciously because I cast my mind back and I do remember very small times when I said to myself I wish I could see the therapist's face right now, but other than that it just didn't cross my mind. It wasn't an issue for me. And all the therapists that I've seen have been quite warm and empathetic and stuff and I've still got that from them. But I think that I would have got that more from them if I could have seen their faces as well, because a lot of therapists rely on communicating their empathy through

their face and eye contact, so I'm sure I could have got more from them if I could fully see them, but it wasn't that it was a big thing.

R: Did you feel that when you were choosing to come to therapy E, when you were thinking about it, what was important to you about your therapist? Or could you describe what were important factors in choosing your therapist?

E3: I wanted to make sure that they had a specialism in what I was keen to address and that also they had the training and things, and that they were close by, within my budget.

But the personal qualities, I just wanted to have a connection with them really, that was the most important thing for me. To be able to feel that they're listening, approachable, going to emphasize with me and not have their own agendas in any way they're just going to listen and be warm. I think that's the main things really.

R: And did the therapist having sight or not affect the choice of therapist given.

E3: Not at all. Like I said it didn't even cross my mind, and I didn't know how to look, I've never actually considered how many non-sighted therapists their might be around, but I'm sure that there's a lot less.

R: So that wasn't something that you felt when you were considering therapy, the difference in sight was something, well I'd really like to see someone who has the same visual impairment that I have, or have experience that themselves.

E3: Not at all. I kind of think it's like saying, well if I've got a broken leg I want to see, I don't think anyone would understand unless they had a broken leg and I don't know about that. I think, I'm half irish, half Turkish myself go to seek out a half irish half Turkish…

R: You'd walk a long way!

E3: (laughs) Yes, that'd be quite hard to find but I think that would be , it wouldn't necessarily make them empathize any more, it really depends on their personality and how you connect with them, and not necessarily their democratic, or whatever and the same with saying that someone wouldn't understand my trauma unless they've experience it themselves. Yes, there's some truth in that I think, but they can still help and support you through it and be there for you without having to have experienced it first hand .

R: So for you, given the fact you've only had therapy with sighted therapists, and you've never had therapy with non-sighted therapists, given the fact that that's never happened, would you like to have therapy experience with a non-sighted therapist now?

E3: Well, yeah, I would, but not… I suppose their advantages to that in a way, like I say, they'd be more used to communicating how they're feeling non-verbally, but that's not necessarily the case thinking about it. It's not necessarily the case.

R: Do you think that might be a bit of a fantasy?

E3: Yes I think it might actually. I mean that's the only benefit, and like you say, I think it's bit of an assumption of mine that they might be more used to communicating how they're feeling without using their expressions and body languages.   It's not necessarily the case, so I suppose no, it wouldn't matter to me whether they're sighted, whether they're non-sighted, as long as we can get along and I can feel fully comfortable talking to them, we have a connection and they can empathise. They're the main things really.

R: Just coming on to that, because you've mentioned that word quite a few times, empathy, and I'd like to ask you about that…

E3: Sorry, I'm a bit repetitive.

R: No, no, not at all, it just shows the importance because you've mentioned quite a few times that the empathy was there with the therapist, and I'd just like to ask you, given the fact that you've had the therapy with sighted therapists and there was that difference of sight, how did you feel you were understood by the sighted therapist, and that they were being empathetic towards you?

E3: How did I feel understood?

Well it's different with each therapist but I felt understood.

R: And what do you feel that they did to help you to feel that they did to help you feel that you were understood, given the fact that there was the difference of sight in the room.

E3: Well, basically, when they indicated that they listening by repeating what I said, or paraphrasing something that I'd mentioned and making connections, I suppose, between one thing and another thing and maybe bringing me back to something I'd mentioned earlier indicated to me that they'd listened. And maybe not necessarily understood, but it did indicated that they understood to some extent how I was feeling, recognising that, acknowledging that. Does that make sense?

R: I'm just wondering, given that there was the difference in sight, you felt the empathy? How did you feel that?

E3: Oh How?

R: Yes given the fact that you were as you said earlier, you were filling in the blanks.

E3: By, them, making small sounds like 'oh' you know or saying 'I feel sad listening to you talking about that' or sort of just verbalizing their emotions in some way.

R: Do you think that, given the fact that you couldn't read the face, and given that a lot of emotion gets shown through the face and you're body, and the fact that they were telling you the feeling, or describing the feeling in a very verbal way, was that helpful for you?

E3: Absolutely. Yes it really was. Because I knew exactly where they were and I felt more connected to them, that they did care and I think I might have a slight issue with silence sometimes, that's my own thing, but I do think it definitely helped. I do think that silence is good, but especially when you can't see I think can be an issue sometimes.

R: Can you just describe what that feeling is like, in the silence in the room, when you can't actually see the other person and they're quiet?

E3: I think, uncomfortable. I might just be curious. I might wonder what they're doing, or what they're feeling. If they might be looking out the window. I think that's the main thing, I might just, I might think they're giving me some space to make sense of things. Don't get me wrong – I'm not feeling uncomfortable all the time when they're silence, I think if someone has built enough trust and enough of a relationship with me I feel a lot more comfortable with silence, their silence, so I can feel ok about it. I guess it's more of an issue right at the beginning when I don't really know the person.

R: What do you think, I mean for you, what helps you build up the trust in the person in the room, so that you get to the place where the silence feels comfortable? Given again the difference of sight.

E3: I think that them being quite open about things, and considerate about sort of the environment and building up trust just being able to feel, I keep going back to it, the warmth and empathy, hearing that they're listening to me, helps all to build up trust and I'm feeling quite safe in that space somehow.

I think them just having some sort of structure can help as well in terms of feeling safe and knowing when I'm finishing, when I'm ending. Making me aware of the time as well.

R: What you described there about the warmth and the feeling and the openness, given the fact you can't really see the therapist, how do you experience that they aim that at you. The little things they did that you know.

E3: Little things. I think I mentioned some of them, the verbalizing how they're feeling. I don't know. The little things they might do. I think touch can be quite useful sometimes, I know that therapists are a bit scared of that, but especially with someone who can't see that well, if you are say balling your eyes out for someone just to reach over and touch your arm. That says a lot actually for me, but then I'm that type of person that likes being touched and stuff on the arms and things because obviously it's more physical.

So anything physical makes me understand them a bit more, it's a way of communicating I suppose.

R: Tell me a bit more about that. The touch, and what that feels like when you're in the room with the person, when they reach over and touch you.

E3: It feels like they're, they're feeling your pain, they're recognising it, they're acknowledging it, and they are not going to run away. They're there. It just feels like they're there and there not sort of shocked, well they might be shocked by, but yeah, I think that's all I can say about that really.

R: And does that, because you're right what you said there, touch is one of those grey areas when it comes to therapy because of boundaries and what not, but in your experience E, did the therapist say 'I'm going to lean over and touch you now' or 'would you mind if I touched you now' or did it just sort of happen organically?

E3: It just happened. I don't know how that would have changed things if they did say that. I guess it's good for them to do that because some people don't like the physical contact, so I suppose it might be helpful to do that, but I just liked them just to do it really.

R: It almost feels that that was kind of unspoken.

E3: Unspoken as in?

R: The therapist didn't say 'I'm going to lean over and touch you now' or you didn't say 'could you lean over and touch me.'

E3: No, no. Though I think it's quite helpful maybe, well it would be quite helpful for me, initially in the first session for the therapist to say, maybe as part of the contract if you like, if you do look really distressed, so I can communicate with you I might be a bit physical with you and put my hand on your arm and stuff just to show that I'm here and listening, that might be kind helpful. Because it gives them the opportunity to say actually, I'd rather not. It's just an idea.

R: It sounds like it was a very powerful thing for you. A very helpful thing for you. But also there's something about what happened there that was almost an unspoken thing between the two of you. And I might just ask you a bit more about that… was there anything more that the therapist did that he or she did, that helped you feel understood, perhaps more non-verbal aspects of the therapy?

E3: Um..

R: Or even verbal aspects.. You've touched on that..

E3: Yes, just making small sounds, acknowledgment in some way.

R: was the voice important at all?

E3: Yes. The tone of the voice of course. That's going back to the verbal isn't it? Yes the tone of the voice is important, you can definitely pick up on things by that and I think that maybe when you're not fully sighted you're more in tune with that. So I think that is very important.

R: Can you tell me a bit more about that? About what you tuned into?

E3: Well I guess that's me, maybe it's a bit of an assumption that people do that, picking up on tone of voice, because I think that I am. I think I am, over other people. How I do it?

R: What things do you pick up on? In tone of voice?

E3: Well if they're sounding quite flat, or their pitch goes up, they're sounding more interested. So pitch and I guess the fastness, the speed of the voice can make a difference. To me if they're quite fast it might sound like they're rushing you through something. But anyone might pick up on that possibly, but maybe I'm just more sensitive to that, because that's what I rely on more, hearing the voice, more so than seeing someone's features and stuff, so...

R: So the voice, the fact that the sight is missing in the room, does the voice become more important or maybe even a replacement for ..

E3: Yes, I think so. In a way. I think it does become more important because we might rely on that a bit more.

R: And would it be helpful for the therapist to hear that? That because of the difference of sight I'm going to be relying on your voice a bit more?

E3: Yeah. Definitely. If someone were to say that to therapist, it would really help the therapist out, because not all therapists, non-sighted therapists, are aware of the impact of sight problems. I don't think all of the responsibility should be with the therapist actually. I think some, the responsibility should be with the client themselves to articulate what they want and articulate the problem clearly, because everyone's sight problem is different. Like I said mine is impacted by light and problems, so everybody's sight problem is different so I think it's their responsibility to tell the therapist, if it is an issue for them, a bit about what might help them.

R: So maybe in the initial assessment, like you were saying, as part of the contract put those things in there?

E3: Yeah. Definitely. I think it's not ever been a huge issue for me. Maybe if I was looking for someone to talk to about my sight problem and how it's impacted on me, maybe a non-sighted therapist might be helpful in a way but, like I say, it hasn't been a priority for me.

R: You see what you described there E, about the difference of sight, and the fact that you knew the therapist had sight and you were coming into the environment as somebody with more limited sight then you're therapist, do you feel that that could bring about any kind of empowerment imbalance in the room at all?

E3: Yeah.. it… don't know. That's a hard question!

R: You know, everybody get's stuck on that one!

E3: I think… if I'm brutally honest, I think it kind of does in away, because like I said earlier, There have been some times, like with that therapist where I felt quite uncomfortable, I did feel that they had an advantage that they could see me, but I couldn't see them. And you feel quite vulnerable in a way, so I could, in a sense, maybe.

Though I think it depends on the therapist, and if they have that inclination to put themselves up on a pedestal or whatever. I don' think it's necessarily down to the fact that they can see more, that I can imagine someone could feel that.

R: So when you go into the room with a sighted therapist, are you feeling going in, that you're potentially at a disadvantage?

E3: No, it was only on that occasion. It only crossed my mind briefly on that occasion, and no, I haven't, I have to say I haven't been consciously aware of that with other therapists. I was more consciously aware of it with that therapist.

R: And with that, do you think there's anything that the sighted therapist could have done to make the experience different for you, or could have been more helpful?

E3: Not other than those things that I've mentioned all ready. Maybe, maybe to say you know, to say I, I don't know how you might phrase it… to openly say I'm one, I don't want there to be any power imbalance here, just generally say that with someone, I don't know if that would help. No, that's not the right way to say it, but to communicate that with somebody somehow in the first instance, in the first session, might be quite good, so that they'd don't end up feeling that.

R: I was wondering, how might they do that, because the communication with the difference of sight, you touched on that with the voice and the openness and the warmth is really important, what I'm just wondering as well, with you having to be in the room with somebody can actually read you the whole time, but you can't read them, obviously there's' a difference of the eye contact, do you feel that that's something you've been able to bridge between you?

E3: That I've been able to?

R: You and therapist yeah. Or does it always feel like there's a bit of a gap there.

E3: No, no. Like I said, it only did on one occasion. It never, it was never even an issue and I don't know why it wasn't an issue. Maybe because being bought up that way, not to think of

it as an issue. It depends on the client's attitude toward their sight problem I think as well. Because I think people might see it as a real issue as well.

R: That's very interesting what you said there. Do you think maybe there's an expectation when a visually impaired person works into a room with a sighted therapist that, it's like someone walking in who's had a history of trauma, do you think that maybe's this person is going to want to talk about their visual impairment because that must be an enormous thing for her, because it's such an obvious thing, it's something you can't hide, you bring it into the room with you?

E3: Well there was an expectation with the Hypnotist, that's what I wanted to address, but it wasn't with anyone else. It wasn't with any other therapist I've had. Never. Never, an expectation on their part.

R: Do you think it's down to, say someone comes in in a wheelchair, or you coming in with a visual impairment, you can't hide that – it's very obvious that this is what you're brining into the room, do you feel there, what you said there about the sighted therapist, when they met you, as the client, that although this was obvious, or maybe they knew by the intake, the referral, that you had an visual impairment, that they just met you.

E3: Say that again.

R: So instead of meeting you as somebody with the visual impairment that what they met was just you.

E3: Yeah, yeah. I did feel that. I didn't think that they were focusing on that all, and they didn't make an assumption about me wanting to focus on that. They just took me as a whole person rather than just someone with a sight issue. I didn't feel categorized.

R: And how important to you was that, and I'm just coming back to what you said at the start, that if you went to see someone who was visually impaired as a therapist, do you feel that there might be a difference there of how you were being met?

E3: Hmm.. interesting question. I think that there could be. With a non-sighted therapist, they could assume because I've sort out a non-sighted therapist that I want to focus on my sight loss as an issue. Possibly. So there might be a difference, but then I've never had that experience of having therapy with non-sighted therapist so, they could assume that I've specifically sort them out because I'd like to explore that further. Does that make sense?

R: Yes it does. And do you think that with the sighted therapist just meeting you as you, meeting you as E, not of assuming that you're there because you're someone with a visual impairment that potentially with someone with a visual impairment, that that might overshadow maybe some of the things that potentially you want to discuss.

E3: Oh, if they did go and they wanted to discuss their sight problem. No, I don't think it should still be an issue, because therapy should still bring an open mind anyway, irrespective of whether they want, whether the clients coming and wanting to talk about it or not they should start with a blank slate anyway.

R: So no assumptions?

Appendix 5

Appendix 5 -
example
Erica

Raw Data	Initial Thoughts	Subordinate Themes
2 E3: I've seen a few different therapists, but I think they all have similarities in terms of the initial meeting and my experience is sort of as a non-sighted person with a sighted therapist – and they're all sighted therapists.	Similarity / Difference of therapists	" "
3 R: So you've only had therapy with sighted people?		
4 E3: Yes I have, and usually, things that might come up in the initial meeting are talking through a contract, you know the usual things, but obviously showing me to a chair and offering water.. actually with one particular therapist they did ask about the lighting because my condition is very much effected by light, actually they didn't actually know that but it was quite a good question whether the light was ok and stuff and to be honest, it was just a lamp, and I couldn't see much anyway, so I said it was ok, even if they'd put on the light I wouldn't have been able to see well anyway, but it was nice that they asked about that, and um, I found that the initial meeting obviously is about kind of about establishing a relationship and building trust and things, and I think it's quite difficult in a way not being able to fully see your therapist but it hasn't ever been an issue for me, I haven't ever sought out a non-sighted therapist, because I've anticipated too much discomfort, so I've never sought out a non-sighted therapist but I think that it has, I have wondered in the initial assessment and any subsequent sessions about what expression they might have, and I've always second guessed that.	How her condition is affected in the room \ Building the rriship in the initial meeting.	Therapist's initiative to esn about her condition \ Discomfort of non-sighted therapist → identification.
5 R: When you say you 'second guessed that' what do you find you're second guessing?		
6 E3: Well, sometimes, they might remain quiet and I might wonder why. For all I know they might look completely bored or not! They might look completely interested. It's really hard to know and I think my own insecurities have crept up now and again, not just in the assessment, in other sessions, whether that is the case, or whether they're interested, because they haven't verbalized that.	What is happening in the silence?	The impact of silence \ Verbalise emotions.

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Ref	Raw Data	Preliminary Code	Final Code	Themes
2	E3: I've seen a few different therapists, but I think they all have similarities in terms of the initial meeting and my experience is sort of as a non-sighted person with a sighted therapist – and they're all sighted therapists.			
3	R: So you've only had therapy with sighted people?			
4	E3: Yes I have, and usually, things that might come up in the initial meeting are talking through a contract, you know the usual things, but obviously showing me to a chair and offering water.. actually with one particular therapist they did ask about the lighting because my condition is very much effected by light, actually they didn't actually know that but it was quite a good question whether the light was ok and stuff and to be honest, it was just a lamp, and I couldn't see much anyway, so I said it was ok, even if they'd put on the light I wouldn't have been able to see well anyway, but it was nice that they asked about that, and um, I found that the initial meeting obviously is about kind of about establishing a relationship and building trust and things, and I think it's quite difficult in a way not being able to fully see your therapist but it hasn't ever been an issue for me, I haven't ever sought out a non-sighted therapist, because I've anticipated too much discomfort, so I've never sought out a non-sighted therapist but I think that it has, I have wondered in the initial assessment and any subsequent sessions about what expression they might have, and I've always second guessed that.	Similarity and difference in experience	Managing difference of sight	Trying to work out the moves to the dance
5	R: When you say you 'second guessed that' what do you find you're second guessing?			
6	E3: Well, sometimes, they might remain quiet and I might wonder why. For all I know they might look completely bored or not! They might look completely interested. It's really hard to know and I think my own insecurities have crept up now and again, not just in the assessment, in other sessions, whether that is the case, or whether they're interested, because they haven't verbalized that.	Silence in the room	Questioning the silence	What's actually happening in the silence?
7	Obviously a sighted therapist, naturally would express themselves through their body language and facial expressions, they wouldn't necessarily have to think about verbalizing that every minute, it wouldn't come naturally to them, and I absolutely don't blame people for that, but I, it's a bit of a difficulty in a way, because I think especially when you're trying to build up that trust if it isn't verbalized, if their warmth and empathy isn't verbalized.	Warmth and empathy	Expressing warmth and empathy	Verbalize the warmth and empathy by use of the voice
8	R: Sounds like that theirs a bit of a gap there. In the silence you're wondering what's going on? Would it be helpful if the therapist said in the silence, this is what I'm feeling right now this is what I'm experiencing?			
9	E3: Definitely. More immediacy, more being congruent and saying how they feel verbally, or how they're perceiving me, yes generally just being more verbal would be helpful.	Therapist needs to say how they feel	Therapist disclosure	Therapist disclosure without eye contact
10	R: If they were to be more verbal, what would you like to them say, or what would be helpful to be able to hear from them in that moment?			
11	E3: Oh god, I don't know, that's a difficult question, because it depends on what the situation is. You know, just things, like I'm sitting here wondering blah blah blah or I'm sitting here, I am interested in what you're saying, I'm pondering on something that you've said. Just to, I don't know, I think silence is still important to have, in many ways because you know it helps me process what' just been talked about. I've been trying to think about my experience, and I think that might be the only thing I could identify that might be a barrier. At the same time I do think silence is important too, so it's getting that balancing act for the therapist pointing things out.	Use of silence	Personal experience of silence	Insecurity creeps up in the silence

12	Also I've noticed in assessment some therapist might take notes and stuff and obviously you do hear the scribbling and things like that and I think for anyone sighted or not, that can be a bit off putting and you kind of wonder what are they writing down. Knowing when they're writing and not writing is a bit difficult when you've not got much sight and if their waiting for you to talk, waiting for you to say something… when they're still scribbling and you can't hear them, so I guess that's hard to identify. Just sort of saying, I'm just taking some notes, I'm just jotting down the last line here and I'll come back to what you're saying.	Difference of sight in the room	The experience of difference of sight	Vulnerability in the room due to difference of sight
13	R: Would that be helpful, what you were saying there, about the sighted therapist giving you a description of what they're doing?			
14	E3: In a way, without it becoming too intrusive, I don't know, it's the same of going to see an audio described TV programme, or a theatre performance and it can be a bit annoying. Obviously being a bit more verbal without having a commentary of what they're doing, I'm just going to get a tissue, or I'm just filling up my glass of water. Sometimes it is nice to know.	Filling in the gap of the sight difference	Filling in the gap of sight difference	Therapist needs to talk about what's real
15	R: Does that help you to fill in the gaps, if the sighted therapist were to be a more active?			
16	E3: I think so. I think it would.			
17	R: So do you think that would make a difference to the experience in the room, if that were to happen?			
18	E3: Yeah.. Yeah.. I think it would. I think it would.			
19	I had a therapist once, I couldn't really see her that well, and she was actually sitting quite far away from me (so I think positioning is quite important as well).	Therapist in the room	Therapist in the room	Physical position of therapist in the room
20	I could hear her yawning away constantly…constant! So I was thinking god, one or two yawns, but constantly yawning, I was thinking… I don't mind that, but as long as she isn't completely bored at the same time. It's just really hard to tell.	Yawning	The meaning of yawning	Does yawning mean she's bored?
21	R: What's that like? I'm quite struck by that. Her yawning away, we can all be tired of course but when you're in a therapy session, you're quite conscious of being present, and a yawn can be interpreted as boredom, or up with kids, or whatever, but for you, not being able to see the sighted therapist and hear that, that yawning coming towards you, what's that experience like E when you're not able to see the therapist?			
22	E3: It has crossed my mind, if I was fully sighted, perhaps they wouldn't do that. Perhaps they would not, sort of, in a way, as I said earlier perhaps my own insecurities might be creeping in such as they're just taking advantage of the face I can't see.	Difference of sight in the room	Experience of sight difference	If I was fully sighted perhaps they wouldn't do that
23	I could be saying something, because I did hear the same therapist, I wouldn't say snigger, but laugh at something, kind of under her breath, but she could be smiling at things that I'm saying, but I would just not be aware of that, and as I say there's mind reading going on there to a certain extent but there is that… there could be that thought. It wasn't a big thing. It fleeted through my mind but yeah obviously they might be aware, we can't see them so they wouldn't need to pay too much attention to their expression and things, their own expressions.	Blindness of therapist	Blindness of therapist	Therapist made me feel more self-conscious of my disability
24	R: And was that you're sense, that sometimes that happened, the difference in sight, maybe for you, that you experience it, that there was the sense that the therapist was yawning, or sniggering under her breath, or whatever, that there was facial expressions there, maybe things that they did, that they wouldn't do with a sighted person?			

25	E3: Only with that therapist. It only crossed my mind with that therapist. Actually that therapist was a fairly recent one, and I only saw her for one session anyway, and that was a hypnotist actually. It was a little while ago actually, but other than that, prior to that, all the other therapists I've seen, it did not cross my mind. It even didn't cross my mind about the difference between myself not being fully sighted and them being sighted. It just didn't at all. But I think that I was aware of it unconsciously because I cast my mind back and I do remember very small times when I said to myself I wish I could see the therapist's face right now, but other than that it just didn't cross my mind. It wasn't an issue for me. And all the therapists that I've seen have been quite warm and empathetic and stuff and I've still got that from them.	Difference of sight in the room	Difference of sight in the room	Powerlessness of not being able to reciprocate gaze
26	But I think that I would have got that more from them if I could have seen their faces as well, because a lot of therapists rely on communicating their empathy through their face and eye contact, so I'm sure I could have got more from them if I could fully see them, but it wasn't that it was a big thing.	Eye contact	Use of eye contact	Frustration at not being able to return gaze
27	R: Did you feel that when you were choosing to come to therapy E, when you were thinking about it, what was important to you about your therapist? Or could you describe what were important factors in choosing your therapist?			
28	E3: I wanted to make sure that they had a specialism in what I was keen to address and that also they had the training and things, and that they were close by, within my budget.			
29	But the personal qualities, I just wanted to have a connection with them really, that was the most important thing for me. To be able to feel that they're listening, approachable, going to emphasize with me and not have their own agendas in any way they're just going to listen and be warm. I think that's the main things really.	Building the relationship	Building the relationship	I just wanted to have a connection
30	R: And did the therapist having sight or not affect the choice of therapist given.			
31	E3: Not at all. Like I said it didn't even cross my mind, and I didn't know how to look, I've never actually considered how many non-sighted therapists their might be around, but I'm sure that there's a lot less.			
32	R: So that wasn't something that you felt when you were considering therapy, the difference in sight was something, well I'd really like to see someone who has the same visual impairment that I have, or have experience that themselves.			
33	E3: Not at all. I kind of think it's like saying, well if I've got a broken leg I want to see, I don't think anyone would understand unless they had a broken leg and I don't know about that. I think, I'm half Irish, half Turkish myself go to seek out a half Irish half Turkish…	Working with difference	Working with difference	Therapy should start with a blank slate
34	R: You'd walk a long way!			
35	E3: (laughs) Yes, that'd be quite hard to find but I think that would be it wouldn't necessarily make them empathize any more, it really depends on their personality and how you connect with them, and not necessarily their democratic, or whatever and the same with saying that someone wouldn't understand my trauma unless they've experience it themselves. Yes, there's some truth in that I think, but they can still help and support you through it and be there for you without having to have experienced it first-hand .	Managing difference of sight	Managing difference of sight	She treated me like a unique person
36	R: So for you, given the fact you've only had therapy with sighted therapists, and you've never had therapy with non-sighted therapists, given the fact that that's never happened, would you like to have therapy experience with a non-sighted therapist now?			

37	E3: Well, yeah, I would, but not… I suppose their advantages to that in a way, like I say, they'd be more used to communicating how they're feeling non-verbally, but that's not necessarily the case thinking about it. It's not necessarily the case.			
38	R: Do you think that might be a bit of a fantasy?			
39	E3: Yes I think it might actually. I mean that's the only benefit, and like you say, I think it's bit of an assumption of mine that they might be more used to communicating how they're feeling without using their expressions and body languages. It's not necessarily the case, so I suppose no, it wouldn't matter to me whether they're sighted, whether they're non-sighted, as long as we can get along and I can feel fully comfortable talking to them, we have a connection and they can empathise. They're the main things really.	The use of eye contact in communication	Non-verbal communication	Therapist reliance on communicating empathy through face and eye contact
40	R: Just coming on to that, because you've mentioned that word quite a few times, empathy, and I'd like to ask you about that…			
41	E3: Sorry, I'm a bit repetitive.			
42	R: No, no, not at all, it just shows the importance because you've mentioned quite a few times that the empathy was there with the therapist, and I'd just like to ask you, given the fact that you've had the therapy with sighted therapists and there was that difference of sight, how did you feel you were understood by the sighted therapist, and that they were being empathetic towards you?			
43	E3: How did I feel understood?			
44	Well it's different with each therapist but I felt understood.	Understanding	Understanding	Need to feel understood
45	R: And what do you feel that they did to help you to feel that they did to help you feel that you were understood, given the fact that there was the difference of sight in the room.			
46	E3: Well, basically, when they indicated that they listening by repeating what I said, or paraphrasing something that I'd mentioned and making connections, I suppose, between one thing and another thing and maybe bringing me back to something I'd mentioned earlier indicated to me that they'd listened. And maybe not necessarily understood, but it did indicated that they understood to some extent how I was feeling, recognising that, acknowledging that. Does that make sense?	Use of voice	Voice as a tool	Voice helps to build the relationship
47	R: I'm just wondering, given that there was the difference in sight, you felt the empathy? How did you feel that?			
48	E3: Oh How?			
49	R: Yes given the fact that you were as you said earlier, you were filling in the blanks.			
50	E3: By, them, making small sounds like 'oh' you know or saying 'I feel sad listening to you talking about that' or sort of just verbalizing their emotions in some way.	Expressing emotion without sight	Voice as a tool	Verbalise the warmth and empathy by use of the voice
51	R: Do you think that, given the fact that you couldn't read the face, and given that a lot of emotion gets shown through the face and you're body, and the fact that they were telling you the feeling, or describing the feeling in a very verbal way, was that helpful for you?			
52	E3: Absolutely. Yes it really was. Because I knew exactly where they were and I felt more connected to them, that they did care and I think I might have a slight issue with silence sometimes, that's my own thing, but I do think it definitely helped. I do think that silence is good, but especially when you can't see I think can be an issue sometimes.	Silence	Working with silence	Silence harder to deal with at beginning of therapy
53	R: Can you just describe what that feeling is like, in the silence in the room, when you can't actually see the other person and they're quiet?			

54	E3: I think, uncomfortable. I might just be curious. I might wonder what they're doing, or what they're feeling. If they might be looking out the window. I think that's the main thing, I might just, I might think they're giving me some space to make sense of things. Don't get me wrong – I'm not feeling uncomfortable all the time when they're silence, I think if someone has built enough trust and enough of a relationship with me I feel a lot more comfortable with silence, their silence, so I can feel ok about it. I guess it's more of an issue right at the beginning when I don't really know the person.	Silence	Silence in the room	Silence can feel punishing
55	R: What do you think, I mean for you, what helps you build up the trust in the person in the room, so that you get to the place where the silence feels comfortable? Given again the difference of sight.			
56	E3: I think that them being quite open about things, and considerate about sort of the environment and building up trust just being able to feel, I keep going back to it, the warmth and empathy, hearing that they're listening to me, helps all to build up trust and I'm feeling quite safe in that space somehow.	Environment	Experience of empathy	Being listened to shows empathy and comfort
57	I think them just having some sort of structure can help as well in terms of feeling safe and knowing when I'm finishing, when I'm ending. Making me aware of the time as well.	Environment	Experience of environment	Therapist needs to talk about what's real
58	R: What you described there about the warmth and the feeling and the openness, given the fact you can't really see the therapist, how do you experience that they aim that at you. The little things they did that you know.			
59	E3: Little things. I think I mentioned some of them, the verbalizing how they're feeling. I don't know. The little things they might do. I think touch can be quite useful sometimes, I know that therapists are a bit scared of that, but especially with someone who can't see that well, if you are say balling your eyes out for someone just to reach over and touch your arm. That says a lot actually for me, but then I'm that type of person that likes being touched and stuff on the arms and things because obviously it's more physical.	Touch	Use of touch	Touch shows empathy and compassion
60	So anything physical makes me understand them a bit more, it's a way of communicating I suppose.			
61	R: Tell me a bit more about that. The touch, and what that feels like when you're in the room with the person, when they reach over and touch you.			
62	E3: It feels like they're, they're feeling your pain, they're recognising it, they're acknowledging it, and they are not going to run away. They're there. It just feels like they're there and there not sort of shocked, well they might be shocked by, but yeah, I think that's all I can say about that really.	Touch	Use of touch	Touch is an acknowledgement of your pain
63	R: And does that, because you're right what you said there, touch is one of those grey areas when it comes to therapy because of boundaries and what not, but in your experience E, did the therapist say 'I'm going to lean over and touch you now' or 'would you mind if I touched you now' or did it just sort of happen organically?			
64	E3: It just happened. I don't know how that would have changed things if they did say that. I guess it's good for them to do that because some people don't like the physical contact, so I suppose it might be helpful to do that, but I just liked them just to do it really.	Touch	Use of touch	Natural use of touch
65	R: It almost feels that that was kind of unspoken.			
66	E3: Unspoken as in?			
67	R: The therapist didn't say 'I'm going to lean over and touch you now' or you didn't say 'could you lean over and touch me.'			

68	E3: No, no. Though I think it's quite helpful maybe, well it would be quite helpful for me, initially in the first session for the therapist to say, maybe as part of the contract if you like, if you do look really distressed, so I can communicate with you I might be a bit physical with you and put my hand on your arm and stuff just to show that I'm here and listening, that might be kind helpful. Because it gives them the opportunity to say actually, I'd rather not. It's just an idea.	Touch	Use of touch	Touch a different medium of communication
69	R: It sounds like it was a very powerful thing for you. A very helpful thing for you. But also there's something about what happened there that was almost an unspoken thing between the two of you. And I might just ask you a bit more about that… was there anything more that the therapist did that he or she did, that helped you feel understood, perhaps more non-verbal aspects of the therapy?			
70	E3: Um..			
71	R: Or even verbal aspects.. You've touched on that..			
72	E3: Yes, just making small sounds, acknowledgment in some way.			
73	R: was the voice important at all?			
74	E3: Yes. The tone of the voice of course. That's going back to the verbal isn't it? Yes the tone of the voice is important, you can definitely pick up on things by that and I think that maybe when you're not fully sighted you're more in tune with that. So I think that is very important.	Use of the voice	Voice as a tool	Voice helps to build the relationship
75	R: Can you tell me a bit more about that? About what you tuned into?			
76	E3: Well I guess that's me, maybe it's a bit of an assumption that people do that, picking up on tone of voice, because I think that I am. I think I am, over other people. How I do it?	Voice	Use of voice	More in tune with voice due to visual impairment
77	R: What things do you pick up on? In tone of voice?			
78	E3: Well if they're sounding quite flat, or their pitch goes up, they're sounding more interested. So pitch and I guess the fastness, the speed of the voice can make a difference. To me if they're quite fast it might sound like they're rushing you through something. But anyone might pick up on that possibly, but maybe I'm just more sensitive to that, because that's what I rely on more, hearing the voice, more so than seeing someone's features and stuff, so...	Voice	Voice as a tool	Sensitivity to changes in the voice
79	R: So the voice, the fact that the sight is missing in the room, does the voice become more important or maybe even a replacement for.			
80	E3: Yes, I think so. In a way. I think it does become more important because we might rely on that a bit more.			
81	R: And would it be helpful for the therapist to hear that? That because of the difference of sight I'm going to be relying on your voice a bit more?			
82	E3: Yeah. Definitely. If someone were to say that to therapist, it would really help the therapist out, because not all therapists, non-sighted therapists, are aware of the impact of sight problems. I don't think all of the responsibility should be with the therapist actually. I think some, the responsibility should be with the client themselves to articulate what they want and articulate the problem clearly, because everyone's sight problem is different. Like I said mine is impacted by light and problems, so everybody's sight problem is different so I think it's their responsibility to tell the therapist, if it is an issue for them, a bit about what might help them.	Individual aspect of visual impairment	Working with actual sight condition	Trying to work out the move to the dance
83	R: So maybe in the initial assessment, like you were saying, as part of the contract put those things in there?			
84	E3: Yeah. Definitely. I think it's not ever been a huge issue for me. Maybe if I was looking for someone to talk to about my sight problem and how it's impacted on me, maybe a non-sighted therapist might be helpful in a way but, like I say, it hasn't been a priority for me.	Non-sighted therapist	Non -sighted therapist	Need to feel understood by therapist

85	R: You see what you described there E, about the difference of sight, and the fact that you knew the therapist had sight and you were coming into the environment as somebody with more limited sight then you're therapist, do you feel that that could bring about any kind of empowerment imbalance in the room at all?			
86	E3: Yeah.. It… don't know. That's a hard question!			
87	R: You know, everybody gets stuck on that one!			
88	E3: I think… if I'm brutally honest, I think it kind of does in away, because like I said earlier,			
89	There have been some times, like with that therapist where I felt quite uncomfortable, I did feel that they had an advantage that they could see me, but I couldn't see them. And you feel quite vulnerable in a way, so I could, in a sense, maybe.	Impact of sighted therapist	Impact of sighted therapist	Therapist made me feel more self- conscious of my disability
90	Though I think it depends on the therapist, and if they have that inclination to put themselves up on a pedestal or whatever. I don' think it's necessarily down to the fact that they can see more, that I can imagine someone could feel that.			
91	R: So when you go into the room with a sighted therapist, are you feeling going in that you're potentially at a disadvantage?			
92	E3: No, it was only on that occasion. It only crossed my mind briefly on that occasion, and no, I haven't, I have to say I haven't been consciously aware of that with other therapists. I was more consciously aware of it with that therapist.			
93	R: And with that, do you think there's anything that the sighted therapist could have done to make the experience different for you, or could have been more helpful?			
94	E3: Not other than those things that I've mentioned all ready. Maybe, maybe to say you know, to say I, I don't know how you might phrase it… to openly say I'm one, I don't want there to be any power imbalance here, just generally say that with someone, I don't know if that would help. No, that's not the right way to say it, but to communicate that with somebody somehow in the first instance, in the first session, might be quite good, so that they'd don't end up feeling that.	Difference of sight in the room	Power dynamic	Power dynamic of sight implicit in every relationship
95	R: I was wondering, how might they do that, because the communication with the difference of sight, you touched on that with the voice and the openness and the warmth is really important, what I'm just wondering as well, with you having to be in the room with somebody can actually read you the whole time, but you can't read them, obviously there's' a difference of the eye contact, do you feel that that's something you've been able to bridge between you?			
96	E3: That I've been able to?			
97	R: You and therapist yeah. Or does it always feel like there's a bit of a gap there.			
98	E3: No, no. Like I said, it only did on one occasion. It never, it was never even an issue and I don't know why it wasn't an issue. Maybe because being bought up that way, not to think of it as an issue. It depends on the client's attitude toward their sight problem I think as well. Because I think people might see it as a real issue as well.	Personal relationship with sight	Personal relationship with sight	Necessity to let you know me needs
99	R: That's very interesting what you said there. Do you think maybe there's an expectation when a visually impaired person works into a room with a sighted therapist that, it's like someone walking in who's had a history of trauma, do you think that maybe's this person is going to want to talk about their visual impairment because that must be an enormous thing for her, because it's such an obvious thing, it's something you can't hide, you bring it into the room with you?			

100	E3: Well there was an expectation with the Hypnotist, that's what I wanted to address, but it wasn't with anyone else. It wasn't with any other therapist I've had. Never. Never, an expectation on their part.	Expectation	Impact of therapist expectation	Expectation on part of therapist for working together
101	R: Do you think it's down to, say someone comes in in a wheelchair, or you coming in with a visual impairment, you can't hide that – it's very obvious that this is what you're brining into the room, do you feel there, what you said there about the sighted therapist, when they met you, as the client, that although this was obvious, or maybe they knew by the intake, the referral, that you had an visual impairment, that they just met you.			
102	E3: Say that again.			
103	R: So instead of meeting you as somebody with the visual impairment that what they met was just you.			
104	E3: Yeah, yeah. I did feel that. I didn't think that they were focusing on that all, and they didn't make an assumption about me wanting to focus on that. They just took me as a whole person rather than just someone with a sight issue. I didn't feel categorized.	Assumption	Therapist assumption	Ask, don't make assumptions
105	R: And how important to you was that, and I'm just coming back to what you said at the start, that if you went to see someone who was visually impaired as a therapist, do you feel that there might be a difference there of how you were being met?			
106	E3: Hmm, interesting question. I think that there could be. With a non-sighted therapist, they could assume because I've sort out a non-sighted therapist that I want to focus on my sight loss as an issue. Possibly. So there might be a difference, but then I've never had that experience of having therapy with non-sighted therapist so, they could assume that I've specifically sort them out because I'd like to explore that further. Does that make sense?	Working with a non-sighted therapist	Working with a non-sighted therapist	Ask, don't make assumptions
107	R: Yes it does. And do you think that with the sighted therapist just meeting you as you, meeting you as E, not of assuming that you're there because you're someone with a visual impairment that potentially with someone with a visual impairment, that that might overshadow maybe some of the things that potentially you want to discuss.			
108	E3: Oh, if they did go and they wanted to discuss their sight problem. No, I don't think it should still be an issue, because therapy should still bring an open mind anyway, irrespective of whether they want, whether the clients coming and wanting to talk about it or not they should start with a blank slate anyway.	Managing difference of sight	Managing difference of sight	Therapy should start with a blank slate
109	R: So no assumptions?			

Erica Pivot

Row Labels	Count of Themes
Ask, don't make assumptions	2
Therapist needs to talk about what's real	2
Therapy should start with a blank slate	2
Being listened to shows empathy and comfort	1
Does yawning mean she's bored?	1
Frustration at not being able to return gaze	2
I just wanted to have a connection	1
If I was fully sighted perhaps they wouldn't do that	1
Insecurity creeps up in the silence	1
More in tune with voice due to blindness or partial sightedness	1
Natural use of touch	1
Necessity to let you know me needs	1
Need to feel understood	2
Physical position of therapist in the room	1
Power dynamic of sight implicit in every relationship	1
Powerlessness of not being able to reciprocate gaze	1
Sensitivity to changes in the voice	1
She treated me like a unique person	1
Silence harder to deal with at beginning of therapy	2
Therapist disclosure without eye contact	1
Therapist made me feel more self-conscious of my disability	2
Therapist reliance on communicating empathy through face and eye contact	1
Touch a different medium of communication	1
Touch is an acknowledgement of your pain	1
Touch shows empathy and compassion	1
Trying to work out the moves to the dance	2
Verbalise the warmth and empathy by use of the voice	2
Voice helps to build the relationship	2
Vulnerability in the room due to difference of sight	1
What's actually happening in the silence?	1
Grand Total	**40**

Summary table of themes and frequency	Alison	Barbara	Diane	Erica	George	Jerry	Kelsey	Nora	Pat	Total
Need to feel understood by therapist	1	1	1	1	1	1	1	1	1	9
Therapist needs to talk about what's real	1	1	1	1	1	1	1	1	1	9
Trying to work out the move to the dance	1		1	1	1	1	1	1	1	8
Overriding nature of blindness or partial sightedness	1	1			1	1	1	1	1	7
Sight loss and personal identity	1		1		1	1	1	1	1	7
I just wanted to have a connection	1			1	1	1	1		1	6
Society can enable or disable you		1	1		1	1	1	1		6
Therapist disclosure without eye contact	1			1	1	1	1	1		6
Therapist made me feel more self- conscious of my disability	1		1	1		1		1	1	6
Therapy should start with a blank slate	1		1	1	1			1	1	6
As if quality forgotten	1		1				1	1	1	5
Being listened to shows empathy and comfort		1		1	1	1	1			5
Natural use of touch	1	1		1			1	1		5
No consideration given to my VI	1	1					1	1	1	5
She treated like a unique person	1	1		1	1		1			5
Touch, a different medium of communication				1	1	1	1		1	5
Willingness of therapist to carry my baggage	1	1					1	1	1	5
Ask, don't make assumptions	1		1	1					1	4
Building trust without sight	1	1				1	1			4
Difference of sight a gap that can't be filled	1		1				1	1		4
Machine like nature of sighted therapist	1	1					1	1		4
More in tune with voice due to blindness or partial sightedness	1			1			1		1	4
Need to listen without judgement	1	1				1	1			4
Power of the connection in the moment		1			1		1	1		4
Powerless to challenge society's position on sight loss						1	1	1	1	4
Sensitivity to changes in the voice	1			1			1		1	4
Struggle between needing assistance and asking for it						1	1	1	1	4
The instinctual nature of touch		1				1	1		1	4
Therapist own responsibility to say they don't understand	1		1		1	1				4

Therapy bias ableist position starts from	1				1			1	1	4
Voice helps to build the relationship				1	1		1		1	4
Dependency on the sighted world					1	1			1	3
Does yawning mean she's bored?	1				1	1				3
Expectation on part of therapist for working together					1			1	1	3
Hard to describe what it's like to live with sight loss	1			1	1					3
Holistic and not fixed in their ways		1						1	1	3
Lack of sight internalised as lack of identity		1				1			1	3
Mind the gap between sight and sight loss				1	1	1				3
Necessity to let you know my needs	1			1	1					3
Non-verbal communication goes beyond a senses thing					1	1		1		3
Physical position of therapist in the room	1				1		1			3
Powerlessness of not being able to reciprocate gaze					1			1	1	3
Silence harder to deal with at beginning of therapy				1	1				1	3
Society is labelling me as disabled						1	1	1		3
Therapist reliance on communication empathy through face and eye contact	1				1				1	3
Use of the voice for atunement and mirroring						1	1	1		3
Vulnerability in the room due to difference of sight					1		1		1	3
Wall of silence was not inviting						1	1		1	3
You just want to fit in really, you don't want to stand out					1		1		1	3
Avoidance on part of the therapist	1						1			2
Eye contact is the springboard for conversation				1	1					2
Frustration of inability to return to gaze					1	1				2
Insecurity creep up in the silence					1	1				2
Not what is said, but how it's said					1		1			2
Power dynamic of sight implicit in every relationship					1	1				2
Silence can feel punishing	1				1					2
The comfort of touch	1						1			2
Tone of voice used for deeper communication	1								1	2
Touch compensates for lack of sight		1				1				2
Touch is reaching out to me to let me know they're there					1			1		2
Verbalise the warm and empathy by use of the voice	1				1					2

										Total
Visibility of disability leads you vulnerable					1		1			2
Blindness or partial sightedness is the elephant in the room						1		1	1	2
What's actually happening in the silence?				1			1			2
You wanted to be seen as normal					1	1				2
Chair closer shows enthusiasm and interest							1			1
Felt unseen due to VI							1			1
I could tell she was lost	1									1
If I was fully sighted perhaps they wouldn't do that				1						1
Inability to control sight loss so need to control everything else							1			1
Much more to it than eye contact	1									1
My blindness or partial sightedness shouts							1			1
Narcissism of can you see me?									1	1
Need to reassure therapist that I was capable							1			1
Never fully accept not being able to make eye contact						1				1
Nothing Holistic about body language and eye contact			1							1
Pressure to put sighted therapist at ease							1			1
Thanking the therapists through touch							1			1
Touch is an acknowledgement of your pain				1						1
Touch shows empathy and compassion				1						1
Two perfect eyes are judging your one bad eye							1			1
Yawning is ugly	1									1
	36	17	17	32	29	32	41	30	30	

Summary Table of Top 20 Themes by Frequency	Alison	Barbara	Diane	Erica	George	Jerry	Kelsey	Nora	Pat	Total
Need to feel understood by therapist	1	1	1	1	1	1	1	1	1	9
Therapist needs to talk about what's real	1	1	1	1	1	1	1	1	1	9
Trying to work out the move to the dance	1		1	1	1	1	1	1	1	8
Overriding nature of blindness and partial sightedness	1	1			1	1	1	1	1	7
Sight loss and personal identity	1		1		1	1	1	1	1	7
I just wanted to have a connection	1			1	1	1	1		1	6
Society can enable or disable you		1	1		1	1	1	1		6
Therapist disclosure without eye contact	1			1	1	1	1	1		6
Therapist made me feel more self- conscious of my disability	1		1	1		1		1	1	6
Therapy should start with a blank slate	1		1	1	1			1	1	6
As if quality forgotten	1		1				1	1	1	5
Being listened to shows empathy and comfort		1		1	1	1	1			5
Natural use of touch	1	1		1			1	1		5
No consideration given to my VI	1	1					1	1	1	5
She treated like a unique person	1	1		1	1		1			5
Touch, a different medium of communication				1	1	1	1		1	5
Willingness of therapist to carry my baggage	1	1				1	1	1		5
Ask, don't make assumptions	1		1	1					1	4
Building trust without sight	1	1				1	1			4
Difference of sight a gap that can't be filled	1		1				1	1		4