A PHENOMENOLOGICAL INVESTIGATION OF LICENSED PROFESSIONAL COUNSELORS' PERSPECTIVES OF CLINICAL INTUITION

by

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ABSTRACT

MELANIE LEIGH WEIS. A phenomenological investigation of Licensed Professional Counselors' Perspectives of Clinical Intuition. (Under the direction of Dr. Lyndon Abrams)

The purpose of this study was to investigate the essence of the experience of clinical intuition through the perspective of licensed professional counselors. Despite the attention that intuition had been given in other professional fields, a lack of research that was specific to the counseling profession existed on this topic. This dearth of literature existed despite the apparent connection between counselor development and intuition. For instance, models of counselor development depicted how counselors increase their awareness of themselves, their clients, and the counseling relationship as they gain more clinical experience, while theories on the nature of intuition suggested that experience and awareness produce intuitive knowledge. In spite of that association, clinical intuition in the field of licensed professional counselors had not been examined.

Given that counselors' clinical intuition was little understood, a phenomenological design was selected for this investigation. This type of qualitative study provided a way to discover the core essential meanings of clinical intuition. Furthermore, it created the foundation for future studies in this area.

The participants were comprised of nine licensed professional counselors in the state of North Carolina and all met the criteria for this study. Their experience ranged from 5 years to 36 years. These counselors worked in diverse settings and had acquired various kinds of postgraduate training.

Interviews were conducted in the offices where counselors usually work with clients. Transcriptions of those interviews yielded the data that were analyzed and synthesized based on Moustakas' (1994) phenomenological method. That process involved the Epoche, phenomenological reduction, imaginative variation, and synthesis. The data revealed six core themes: (1) unconscious associations; (2) conscious associations; (3) moments preceding the arrival of intuitive knowledge; (4) initial appearance; (5) manifestation of intuitive knowledge; and (6) the nature of the intuitive information.

Each of the six themes was composed of clusters. Within the first theme of unconscious associations, participants made inferences about clinical knowledge and countertransference reactions that had occurred outside of their conscious awareness. The second theme of conscious associations contained counselors' attention to their identification and resonance with clients as well as their countertransference to clients. This theme also included awareness of clinical knowledge and clients' nonverbal and verbal communication.

The third theme concerned the accepting, present, and expectant qualities that preceded the arrival of the intuitive knowledge. The fourth theme captured the holistic, immediate, certain, and sacred characteristics that seemed to imbue the presentation of the intuitive information. The fifth theme captured the way clinical intuition manifested in counselors, and it seemed to conform to the sixth theme which described the degree and quality of that information.

Clinical intuition appeared to be a slow development of increasing levels of unconscious and conscious associations. In a state of alert receptivity, something in the

clinical situation seemed to catalyze those developing connections. Counselors experienced that moment as a felt sense, gut feeling, recognition of a pattern, or symbolic representation. The manner in which clinical intuition arrived seemed to correspond with the degree of consciousness and the amount of affective and cognitive material contained in the knowledge.

These findings were reviewed in relation to the relevant literature on intuition. The implications of this study to the field of counseling were also offered. Furthermore, suggestions for future studies on this topic were provided.

DEDICATION

This research is dedicated to my mentor and friend, Jim Jenkins, who inspires me everyday to listen to and see into myself and the world around me. I am grateful for how you challenge me to find the purpose in all I do, to do what is required, and to live authentically. You have taught me to listen to, understand, and value myself. I am forever grateful for your guidance, support, and encouragement in my journey to find my place in the world.

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CHAPTER 1: INTRODUCTION

Overview

The integration of personal and professional identities into a counselor identity had been a critical focal point in the professional counseling field (Loganbill, Hardy, & Delworth, 1982), and for the past twenty-five years, that facet was studied within a predominately developmental framework of supervision (Stoltenberg, 1981; Ronnestad & Skovholt, 1993; Pearson, 2001). Developmental supervision theories had offered conceptual models of the changing needs and issues of counselors as they progress from a graduate-level practicum to pre-licensure status and beyond. Within these models, counselors initially focused on acquiring concrete and context-free information regarding therapeutic theories and techniques. As counselors acquired more experience, developmental supervision theory proposed that therapists' integrated their clinical knowledge with an increased awareness of themselves, their clients, and the counseling process (Stoltenberg, McNeill, & Delworth, 1998). Consequently, counseling supervision provided the context for the integration of experience, awareness, knowledge, and skill.

Developmental models asserted that as counselor identities emerged, therapists were more attuned to their own personal reactions to clients, their clients' nonverbal communication (tone of voice, body posture, facial movements), and the interaction between themselves and their clients (Stoltenberg et al., 1998). Bohart (1999) argued that therapists used that awareness of themselves, clients, and the therapeutic process as the

basis for their clinical intuition. He conceived intuition as a type of knowledge derived from experience. The combination of awareness and experience provided therapists with the necessary information to form patterns of perception (Bohart; Welling, 2005).

Furthermore, Eisengart and Faiver (1996) utilized a pattern-recognition model to propose a conceptualization that captured the critical elements of clinical intuition. They explained that intuition was the degree of consistency between knowledge gained through clinical practice and the perception of a client's current affect, thoughts, and interactions. This description was consistent with inherent aspects of developmental models of supervision such as progressive levels of self-awareness, client-awareness, process-awareness, and clinical skills (Loganbill et al., 1982; Stoltenberg et al., 1998).

Need for the Study

Despite the apparent overlap between the development of clinical intuition and developmental models of supervision, research specific to clinical intuition in counselors-in-training was lacking. Researchers concerned with clinical intuition have tended to focus on the ways psychologists or nurses utilized intuitive knowing within the clinician-patient relationship (Benner, Tanner, & Chesla, 1992; Bohart, 1999; Eisengart & Faiver, 1996). Alternatively, theorists concerned with counselor development have discussed counselors' increasing ability to form clinical judgments based on personal and professional awareness, but those theorists did not explicitly connect that development with intuition (Loganbill et al., 1982; Skovholt & Ronnestad, 1992; Stoltenberg et al., 1998).

The apparent parallel and overlap between clinical intuition and counselor development was presented in Chapter 2's review of relevant literature. However, that

review revealed that the phenomenon of clinical intuition had not been studied through the lens of counselor development, in spite of that evident connection. Williams and Irving (1996) stated: “To say that ‘I acted without knowing why’ would be almost to plead incompetence…it was indefensible for a counselor to argue that ‘I don’t know what I’m doing” (p. 2). Their contention captured the need for an examination of how clinical intuition within counselor development was considered.

The lack of attention to counselors’ clinical intuition within developmental models was indicative of a deficient understanding of the concept of intuition in counseling practice. In other words, the theorists studying intuition may have reached conceptual understandings of how intuition was utilized (i.e., a counselor responds to a client based on how the current situation aligns with or deviates from patterns formed from theory and experience), but the researchers contributing to counselor development models had ignored this phenomenon. Despite this dearth of research on counselors’ experiences of clinical intuition, counselors continued to assert that intuition was an essential component of how they work (Welling, 2005; Williams & Irving, 1996).

Eisengart and Favier (1996) argued that science’s historical adherence to verifiable observations had excluded the study of such implicit processes. Within the realms of science and academia, a phenomenon that was considered unobservable and irrational was not considered a valid way of understanding the world. However, counseling issues such as countertransference (Agass, 2002; Grey & Fiscalini, 1987), emotional awareness (Rosiello, 1989; Wetcher, 1998), and empathy (Peabody & Gelso, 1982) had been investigated. While those seemingly ineffable elements of counselor development had been studied, intuition had not been given similar attention.

To address that gap in the literature, counselors' experience of clinical intuition had to be understood. Furthermore, prior to an investigation of how the intuitive ability develops or the role of supervision in that development, clinical intuition from the perspectives of counselors had to be initially comprehended. Therefore, this study addressed the need to understand this phenomenon. Moreover, this investigation expanded the literature base by contributing an in-depth description of the essence of counselors' experience of clinical intuition.

In order to discover that essence, participant selection was critically important. Therefore, as clinical experience was the common element in both counselor development models and pattern recognition theories of intuition, it appeared that clinical experience might be a precondition of clinical intuition. Consequently, clinical practice would then presuppose counselors' ability to articulate their understanding of clinical intuition. Accordingly, this study explored *experienced* counselors' views and descriptions of clinical intuition.

Participant criteria ensured a minimum of experience and contributed a rich understanding of clinical intuition. A study of the experiences of licensed professional counselors (LPCs) provided a comprehensive exploration of the experience of clinical intuition in one specific profession within the clinical community. Although this study added only a tiny piece to the work that future research could build upon, it was a necessary first brick in the construction of a deeper conceptualization of this phenomenon.

Purpose of the Study

The purpose of this research was to understand LPCs' experience of clinical intuition. The research questions that guided this study were:

1. How did counselors define clinical intuition?
2. How did they describe their intuitive experience in a counseling context?
3. How did counselors perceive and understand their development of the ability to use clinical intuition?
4. How did counselors relate their professional and personal experiences to their development of the ability to use intuition?

Research Design

While the developmental model of counselor training and a pattern-recognition theory of intuition provided theoretical support for the importance of this study, this was a qualitative investigation. Rather than testing a theory, as in a quantitative design, this qualitative study allowed participants to explore and expand their perspectives so that novel theories emerge (Glesne, 2006). This current phenomenological investigation contributed a deeper understanding of clinical intuition through a process of gathering, analyzing, and synthesizing counselors' perspectives on the essential nature of this phenomenon. While the theoretical models of counselor training and intuition (i.e., developmental paradigms of counselor supervision and pattern-recognition models of intuition) served as a basis for the questions that guided this study, the essence of intuition was examined from counselors' points of view. That perspective enlarged the existing theoretical research by adding an understanding of LPCs' experience of clinical intuition.

Assumptions

Inherent assumptions existed within this study because of the dynamics of self-report and the subjective nature of counselors' perspectives. It was assumed that participants would answer honestly, without distortion. That honesty entailed a lack of censorship or, alternatively, an absence of exaggerated responses about their actual experiences as a counselor. Therefore, it was assumed that participants would not depict how they would *ideally* engage in counseling practice.

Stoltenberg's et al. (1998) model of counselor development depicted how such distortions might occur. Those authors proposed that counselors progress through stages designated by changes in the following areas: (a) competency; (b) autonomy; (c) theoretical identity; and (d) self-awareness. If counselors were feeling insecure or uncertain about any of those issues, it was possible that they might have embellished their responses to compensate for their sense of ineffectiveness. However, it was assumed that embellishment did not occur in this study.

Furthermore, this investigation was in accordance with Rea's (2001) assumptions about clinical intuition. According to Rea, in order for clinical intuition to exist, counselors would not be able to predetermine clients' lived experiences based on manualized or diagnostic criteria. Rea also noted that counseling was not a practice of merely applying treatments to clients; rather, it involved a dynamic and therapeutic relationship. Therefore, it was assumed that counselors utilized more than rigid guidelines, techniques, and rules in the process of the therapeutic encounter.

Finally, this topic would not have been chosen were it not for the assumption that it was possible for clinical intuition to exist. That belief was extended into the idea that it

could be described. Petitmengin-Peugeot's (1999) investigation of intuition supported the argument that unconscious processes could be consciously reflected on. While her study examined the general experience of intuition, this current exploration assumed that intuition specific to counseling practice existed and was describable.

Delimitations

In an effort to minimize threats to the trustworthiness of this study, participant selection criterion was established. Erlandson et al. (1993) wrote that purposive sampling was a strategy that could strengthen the likelihood that researchers were investigating what they intended to study. Therefore, the participants in this study were intentionally identified in order to enhance the probability that they were describing professional counselors' experience of clinical intuition.

Accordingly, involvement in this study was based on several stipulations. First, counselors had to believe in the existence of clinical intuition in order to provide a description of this phenomenon. In addition, a minimum of clinical experience was necessary to ensure the possibility that participants have had the experience of intuition in a counseling context. Furthermore, a common training and educational foundation supported the likelihood that participants would share common themes in their perspectives that would lead to an emergent conceptualization of clinical intuition.

To regulate participants' training, education, and length of experience, only counselors who were LPCs in North Carolina were included in this study. This criterion ensured that participants shared similar training and educational experiences. The North Carolina Board of Licensed Professional Counselors (NCBLPC) stipulated that a LPC must have earned a masters degree in counseling, although licensure applications from

counselors who received graduate degrees in related fields can be reviewed and considered. The coursework in a graduate program in counseling was specific to the counseling profession and was different from related fields such as social work or psychology.

Additionally, the board required two years of post-masters experience in counseling, 2,000 hours of supervised experience, and 100 hours of individual supervision. As experience was inherent in models of intuition and counselor development (Loganbill et al., 1982; Welling, 2005), the licensure criterion established a way to regulate a minimum of experience. Furthermore, as supervision fostered counselor development by facilitating an integration of theory and experience (Stoltenberg et al., 1998), the stipulation of supervision experience supported the possibility that counselors were more likely to have had clinical intuitive moments.

Limitations

The phenomenological design of this study limited the ability to generalize the results. This kind of research required that an in-depth interviewing process occurred, which did not capture the necessary scope of participants to make inferences to all counselors' experiences of clinical intuition. Furthermore, the sampling size and inclusion criteria restricted inferences to clinicians in counseling-related fields, such as social work or psychology.

Summary

Developmental models of supervision have offered an understanding of counselors' growth processes, and pattern recognition models have provided a frame for the intuitive process. However, a lack of research existed regarding counselors'

experiences of the nature, role, and development of clinical intuition. Furthermore, if it was possible that intuition could be developed, then it behooved researchers to study it (Rea, 2002). This phenomenological investigation was designed to contribute a foundational piece to a greater comprehension of the essence of LPCs' experience of clinical intuition. Through comprehension interviews and a phenomenological analysis, a description of the core of clinical intuition emerged. This understanding marked the beginning of future investigations of the development of the intuitive ability and the role of supervision in that development.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

Philosophers mused for centuries about how we know what we know. In ancient Greece, Socrates posed that question to experts in their respective fields and discovered that they could not articulate the governing rules of their behavior. Rather, the artists and laborers described *what* they did without reducing it to *how* they did it. Plato wondered if experts' knowledge of the guiding rules of their trades moved from conscious awareness to unconscious memory as they gained more experience (Dreyfus & Dreyfus, 1986).

Philosophers also examined whether human understanding was holistic or reductionistic. Philosophers such as Kant and Plato believed that our experience was holistically understood. However, Locke, Aristotle, and Descartes argued that the world could be reduced to the 'ultimate given' (Rychlak, 1973). In this century, researchers examined the influence and interplay of analytic and holistic perception through studies of the nature of intuition (Atkinson & Claxton, 2000; Wilson & Schooler, 1991).

Further complicating the debate on human understanding was the division between philosophers who argued that some knowledge could originate from divine sources and those that contended that knowledge could come only from empirical investigations. Claxton (2000) traced that argument from the Enlightenment to the present and found that some philosophers described intuition as divine knowledge

belonging to the realm of mystery and spirit. More recently, scholars defined intuition as a kind of dialectic of emotion and reason. Despite disparate definitions, Claxton discovered that intuition was consistently discussed as a way of understanding the world.

In the past 20 years, intuition had been studied as a mechanism that informed professional judgments (Atkinson & Claxton, 2000, Benner et al., 1992; Dreyfus & Dreyfus, 1986). Counselors frequently claimed that they intuitively knew something, but failed to communicate how they became aware of that information (Berne, 1949; Williams & Irving, 1996). Williams and Irving claimed that counselors' inability to describe how they formed a clinical judgment would be considered negligent practice, were it true. At the same time, they argued that the concept could be articulated because intuition was merely a way of making sense of the world.

Williams and Irving (1996) also claimed that the wisdom of experienced counselors must be revealed to developing counselors in order for this profession to progress. According to Ronnestad and Skovholt (1993), the wisdom that came with experience was comprised of internalized and integrated experiences and knowledge. They further contended that counseling supervision provided a *method* for senior clinicians to impart their clinical wisdom and a *context* for supervisees to integrate that knowledge with new experiences.

Welling (2005) described intuition as a progression of phases which existed along a continuum. At one end, intuitive understanding was relatively outside of conscious awareness; at the other, within. When intuitive understanding was available to counselors' awareness, they examined its meaning in order to form an intuitive response.

Welling described that kind of reflection as an unraveling that allowed counselors to transition from *sensing what was happening to responding to what was required*.

Theoretical and empirical research on intuitive knowing had been conducted in the fields of nursing (Benner & Tanner, 1987; Paley, 2004), neuroscience (Gallese, Eagle, & Migone; Lieberman, 2000; McKinnon, 2005), education (Atkinson & Claxton, 2000), and cognitive psychology (Cohen and Andrade, 2004; Epstein, 1994; Lewicki, Hill, & Czyzewska, 1992). Across those fields, researchers defined and labeled the concept and process of intuition in various ways.

Ambiguity also existed with terms commonly associated with intuition, such as insight and extrasensory perception (Hodgkinson, Langan-Fox, & Sadler-Smith, 2008). Consequently, this literature review utilized a matrix in order to explore and integrate the points of similarity and places of divergence (see Table 1). This framework depicted how different aspects of the intuitive process have been researched and conceptualized within affective and cognitive realms during non-conscious and conscious states.

Table 1

Intuition Matrix

	Affective	**Cognitive**
Unconscious	Implicit Physiological Reaction Damasio (1999) Emotions de Rivera (1998) Emotions Gendlins (1978) Felt Sense	Implicit Knowing Cohen & Andrade (2004) Implicit Judgment Lieberman (2000) Neuroscience Kihlstrom (1987) Automatic Processes; Subliminal Perception, and Implicit Memory
Conscious	Explicit Response to Physiological Reaction Damasio (1999) Feelings	Explicit Knowing Lieberman (2007) C-System Epstein (2000) Rational System

The quadrants in Table 1 consisted of the constructs and the sources of research related to those constructs. A more detailed description of how these concepts were related to intuition was examined in subsequent sections. In this current section, the quadrants in the unconscious realm and the constructs that compose them were reviewed first, followed by the quadrants in consciousness.

In the unconscious affective quadrant, individuals' emotional reactions were outside of their full conscious awareness and were based in their physiological responses. Researchers such as Damasio (1999) and de Rivera (1986) noted the connection between physiological reactions to the environment and emotions. According to them, emotions move humans to take action based on cues in the current setting.

Damasio explained that the movement of emotions was due to chemicals in the bloodstream and neural impulses in nerve networks. Gendlin (1978) proposed that individuals could learn to focus on their otherwise unconscious felt-sense experience of those physiological reactions. Through a process of focusing, he outlined the ways an individual could access the somatic underpinnings of concerns and issues.

The constructs in the unconscious cognitive quadrant were also occurring outside of awareness. In this section of Table 1, an individual was not cognizant of learning knowledge, skills, and abilities. For instance, Cohen and Andrade (2004) demonstrated that individuals might have implicitly learned to adjust their mood in order to improve their performance on analytic or creative tasks. The results of an experiment to test that hypothesis suggested that people facing certain tasks engaged in strategies to alter their mood without knowing why they made particular choices.

As conscious awareness increased, the constructs in the conscious quadrants of Table 1 were brought into focus. Damasio's (1999) conceptualization of the nature of feelings placed this concept in the conscious affective quadrant. In his view, emotions were physiological changes and feelings were the neurological image of that change. He went on to suggest that the self was comprised of images of the state of the organism, just as feelings were made up of representations of an emotion. Therefore, people were aware of their feelings in the moment that the neural pattern of the self was connected to the neural pattern of feelings.

The shift from conscious feelings into the conscious cognitive quadrant was accompanied by reason and explicit understanding. Reik (1948) argued that an individual used reason to examine and evaluate that which was perceived by the third ear (the ear

that perceives what was not spoken). Following Reik's seminal work, the distinction between reason and the third ear continued to be explored and debated in the literature. Hodgkinson, Langan-Fox, and Sadler-Smith's (2008) review of the literature on this argument led them to include the notion that unconscious reasoning was based on a rational comparison of previous experiences and the current situation. That finding supported the theory that different styles of information processing were interrelated.

The matrix presented in Table 1 provided a container for the roles of emotion, cognition, and neurology which were inherent in implicit and explicit processes. Consequently, the implicit and explicit development of the intuitive process served as an organizing frame for the research presented in this review. A pattern recognition model was also presented in this chapter. That model was a continuum of intuitive processes and it incorporated elements that have been identified in Table 1. Then the concept and process of intuition as it pertains to clinical work was examined and followed by an overview of the development of the ability to use clinical intuition. This review concluded with a study of developmental models of counselor supervision and a glimpse into clinical intuition within counselor development.

While intuition had been examined apart from counselor supervision in both theoretical and empirical studies, the link between them had not been explored in the literature. Therefore, an examination of the connection between counselor development and clinical intuition contributed to an existing gap in the professional literature. For supervisors, this review provided implications for clinical practice in terms of supervisory roles, relationships, and interventions.

Intuition

Overview and Definition

Defining intuition provided a way to conceptualize what individuals knew and how they knew it. Depending on the context of the research, intuition and the processes that comprised it have been labeled in various ways. For the purpose of this review, Williams and Irving's (1996) description of intuition sufficed. They wrote, "On a truly phenomenological analysis, intuition did not differ from any other way of making sense of the world, and so should be capable of being analyzed and articulated" (p. 8). Therefore, for this review, intuition was defined as a way of making sense of the world. That definition was broad enough to encompass definitions that described intuition as an understanding that was reached without rational reflection and models of intuition that incorporated emotional, cognitive, unconscious, and conscious processes (Hodgkinson et al., 2008).

As this definition accounted for divergent ways of conceptualizing the term, it functioned as a foundation for investigations of clinical intuition. Inherent in this description were the assumptions that intuition existed, that it could be researched, and that it could be explained. Furthermore, this study asserted that intuition, particularly in a counseling context, had not been definitely understood. Easen and Wilcockson (1996) agreed with that perspective, noting that the various terms used to label and explain intuition had not been consistently described.

Related Terms

Intuition was frequently related to constructs that described phenomena that existed outside of conscious awareness. Implicit learning, tacit knowledge, extrasensory

perception (ESP), whim, heuristic thinking, and insight were terms that have been used either interchangeably with or in relation to the concept of intuition. Intuition had also been linked with creativity.

Many theorists and researchers also delineated intuition from terms that have been associated with it. Reik (1948) differentiated intuition from ESP by suggesting that ESP might have actually been an ability to utilize senses that were keener at an earlier time in our evolution. He described the capacity to send and receive messages that existed below the level of awareness as "instinct-reading" rather than "thought-reading" (p. 139). Moreover, in McKinnon's (2005) review, individuals with ESP were described as having the ability to access information beyond their current or past experience. Alternatively, he noted that people with intuition utilized information based on their personal experience.

McKinnon (2005) also distinguished intuition from the term 'whim.' He explained that the distinction between the two constructs was the ability to reflect upon and analyze how individuals came to know what they know. Concerning a whim, individuals did not have a connection to the experience that guided them to that moment. However, people with an intuitive awareness were able to consider the preceding process. Therefore, individuals could not trace the elements that make up a whim, but they would be able to reflect back to what composed an intuition.

The phrase 'heuristic thinking' had also been associated with intuition in the literature. Epstein (1994) defined the concept as a cognitive shortcut. Tversky and Kahneman (1974) examined the utility of heuristics in assessing complex situations. However, the focus of their work was on the errors in judgment that were frequently made when using this kind of process, rather than on the ways that heuristic thinking

provided efficient problem solving. Gigerenzer (2007) described heuristics as unconscious inferences and compared them to what the brain did to finish the pattern that was left incomplete by the eye. He explained that the eye had a blind spot because of the location of optical nerves in relation to the retina, and the brain used information from the surrounding environment to infer what should be there. Similarly, heuristic devices were general rules based on context and used to assess a situation.

Implicit learning and tacit knowledge have been linked to intuition as well. Reber's (1989) review of empirical research on implicit learning revealed that participants acquired tacit knowledge about complex rules of grammar and probability without an awareness of that process. Furthermore, his research supported the contention that implicit processes guided behavior. This notion was also explored in Damasio's (1999) research on individuals who sustained damage to different areas of the brain.

Additionally, the relationship between creativity and intuition was described throughout the literature. In a review of this connection from an information-processing system perspective, Hodgkinson et al. (2008) suggested that intuition guided the creative process by directing attention to new ways of conceiving a situation. Additionally, Reik (1948) compared the intuitive work of psychotherapists to the work of great writers, musicians, and actors, noting how those creative individuals have the capability to comprehend others' lived experiences.

Bohart (1999) further supported the contention that intuition directed the creative process. In his examination of the relationship of intuition and creativity in a therapeutic context, he proposed that counselors were creative when they transform an intuitive

awareness into an explicit form. Therefore, the creative process involved the movement of an implicit understanding into the realm of rational and conscious thought.

Insight was also associated with intuition. Although both terms share a quality of surprise, Reik (1948) described the difference, noting that insight occurs as a *flash* and intuition happens as a *flash-back*. In his view, intuition was the reappearance of previously conscious information, while insight was a novel awareness. Bowden and Jung-Beeman's (2003) research on insight, however, muddies this distinction. In their research on semantic activation, they proposed that a feeling of insight was generated when participants recognized a solution that they had previously been exposed to.

The differentiation grew clearer when the stimulus that activated either an insight or an intuition was considered. While Reik (1948) believed that individuals experienced an intuition when they flashed back to something that was once conscious, the results of Bowden and Jung-Beeman's (2003) experiment suggested that individuals experienced insight when they flashed to something that was never in conscious awareness. In their study, participants were instructed to identify whether target words were solutions to three word combinations. They then rated their experience using a scale anchored on one end by low insight (e.g., they used a problem solving strategy) and on the other end by high insight (e.g., they experienced a felt-sense of knowing with knowing how). Bowden and Jung-Beeman discovered that when participants had previously and unconsciously viewed target words, they were more likely to experience a feeling of insight when they identified the target word as the solution.

In another study on the feeling of insight, Bowers et al. (1990) presented participants with two word tasks and a gestalt closure task. In each study, participants

were able to identify that a group of words or a group of lines were associated without knowing how they were. For example, participants recognized that the words should go together (e.g., playing, credit, and report were coherent) even when they could not identify the solution word (e.g., card). Bowers et al. proposed that this study indicated that the process that leads individuals to discover solutions was not the same process that allows individuals to verify those solutions.

The preceding overview of related terms revealed some of the varied and multifaceted ways of understanding the intuitive process. A deeper examination into that process revealed how implicit and explicit properties of intuition involved both affective and cognitive elements. Furthermore, a pattern recognition model of intuition synthesized conscious, nonconscious, emotional, and rational processes.

In this review, implicit processes were synonymous with nonconscious processes. The term nonconscious described that which occurs outside of conscious awareness and is, therefore, rendered incapable of verbal description. Thus, implicit and nonconscious processes were ways of assimilating information without the required level of rational awareness needed to verbalize what had been processed (Schooler & Dougal, 1999). Alternatively, the term explicit was used to describe any process that occurred in conscious awareness and, as a result, could be verbalized.

Implicit Processes

Overview and Definition

The term implicit had been defined as an unexpressed understanding (Lewicki et al., 1992). In an effort to analyze implicit knowing, affective processes were separated from cognitive processes so that varied and complex interactions could be clarified. This

examination of implicit knowing did not maintain that emotional or cognitive responses were the same as intuitive understanding; rather, it asserted that affects and thoughts may be involved in intuition. Furthermore, the dynamic interplay between implicit processes, explicit functions, emotion, and cognition prevented a definite delineation between them. However, for the purpose of analysis and clarity, a differentiation was made in the following sections.

Theories of Processes in the Unconscious

A cursory overview of theories of the unconscious provided the foundation for an exploration of emotional and cognitive aspects of implicit processes. The degrees of the unconscious were predominately examined through Carl Jung's (de Laszlo, 1990) and Damasio's (1999) hypotheses. Those theorists provided a dynamic model of the unconscious based on movement from the collective to the personal unconscious.

McFarlane (2000) also noted that the unconscious existed along a continuum with universal elements on one end and personal elements on the other. The universal end was what Carl Jung (de Laszlo, 1990) termed the collective unconscious. This level did not consist of personal experiences that had been regulated out of conscious awareness; rather, this was the depository and wellspring of humanity's shared experiences.

Beyond the collective unconscious, the personal unconscious was encountered. Damasio's (1999) theory about feelings and the proto-self was related to this realm of the unconscious. Damasio described feelings and the proto-self as separate neural representations which existed below the threshold of core consciousness. In his theory, it was only when the two images were connected that the self knew it was having a feeling.

When the self was aware of a feeling, consciousness had been reached. Jung proposed that a threshold divides subliminal content from conscious awareness (de Laszlo, 1999). He theorized that an unconscious thought would emerge into consciousness only when a sufficient level of intensity within that thought was reached. Jung speculated, however, that unconscious material did not necessarily require a particular degree of energy in order to still exert an influence on an individual's conscious thoughts and behaviors. He described a complex as an example of how processes in the unconscious shaped an individual's response to his or her environment, noting that complexes manifested as habitual patterns of response which occurred outside of awareness. According to Jung, it was the function of psychotherapy to move these patterns into conscious awareness.

More recently, the threshold separating subliminal processing and conscious awareness had been explored through the work of cognitive psychologists. Reber (1989) used the phrase 'unconscious cognition' to describe the processes that formed the ground from which consciousness emerges. Research on implicit learning, automatic processes, subliminal perception, and implicit memory suggested that rather than an abyss of repressed knowledge, the unconscious actively responded to and guided behavior (Kihlstrom, 1987; Reber).

The unconscious appeared to exert influence on and be impacted by an individual's interactions with the world. Therefore, the affective and cognitive elements contained in the unconscious also effected and were influenced by the environment. The remainder of this section on implicit processes focused on the roles of emotions and cognition in the intuitive experience.

The Role of Emotion

Affective and unconscious processes were labeled emotions. Joseph de Rivera (1977) offered a review of major theories of emotions in his effort to identify the core concepts that formed his integrated theory. He concluded that emotions were more than the creations of instincts and values in that they arose from and gave rise to changes in the interactions between people and the world. According to de Rivera (1986), emotions were internal and relational states that were subjectively experienced and interpersonally determined.

In de Rivera's (1986) theory, emotions structured interactions between a person and the environment, thus providing information to an individual about how to behave in relation to others. For example, anger structured an interaction so that individuals would increase the distance between them and the objects of their anger, and love would structure an interaction so that individuals would decrease the distance.

Greenberg and Safran (1989) also described the form and function of emotions as related to interactions between a person and the environment. Those authors outlined the following four categories of affective responses: (a) emotions that provided a biologically-based drive to survive (e.g., love served an adaptive function in child rearing); (b) emotions that arose as responses to unexpressed or unmet emotional needs (e.g., anger as a reaction to hurt); (c) emotions that influenced the environment (e.g., the expression of sadness as a request for comfort); and (d) emotions that were habitual and conditioned responses to stimuli (e.g., fear in response to loud noises). Those groupings highlighted the ways in which emotions provided information and energy to interact with others.

Although emotions provided individuals with feedback regarding environmental stimuli, emotional reactions were frequently difficult to articulate and defend (Pretz & Totz, 2007). Therefore, an individual might have been able to describe an action, but not able to understand or identify the processes that prompted the response. Averill, Chon, and Hahn (2001) also conceptualized an emotion as a tendency to act that was based on experience. In their theory, behaviors were informed by emotional schemas that were created out of implicit beliefs and rules which have been formed through experience.

Those emotional reactions to the environment typified the processes found in the affective unconscious quadrant of Table 1. As previously described, Damasio (1999) made a distinction between emotions and feelings. An emotion occurred without conscious awareness, and a feeling was the self's awareness of experiencing an emotion. In support of this hypothesis, Damasio detailed an experiment that involved a woman with brain damage that rendered her incapable of recognizing faces. When presented with a series of photographs of faces, she could not consciously identify any of them. However, her skin-conductance response was different when she viewed familiar faces compared to when she viewed faces of strangers. Furthermore, her response varied in proportion to her intimacy with the familiar faces. In another study, Damasio (1999) reported that a woman with a compromised amygdala could not identify, express, or register fear or anger. Both studies contributed to the growing research on the neurological underpinnings of emotions.

Theorists also examined the interaction of biology and culture in the creation of emotions. In their study of the role of implicit beliefs and social rules in the creation of emotions, Averill et al. (2001) presented a theory that combined genetic information with

societal customs, forming an individual's tendency to respond in particular ways to the world. That emotional predisposition, directed by internalized and implicit beliefs and rules, dictated what was socially appropriate. Damasio (1999) agreed that cultural norms influenced what induced a particular emotional reaction, how that emotion was expressed, and what judgment was made about that expression.

Rustin (2003) also described how emotional learning was an implicit part of the socialization process. That researcher argued that emotional and behavioral responses were contextually influenced. Moreover, it seemed that the environment that gave rise to emotional responses also influenced unconscious cognitive processes.

The Role of Cognition

Researchers also studied implicit cognitive processes that influenced behavior (see Table 1). These processes indicated that people gained information without conscious awareness that they learned it or an ability to articulate *how* they acquired the knowledge. Based on a review of research in the field of cognitive psychology, Kihlstrom (1987) proposed that information processing was more complex than older models of serial processing had suggested. He proposed a newer model that described how unconscious knowledge impacted individuals' conscious way of being in the world, without their explicit awareness of that influence. That view implied that unconscious processes were actively involved in conscious experience.

Kihlstrom (1987) found that the cognitive unconscious was made up of automatic processes, subliminal perception, and implicit memories. He explained that automatic processes were the result of conscious behaviors that were repeated, and therefore, individuals learned complex procedures without explicit knowledge of the rules.

Furthermore, Kihlstrom noted that the information contained in subliminal knowledge was formed through unconscious perception, while the contents of implicit memory were once consciously known. Therefore, subliminal knowledge could not be consciously perceived, and implicit memory contained knowledge that could not be consciously remembered.

Researchers also devised experiential studies to test the validity of implicit knowledge. In one investigation, Cohen and Andrade (2004) discovered that participants engaged in mood-altering strategies without an awareness of how their actions enhanced their performance on upcoming tasks. In a series of four experiments, researchers discovered that participants choose music that either induced a positive mood when faced with a creative task or a negative mood when confronted with an analytical task. Their choices were determined without their prior explicit knowledge of how a negative mood enhanced analytic processing or how a positive mood improved creative thinking. Based on these findings, Cohen and Andrade proposed that participants' intuitive knowing directed their decisions about the type of music they selected.

Cohen and Andrade's (2004) research supported the theory that implicit learning and intuition were related, while Lieberman (2000) examined this connection from a social cognitive neuroscience approach. He studied the neural substrates of both processes and discovered that the basal ganglia was pivotal to both intuition and implicit learning. His research revealed that the basal ganglia encoded patterns of behavior based on associations formed through experience. Furthermore, when a particular sequence of events indicated that certain actions should occur, the basal ganglia activated a neural pattern that corresponded to the expected behavior, and then it alerted other areas of the

brain about the anticipated event. Therefore, the basal ganglia appeared to be directly involved with pattern recognition.

Additionally, researchers discovered evidence of a unique neural network system which supported the idea that intuition had a neurological base. Gallese et al. (2005) discovered that a particular pattern of mirror neurons was activated in both the observer and the observed. Consequently, a corresponding network of neurons was stimulated when an individual performed an action or observed someone else perform an action. Mirror neuron networks were also activated when an individual expressed an emotion or witnessed someone else display an emotion.

Damasio (1999) further examined the neural underpinnings of unconscious cognitive processes in an experiment that involved a man with temporal lobe damage and no short term memory. While the man could not learn new facts, he appeared to exhibit preferences. To study that possibility, three situations were created to test whether he favored certain people more than others. He interacted with a person who was friendly, a person who asked him to perform boring tasks, and a person who was neutral. Over the span of a week, this man engaged in each of the conditions at various times. Next, he examined pictures that included the friendly, tedious, and neutral individuals who were involved in this experiment. When asked to identify the picture of the person who would likely be his friend, he rarely chose the individual who asked him to engage in a tedious activity; he chose the neutral person with a probability close to chance; and he chose the individual who was friendly more than 80% of the time. These results were indicative of his ability to form preferences without the memory of meeting the individuals involved that study.

Other researchers have examined implicit learning in individuals without damage to the brain. In an investigation of how information was assimilated without conscious awareness of that process, Lewicki et al. (1992) examined how associations were formed. In their study, a personality feature was paired with a physical aspect of a stimulus. That association was followed by a pairing of the initial physical trait with a second physical characteristic. When presented with only the second physical trait, participants attributed the personality feature to it, although the two were only indirectly linked by association. This study supported the theory that complex learning occurred without an awareness of its occurrence.

Summary

A review of research on the roles of emotion and unconscious cognition illustrated how interactions were structured and learning occurred outside of awareness. As the empirical work of Lewicki et al. (1992) highlighted, individuals had the capacity to process vast amounts of information without the ability to verbalize either what they did it or how they did it. Furthermore, the work of Cohen and Andrade (2004) pointed to the complex interplay of emotions and cognition in participants' ability to unconsciously choose particular strategies.

The preceding overview of implicit processes captured the ways individuals knew without knowing how they knew. In a forthcoming section, research suggested that when the implicit became explicit, individuals had the capability to reflect on what they knew and could begin to tease out how they knew it. The following review of literature on dual process models of intuition served as a bridge between implicit and explicit realms.

Intuitive Understanding and Intuitive Responding

In a recent and thorough review of intuitive understanding and intuitive responding, Hodgkinson et al. (2008) characterized intuitive understanding as a process that was slow to learn, fast to perform, (e.g., a ballerina slowly learning the steps and then seamlessly dancing), contextual, unconscious, implicit, associative and reflexive. In contrast, intuitive responding involved processes which were fast to learn, slow to perform (e.g., a driver quickly learns the mechanics of driving a manual transmission and then slowly learns to actually drive), context-free, explicit, conscious, rational and reflective. Hodgkinson et al. proposed a dual-process model to account for the interactive processes within and between these two systems.

Hodgkinson's et al. (2008) review of those systems focused on the work of Seymour Epstein (1994). Epstein's dual-process model encompassed the information processing of system one (experiential) and system two (rational). System one and system two correspond with Lieberman's (2007) X-system (slow to learn and quick to perform) and C-System (fast to learn and slow to perform), respectively. The X denoted a reflexive way of processing information and the C signified a reflective and more conscious way. Therefore, intuitive understanding was in accord with system one and the X-system; and intuitive responding conformed to system two and the C-system.

On one side, Epstein (1994) described an automatic and fast performing reaction to the environment that might have served an evolutionary advantage. On the other side, he linked the rational system with the origin of creativity. The experiential and rational systems corresponded to unconscious and conscious processes. Table 2 presented and illustrated the parallel of these processes.

Table 2

Intuitive Understanding and Intuitive Responding

Unconscious →	Unconscious →	Conscious →	Conscious
Affective	Cognitive	Affective	Cognitive
Emotions	*Implicit Learning*	*Feelings*	*Rational*
System One: Experiential, Slow to Learn		→ System Two: Rational, Slow to Perform	
Intuitive Understanding →		→ Intuitive Responding	

In Epstein's (1994) view, creative processes produced the language and symbols which were expressed in the rational system. Essentially, words concretized implicit understanding. Epstein suggested that the interactive processes of both systems were responsible for behavior. Therefore, intuitive understanding and intuitive responding were interconnected and together produced action.

The interrelatedness of system one and system two was further revealed through a social cognitive neuroscience perspective. Lieberman's (2000) work on the basal ganglia discovered that the caudate was responsible for decoding the nonverbal communication of others, and the putamen was central to responding to those messages. His investigation of the neural underpinnings of implicit learning and intuition supported the contention that distinct but connected neural substrates were responsible for understanding and responding. This type of work contributed to the study of both implicit and explicit processes of intuition.

Explicit Processes

Overview and Definition

At the point when implicit processes have breached consciousness, the explicit response and an evaluation of the intuitive understanding could commence. In an effort to examine those processes, Laquercia (2005) described how the left hemisphere of the brain (the center of language) and the right hemisphere (the seat of abstract thought) operated in conjunction with the limbic system (the emotional center). That dynamic system allowed explicit responses to rise from affective reactions and unconscious knowing. Consequently, as was true with implicit processes, a clear delineation between emotions and thoughts did not appear to exist. However, for the purpose of this review of the factors inherent in explicit processes, affect and cognitions were artificially and incompletely separated.

Theories of Processes in Consciousness

An overview of theories of consciousness provided a base for a further exploration of the affective and cognitive elements of explicit processes. Speculation about the movement from the unconscious to consciousness was reviewed. This progression suggested that increasing levels of awareness existed in the unconscious and consciousness.

Jung stated that the psyche, comprised of the unconscious and consciousness, was the meeting ground and place of struggle between instinct and free will (de Laszlo, 1990). Jung's theory of the psyche illustrated his belief in the interconnectedness of the unconscious and consciousness. That interrelatedness was viewed as an emergence of consciousness from the unconscious. Bowers et al. (1990) proposed that consciousness

occurred when a cognitive pattern had been sufficiently activated to move unconscious awareness to conscious awareness. That movement implied that the unconscious and consciousness existed on a continuum.

Corresponding to the idea of a continuum of consciousness, Newman (2001) described orders of consciousness. The first-order consisted of what one knew or perceived but not *how* one knew it. Consequently, an individual could understand why something worked without fully comprehending how it did.

The second-order concerned *how* we knew. In the first-order, an individual could have a feeling without an accompanying insight into its causes or consequences. However, in the second-order, an individual could understand the antecedents of feelings.

The third-order seemed to be the conscious version of Carl Jung's collective unconscious and it was the location of myth. Jung discriminated between archetypal images and the archetypes themselves. He noted that once an archetype moved from the collective unconscious to conscious awareness, it was no longer the thing itself but a representation. He reasoned that the difference explained the variations of archetypal themes found among people, cultures, and history (de Laszlo, 1999).

This cursory review of theories of consciousness created the stage for the following overview of the roles of emotion and cognition in a conscious state. When affect and thought emerged into conscious awareness, an individual was able to reflect and intentionally respond to the environment, rather than react.

The Role of Emotion

Theoretical models of emotions (de Riveria, 1986; Greenberg & Safran, 1989) suggested that an individual's awareness of an emotion was the first step in responding to

the environment. Greenberg and Safran proposed that individuals intentionally responded when their awareness was followed by an acceptance of their emotional reaction. In their theory, individuals who accepted and comprehended their emotional *reaction* had the ability to transform it into an emotional *response*.

Damasio (1999) described how emotions might have emerged into awareness. He argued that a self was necessary to consciously experience a feeling. Therefore, when a neural pattern corresponding to the proto-self was connected to the neural representation of emotions, the self was aware of a feeling. The self was the 'I' in 'I feel a feeling' and 'I know that I know.'

The Role of Cognition

Berne (1949) maintained that implicit understandings could be transformed into language. Decades after Berne's publications on intuition, the capacity to articulate previously tacit information continued to be supported by theorists (Welling, 2005; Williams & Irving, 1996). Laquercia (2005) credited the efforts of the brain's left and right hemispheres for an individual's ability to understand an intuition and then verbalize that knowledge. He noted that the logical and verbal center of the left brain ascribed meaning to processes in the abstract and creative center of the right brain.

He went on to discuss the role of the limbic system as the seat of memory and feeling. When both hemispheres and the limbic system were operating in concert, Laquercia (2005) proposed that the integration of past experiences, perceptions, and knowledge formed intuitive knowing. Rustin (2003) described this kind of cognitive processing as a way to make sense of emotions, sensations, and perceptions. These

researchers credited the brain with organizing and attributing meaning to both tacit and expressed information.

The influence of rational processes on intuition. Although conscious and cognitive processes were involved with making sense of the world, speculation existed about whether rational awareness interfered with or, alternatively, facilitated intuitive understanding. Therefore, the question of whether or not intuition involved both implicit and explicit processes expanded to include questions of how and when intuition was influenced by conscious and unconscious awareness.

In a study of intuition, Berne (1949) examined both processes. Through his work in an Army Separation Center, Berne noticed that processing agents were quickly able to identify the occupation of the men they had interviewed. The results of his investigation supplied a list of observations that an agent then utilized to form intuitive judgments about future recruits. When those explicit instructions were then used in subsequent assessments, the ability to form correct impressions declined. However, Berne believed that the diminished accuracy was caused by an incomplete set of instructions that did not contain all of the necessary criteria to make an intuitive judgment. He tested that theory and discovered that the accuracy rate increased when more criteria were added to the instructions.

However, recent research on the brain's role in learning and intuition suggested that explicit instructions to facilitate implicit learning might have interfered with the formation of unconscious associations (Lieberman, 2000). Reber (1999) suggested that verbalized instruction slowed the process of learning complex rules of grammar. Furthermore, this kind of interference was similar to Berne's (1949) finding that the

accuracy of assessment decreased when agents consciously attended to certain criteria (e.g., eye contact), while ignoring others.

Furthermore, Reik's (1948) contended that poised attention was a necessary element of the intuitive process, which had implications concerning the timing of explicit guidance. His description of the role of attention suggested that verbalized instruction had the power to direct clinicians' attention to particular information and away from other cues. Consequently, the counselor was not able to form a gestalt of the clinical situation.

Additionally, intuition might have been impacted by conscious reflection. Empirical research on the impact of reflection revealed that participants altered their more accurate initial responses based on their conscious analyses of their judgment (Wilson & Schooler, 1991). Wilson and Schooler examined individuals' preferences for a particular brand of jam and found that the participants' initial judgments corresponded with those of the experts. However, when participants were directed to evaluate their responses, judgments were changed and were, consequently, no longer in agreement with the experts.

Wilson and Schooler (1991) theorized that individuals who were not consciously aware of their attitudes examined aspects of their preference that were more easily articulated. This finding suggested that individuals who were more conscious of their implicit beliefs were more likely to trust their initial assessments. This theory had implications for counselors' ability to trust their intuition. Based on Wilson and Schooler's proposal, counselors' awareness of their attitudes might have supported their willingness to attend to their intuitive understandings and then initiate intuitive responses.

However, that study examined judgments made by individuals who did not have experience with the research task. Wilson and Schooler (1991) then compared those subjects' preferences (with and without conscious analysis) to individuals who were experts in that area. Compared to the experts, the novice participants did not have the associational information to draw on and, consequently, did not have a possibly essential element of intuition. Therefore, this study might have been more of a reflection of novice decision making rather than intuitive judgment.

Wilson and Schooler's (1991) research left the question about the impact of conscious awareness unanswered. In an effort to provide such answers, studies in the field of social cognitive neuroscience have focused on the impact of attention on individuals' capacity to form judgments. For instance, Lieberman (2007) examined the mechanisms behind internal and external reflection. His work revealed that the neural correlates of someone who was focused internally were distinct from the correlates of someone who was focused externally. Consequently, when individuals reflected on their internal thoughts, sensations, or emotions, different neuron structures were activated than when individuals were observing the external world. That evidence invited the notion that counselors would be able to reflect on either external or internal processes without diminishing their awareness. Therefore, when counselors examined their internal sensations and thoughts, a different neural substrate would be activated and engaged in the process of attending to external cues, such as client behaviors. Accordingly, it would be plausible that counselors could actively strive to increase their awareness of what was happening in the moment without disrupting the clinical flow.

Summary

In the preceding description of the roles of conscious feelings and thoughts, the impact of emotional reactions and rational processes on intuition and behavior was explored. As previously noted, the distinction between affect and cognition had been made for the purpose of explanation and clarity. However, in an individual's actual lived experience, it appeared that affect and reason was dynamically integrated (Carter, 2003). According to Carter, neuroscience created a bridge between the brain and the heart. The study of the brain also supported the theory of intuition based on pattern recognition (Lieberman, 2000).

Pattern Recognition Model of Intuition

As early as 1949, Berne defined intuition as way of forming judgments based on accumulated experiences and information. Furthermore, he hypothesized that intuition was comprised of both unconscious perception and conscious articulation. While his theory was not proven false, researchers in the past ten years furthered the exploration of this process through a model of pattern recognition (Bohart, 1999; Eisengart & Faiver, 1996).

Williams and Irving (1996) explained how individuals attributed meaning to tacit sensations and emotions through a cognitive process of matching new experiences with existing patterns. Bohart (1999) used the term 'schema' to describe established patterns that were formed from experience and were utilized to understand the world.

Furthermore, the pattern recognition model provided a continuum of concepts and processes that seemed to integrate both sides of the debate on intuition concerning the roles of rational versus unconscious information processing. As Bohart (1999) noted,

counselors used both ways of knowing to recognize and understand what was happening with their clients. Table 3 depicted a continuum of unconscious to conscious processes and contrasted it with the pattern recognition model.

Table 3

Continuum of Intuitive Process

Unconscious Affective to Conscious Cognitive

Unconscious Affective	Unconscious Cognitive	Conscious Affective	Conscious Cognitive
Emotions	Implicit	Feelings	Rational
Physiological	Automatic	Explicit Response	Logical
Reaction	Procedural Learning		

Implicit Processes →→ Explicit Processes

*Unconscious *Receptive *Understanding →→→→ Conscious *Reflective*Responding*

Welling's (2005) Pattern Recognition Model

Detection Attention	Dichotomic Awareness	Related Object	Metaphorical Solution	Explicit Verbal Understanding
Attention Peaked	Sense of peculiarity	Aware of related elements	Image, Sound, Taste, Smell	Able to articulate Meaning

The pattern recognition model provided another way to conceptualize the intuitive process and to organize unconscious, conscious, affective, and cognitive mechanisms. Welling's (2005) five-stage pattern recognition model provided a structure for the process of intuition so that it could be understood and intuitive knowing could be articulated. This model also provided a framework to organize related concepts and relevant research.

The first three stages were linked with a sensory awareness of an experience that matched or contrasted with past experiences. That conceptualization was supported by Eisengart and Faiver's (1996) notion that intuition was only possible because one had a memory of past experience that could be aligned with the current situation. That idea also corresponded with Gobert and Chassy's (2008) thoughts about perceptual detection. In their template theory, professionals learned from reoccurring situations to organize incoming stimuli into patterns and then to form those patterns into templates. According to this theory, information and experiences were stored in long-term memory and rendered unconscious until an environmental cue activated the template and brought it into conscious awareness. Thus, the process of pattern recognition involved accessing that unconscious perceptual information.

Bowers's et al. (1990) study on individuals' ability to identify whether an incomplete pattern was either coherent or incoherent was also in accord with the pattern recognition theory. In those tests of coherence, individuals did not feel secure about their responses even when they were accurate. Bowers et al. suggested that participants' insecurity might have been based on their inability to articulate how they knew what they knew. That study supported the notion that the recognition of patterns may occur without full conscious awareness.

Welling's (2005) model provided an outline for how those patterns were activated and then assessed for relevance and meaning. In the first phase, a diffuse but pressing feeling alerted and directed an individual to attend closely to a stimulus. Bohart (1999) described that experience as a sensation that something was not right, triggering a desire to determine what "that something" was.

Following that initial stage of increased attention, an individual then had a global sense of something that was a familiar or strange. In Welling's (2005) second phase, an individual had a feeling that something was incomplete, amiss, or familiar. That felt-sense, described by Gendlin (1978), captured the holistic-physiological sense that was representative of this phase. In this second stage, attention was not focused on any one particular aspect of the situation. Gobet and Chassy (2008) described the importance of unconscious perception at this point in the intuitive experience, noting that conscious attention may restrict observations.

This second phase was supported by an empirical study that examined the accuracy of judgments based on silent video clips of professors. Ambady and Rosenthal (1993) found that participants' assessments of the professors in those short videos were predictive of the ratings given by students who learned from the instructors for an entire semester. Relevant to this phase of the pattern recognition model, the accuracy of the judgment was based on global behaviors and not micro-behaviors. That is, the observers who rated the professors according to gestalt descriptors (e.g., accepting or confident) were more accurate than those who made judgments based on specific behaviors (e.g., touched head or leaned forward).

By the third phase, an individual was able to connect a felt-sense with something specific, but was still unable to fully comprehend the meaning of the current situation (Welling, 2005). Particular cues were more apparent than others and attention was drawn to those details. As English (1993) noted, when the expected events in the current situation did not happen, an individual would focus on that incongruence. In this stage, a

previously felt sense of familiarity or oddness was integrated with an awareness of the specific cues that were generating that reaction.

In Welling's (2005) fourth stage, awareness was accessible through forms such as metaphors or music. Although an individual was now able to detect a pattern, the meaning was still not completely understood. Bohart (1999) described this moment as an unexpected awareness of feelings and thoughts. That unbidden understanding corresponds with Kaplan and Simon's (1990) definition of insight. This metaphoric phase also seemed consistent with Bohart's (1999) conceptualization of creativity as the symbolic and concrete representation of implicit thinking, which transformed thought into explicit words.

It was not until the fifth phase that a complete understanding was realized. This stage corresponded with the conscious cognitive quadrant in Table 1. In this final moment of the intuitive process, one was able to articulate the information provided in the felt sensations and perceived images of former phases.

Welling's (2005) model offered a way to conceptualize how counselors might increase their awareness of the intuitive process *during* its development. Schon (1983) termed that possibility 'reflection-in-action,' noting that professionals examined what they were doing while they were doing it. Eisengart and Faiver (1996) also explained that the function of analysis was to examine, verify, and develop intuitive understanding. Therefore, analysis during and following the process of intuitive knowing provided a way to heighten counselors' attention to the process, confirm its accuracy, and elaborate on the intuitive information. Clinical intuition might have be impacted when counselors consciously brought their attention to their felt sense during Welling's (2005) first phase;

actively noticed whether something felt amiss or familiar during the second phase; gave their energy to the connection between their feeling and what was happening during the third phase; and trusted the image they might have received the fourth phase.

Clinical Intuition

Overview and Definition

When counselors ascribed meaning to their comparison of patterns in a current situation and patterns in previous experiences, they were engaged in an aspect of their intuitive process. Eisengart and Faiver (1996) explained that clinical intuition formed when the current clinical situation aligns with or deviates from previous counseling experience. Rosenblatt and Thickstun (1994) also noted that experienced counselors were more likely than novice clinicians to match patterns from previous clinical situations to the current clinical presentation.

Furthermore, Rosenblatt and Thickstun (1994) emphasized the difference between the *process* of intuition and the *ability* to intuitively respond to a clinical situation. The process was the experience of clinical intuition in the moment of occurrence. The process happened in a counseling session and may be based on pattern recognition. *In contrast,* the ability to use intuition occurred over the course of a counselor's development.

While Welling's (2005) pattern recognition model detailed an intuitive process, professional development models provided insight into the development of the ability to use intuition (Dreyfus & Dreyfus, 1986). A comparison of the intuitive process and professional development was presented in Table 4. The development of a clinician's ability to intuit a situation required knowledge and experience (Benner, Tanner, & Chesla, 1992; Lyneham, Parkinson, & Denholm, 2008). Empirical studies on semantic

activation (Bowden & Jung-Beeman, 2003) and word groupings (Bowers et al., 1990) supported the contention that insights, hunches, and solutions were based on previous knowledge and experience. As professionals transition from novices to experts, their process of organizing and understanding incoming stimuli was qualitatively different (Gobet and Chassey, 2008). Consequently, the experience of clinical intuition might have changed with different levels of development.

Table 4

Parallel of the Intuitive Process and the Development of the Intuitive Ability

Welling's (2005) Pattern Recognition Model				
Detection Attention	Dichotomic Awareness	Related Object	Metaphorical Solution	Explicit Verbal Understanding
Attention Peaked	Sense of peculiarity	Aware of elements related to peculiar	Image, Sound, Taste, Smell	Able to articulate Meaning

Context-free Data →Sense of Relevance →Aware of Context→ Aware and Responsive

Does not Know What was Required→Aware but Cannot Respond→Aware and Responsive

Novice to Expert Model of Intuitive Ability (Dreyfus & Dreyfus, 1986)				
Novice	Advanced Beginner	Competent	Proficient	Expert
Context-Free Rules guide Behavior	More Aware in the moment	Plan but not accommodate to changes	Aware of relevant changes	Aware and responsive to changes

The Development of Clinical Intuition

The development of clinical intuition was viewed as the *long-term development of the ability to use intuition* in a clinical setting (Benner et al., 1992). This definition was in contrast to the *experience of clinical intuition* that occurred during a counseling session.

The development of clinical intuition had been explored in the fields of nursing and education. Researchers in those professions have extensively studied the interplay of theoretical knowledge and clinical experience in professional development (Atkinson & Claxton, 2000; Benner et al., 1992; Eva, Hatala, LeBlanc, & Brooks 2007; Gobert & Chassey, 2008; King & Appleton, 1997). That research was based on the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1986), and it was used to explore clinical intuition in the novice, advanced beginner, competent, proficient, and expert stages of practice.

The following overview of the novice to expert model was utilized to depict the development of the ability to use clinical intuition. *The necessity to utilize research from allied professions to explore the intuitive ability underscored a need in the counseling field to examine the development of the ability to use clinical intuition*. While a subsequent section in this chapter highlighted a similar issue regarding the process of intuition (the process of clinical intuition within counselor development was examined through literature in the field of nursing), the following review was focused on the long-term development of the clinical intuitive ability.

In the novice stage, context-free rules dominated, and clinicians were less likely to consider the subtle cues in a situation. Rather, novices utilized facts and theoretical information to solve problems in a trial and error fashion (Gobet & Chassy, 2008). Although this heuristic thinking was an effort to increase the response rate to a presenting situation, it frequently led to errors in judgment (Tversky & Kahneman, 1974). Furthermore, the speed that was acquired through this error-prone process was impeded by the necessity to consciously integrate textbook knowledge into their current

experience (Gobet & Chassy). Consequently, the use of clinical intuition might have been impeded or absent at this stage of development.

In the next stage, the advanced beginner possessed an ability to perceive current circumstances. However, this clinician probably did not consider the context of what came before and what might come next. For instance, Benner et al. (1992) noted that advanced beginners assessed the current clinical situation based on the information they learned in school. At this point, they lacked the experience that would direct their attention to relevant changes, characteristic of phases one and two in the pattern recognition model of intuition. Furthermore, they have not developed the competence to anticipant changes in the future.

During the third stage, Benner et al. (1992) explained that competent clinicians were able to set goals and then implement plans to meet those goals. However they were not able to detect or respond to changes in the plan. Tasks to be accomplished served to organize their perception of the current situation. At this level, practitioners also struggled to identify relevant changes in the clinical situation.

In the fourth stage, proficient clinicians were no longer focused on predetermined goals. They attended to the presenting situation and detected changes in pertinent cues. They noticed when changes occurred because they had patterns to compare to the current situation. While competent professionals adhered to established goals and interventions, proficient clinicians adapted those goals to what was relevant in the present moment (Benner et al., 1992).

Finally, when professionals reached the level of expert, they noticed the relevance of continually changing circumstances. Additionally, they assimilated more information

than they did at earlier times in their development (Benner et al., 1992). Essentially, experts recognized how the current situation fell into or out of a pattern, and they quickly adapted their interventions according to changes in the clinical situation. Relative to Welling's (2005) model, expert clinicians' ability to recognize patterns signified their ability to intuitively respond to current circumstances.

The novice to expert model had been used by nurses and teachers as a way to understand the development of the intuitive ability in a professional context (Atkinson & Claxton, 2000; Benner et al., 1992). Developmental models of counselor supervision provided a similar conceptualization of how counselors moved from beginning stages to more advanced ways of understanding and responding to the clinical picture.

Developmental Model of Counselor Supervision

Definition of Clinical Supervision

Loganbill et al. (1982) defined clinical supervision as "an intensive, interpersonally focused, one-to-one relationship in which one person was designated to facilitate the development of therapeutic competence in the other person" (p. 4). That definition captured the supervisory relationship, the supervisor's role, and the supervisee's ultimate goal (therapeutic competence).

Developmental Model of Counselor Supervision

In addition to providing the definition of supervision utilized in this chapter, Loganbill et al. (1982) also introduced the developmental model of supervision to the counseling profession. In this supervision model, counselors progressed from a beginning stage marked by a focus on skills and techniques to a final stage characterized by an

integration of knowledge, experiences, and awareness. This development corresponded to Benner's et al. (1992) application of the novice to expert model to clinical practice.

In the years following Loganbill's et al. (1982) publication, the developmental model of supervision had dominated practice and research (Stoltenberg et al., 1998; Watkins, 1995). Inherent in the developmental paradigm was the assumption that counselors progressively integrate therapeutic skills, theoretical knowledge, self-awareness, awareness of clients, an integration of professional and personal identities, and awareness of the therapeutic process and relationship (Loganbill et al., 1982; Stoltenberg et al.). Thus, the developmental model depicted a progression and an integration of counselors' skills, experience, and a personal and professional identity.

Counselor Development

Loganbill et al. (1982) argued that counselor supervisors provided the means and context for the integration of counselors' skills, theories, experiences, awareness, personal identities and professional self-concepts. Counselors began their developmental process with a motivation to appear competent and to find the right solution to a clinical problem. As they developed, the anxiety of earlier stages decreased and was replaced with the ability to better understand clients' lived experiences.

With continued development, counselors were able to integrate their awareness of clients' assumptive worlds with the knowledge that had accumulated through their education and training (Loganbill et al., 1982). Counselors with more experience incorporated greater amounts of information about the clinical situation and the changing needs of the client. In a study of 100 counselors, Skovholt and Ronnestad (1992) found

that advanced clinicians were better able to identify relevant information within clients' presentations.

Furthermore, the developmental model of supervision illustrated the evolution of counselors' awareness of themselves, their clients, and the counseling process. For instance, Stoltenberg et al. (1998) depicted counselors at level three as capable of balancing their awareness of themselves with their awareness of the client. At this level, counselors had the necessary self-awareness to process their own emotions and thoughts, while simultaneously attending to the inner experience of clients (e.g., attending to nonverbal communication and subtle cues).

Agass (2002) further asserted that awareness of internal reactions was a prerequisite to effective clinical work. He explained that counselors' reactions were often their countertransference to clients, requiring counselors' attention and exploration. Furthermore, Peabody and Gelso (1982) stated counselors who possessed a heightened awareness of their inner emotional world were more likely to be empathic. Counselors' ability to have an awareness of both themselves and their clients was also inherent in Rogers' (1992) definition of empathy.

Furthermore, counselors' self-awareness informed their empathic responses (Stoltenberg et al., 1998). Rogers (1992) stated that empathy was a vital component to both clients' change process and counselors' ability to distinguish between their own experience and their clients'. In order to achieve the degree of empathy apparent in later stages of developmental models, supervisors were required to provide the necessary interventions to assist supervisees in their growth.

As counselors gained increasing levels of self-awareness through the supervisory process, they were better able to understand and articulate their emotional reactions. Young (2005) explained that clients benefited from counselors' ability to identify and differentiate among the myriad of emotions within themselves, their clients, and the clinical interaction. Therefore, counselors were charged with the task of attending to their emotional experiences, distinguishing their own experiences from their clients (Rogers, 1992), and articulating their understanding to their clients (Young). The benefit of verbalizing an empathetic understanding seemed related to the impact of articulating an intuitive awareness: Clients were given a deeper and broader understanding of themselves or their situations.

Additionally, counselors who were aware of their emotional reactions to clients utilized that knowledge to construct responses that served a regulatory function for clients. Gallese et al. (2005) provided research that supported the notion that clients' emotional reactions may be moderated when they observed their counselors' emotional responses to them. As individuals witnessed a shared but dampened emotional response in others (their counselors), mirror neurons activated a pattern that signaled a decrease in emotional intensity.

Moreover, counseling supervision was a forum for the development of counselors' awareness and the emergence of a counselor identity (Stoltenberg, 1981). Supervisors supported that development by facilitating the counselor's awareness of self, client, and the process. When that awareness combined with theory, counselors progressed through the developmental stages. Integrated awareness, experience, and knowledge also seemed to be involved in the development of the ability to use intuition.

However, clinical intuition as a separate phenomenon was not listed as an issue in counselor developmental models.

Clinical Intuition within Counselor Development

Overview and Conceptualization

Clinical intuition as a component of counselor development concerned the *experience* and *process* of clinical intuition, rather than the *development of the intuitive ability* which was previously reviewed. Therefore, in this section, consideration was given to the inclusion of clinical intuition as another issue in counselor developmental models of supervision.

Loganbill et al. (1982) argued that supervision offered a context for counselors to process and integrate experience and knowledge. Therefore, counselors had a forum to examine the emerging patterns in their clinical practice. They also had a place to explore how those patterns were matching or deviating from preexisting expectations. Welling (2005) contended that those patterns must be analyzed and understood in order to progress from an intuitive sense of a situation to an intuitive response.

According to Welling's (2005) five-stage model of pattern-recognition, intuitive knowledge developed from an initial sense of alertness to a final articulation of how a current situation fit with or deviated from previous clinical experience. Consequently, counselors should be able to trace and describe their felt-sense of the situation at the beginning of the process, their detection of the cues that were drawing their attention, and their rational analysis of what their intuitive experience was concerning. Supervision created the time and context for counselors to reflect on that process.

Clinical Intuition within Professional Development

Developmental models of counselor supervision posited that as counselors gained more experience, the roles and tasks of supervisors changed with the needs and issues of counselors (Loganbill et al., 1982). For instance, supervisors were more likely to be in a teacher role in the early phase of a counselor's career. However, the instructional interventions that facilitated growth in the beginning may not be as warranted as counselors gain experience.

Although a parallel existed between developmental models of supervision and the development of the intuitive ability (see Table 4), the lack of research in this area required that the link between the two was examined through research from another professional field. The need to utilize research from the field of nursing also highlighted the need for research on counselors' *experiences* of clinical intuition.

In an exploratory study of nurses' clinical judgments and decision making processes, Holland and Noerager (1983) discovered that nurses integrated theory, field experience, self awareness, and patient cues. Those findings corresponded with components of the intuitive process outlined in the pattern recognition model and in counselor developmental models. For instance, patterns emerged from knowledge and previous experience and were then compared to novel situations. The contrast was necessary in order for clinicians to feel the quality of familiarity or incongruence depicted in Welling's (2005) second phase.

Additionally, the identification of patient cues was similar to Welling's (2005) description of the third (related objects) and fourth (metaphoric) stages. Research on implicit learning (Lewicki, 1986; Lewicki et al., 1992) also suggested that awareness of

those cues occurred on both an unconscious and conscious level. Unconsciously, the clinician might have attended to a spectrum of behaviors.

Alternatively, clinicians were also consciously aware of attending to salient features of the situation. Reik (1948) insisted that nonverbal communication (e.g., the slight muscle twitch, the adverted eye, or the blushed check) provided a greater amount of information than articulated words. Therefore, whether it was implicit or explicit, counselors registered information about clients.

Furthermore, Holland and Noerager (1983) discovered that attention to sensory clues was a component of how clinicians assessed and diagnosed. This self-awareness corresponded with the conscious affective realm of Table 1. Reik's (1949) written reflection of his own process offered concrete examples about the information provided by his internal reactions. Through a reductionistic process, Reik identified the steps that brought him to an intuitive awareness. Importantly, he articulated it so that future analysts could read about his intuitive process.

Reik's (1949) ability to verbalize his internal process suggested that supervisors and counselors could do the same. In the field of nursing, English (1993) also contended that the 'gut reactions' of expert nurses needed to be articulated to novice practitioners. English agreed with Benner et al. (1992) about the function of experienced clinicians to act as role models to students. He went on to assert that as role models, experienced professionals needed to teach the process of intuitively identifying a presenting problem.

Additionally, supervisors provided explicit guidance to counselors about utilizing clinical intuition. For example, Eva et al. (2007) provided different ways of instructing new students to diagnose cardiac problems. When those diagnosticians were told to

utilize a combined reasoning approach with data from electrocardiograms, their accuracy was higher than students who were given no instruction. The combined approach demanded that students rely on a global sense of an emerging pattern while also focusing on salient features of the presenting data. The students who did not receive that kind of supervision did not perform as accurately.

Summary

This review of the literature presented intuition as a way of understanding the world based on the recognition of patterns that formed as the result of experience. An apparent connection existed between the patterns that formed through clinical experience and the development of clinical intuition. Table 5 illustrated the progression of the intuitive experience, the development of the ability to use it, and the development of counselors. However, while the development of clinical intuition had been examined in allied fields, it had been given little attention in the field of professional counselors.

Table 5

Meta-Model of Intuitive Process and the Development of the Intuitive Ability

Intuitive Process: Unconscious Affective to Conscious Cognitive			
Unconscious Affective	Unconscious Cognitive	Conscious Affective	Conscious Cognitive
Emotions	Implicit	Feelings	Rational
Physiological Reaction	Automatic Procedural Learning	Explicit Response	Logical

*Unconscious *Receptive *Understanding →→→→ Conscious *Reflective*Responding*

Table 5 (continued)

Intuitive Process: Welling's (2005) Pattern Recognition Model

Detection Attention	Dichotomic Awareness	Related Object	Metaphorical Solution	Explicit Verbal Understanding
Attention Peaked	Sense of peculiarity	Aware of elements related to peculiar	Image, Sound, Taste, Smell	Able to articulate Meaning

Context-free Data →Sense of Relevance →Aware of Context→ Aware and Responsive

Does not Know What is Required→Aware but Cannot Respond→Aware and Responsive

Novice to Expert Model of Intuitive Ability (Dreyfus & Dreyfus, 1986)

Novice	Advanced Beginner	Competent	Proficient	Expert
Context-Free Rules guide Behavior	More Aware in the moment	Plan but not accommodate to changes	Aware of relevant changes	Aware and responsive to changes

Merging of Personal and Professional Identity into Integrated Counselor Identity

Self-Conscious → Self-Aware → Aware of Client → Aware of Process → Integration of Awareness

Developmental Models of Supervision (Loganbill et al., 1982; Stoltenberg, 1998)

Dualistic thinking	Disequilibrium	Able to detect and Respond to what is required
Context-free rules	Predetermined plans	
Search for the one correct Answer	Cannot see changing relevance	

Furthermore, developmental models of counselor supervision were reviewed, and the lack of research on the nature of clinical intuition within these models was highlighted. While intangible issues such as awareness and countertransference have

been studied in relation to counselor development, clinical intuition had not been explored.

This literature review supported the need for research on the role of clinical intuition in counselor development. However, an understanding of counselors' experience of clinical intuition was necessary prior to an extensive investigation of the development of counselors' ability to use clinical intuition. Therefore, this phenomenological investigation contributed to the research base by gathering, analyzing, and synthesizing LPCs' perspectives of experiences of clinical intuition.

CHAPTER 3: METHODOLOGY

The methods used to explore and discover how counselors experienced clinical intuition were described in this chapter. The design, participant selection, data collection, and data analysis utilized in this study were explained. My efforts to establish trustworthiness were detailed, and my reflections on the research process were presented.

Qualitative Research Paradigm

This study of clinical intuition was a qualitative investigation of counselors' experiences. Denzin and Lincoln (2005) explained that qualitative research was an attempt to understand the meaning of phenomena within the experience of those in their natural settings. They went on to compare the role of the researcher to a quilt maker who weaves threads of a shared reality. The result was an emergent interpretation of the experiences of individuals who provided the fabric, textures, and colors.

Denzin and Lincoln (2005) described how qualitative research was understood through perspectives that varied with the worldview of the researcher. For instance, the positivist maintained that an objective reality existed which could be explored and understood, while the critical theorist believed that reality was socially construed. Despite that complexity, Denzin and Lincoln proposed a definition of qualitative research that described the essence of different paradigms. They wrote that qualitative researchers situated themselves in the world, studied the lived experiences of individuals, and formed representations of those meanings.

The process of qualitative research also emerged from various ways of understanding the world. Denzin and Lincoln (2005) described the common approaches involved in this kind of research. The crucial elements in qualitative research were the role and worldview of the researcher, the methods used to explore individuals' experiences, and the type of analysis utilized to understand the meaning of the phenomena. Thus, the researcher had a particular set of interpretive practices that he or she used to make sense of the world. The ways the researcher comprehended the world was then brought into contact with the ways the observed individuals made sense of their world. That interpretative approach to qualitative research promoted a holistic view of observed individuals' lived understandings within the context of their individual lives.

The interpretative tradition also acknowledged the role of the researcher's worldview on how the experiences of others were studied and understood. An exploration of the intuitive experiences of counselors was in keeping with an interpretative approach to understanding the contextual meaning and perspectives of individuals (Ritchie & Lewis, 2003).

The interpretative paradigm was comprised of several theoretical perspectives which researchers based their exploration and sense-making of the world. Phenomenology was one such theory within the interpretative tradition. A phenomenological design was based in a unique philosophy of thought, history, and specific methods of collection and analyzing data (Denzin & Lincoln, 2005).

Research Design

The research question in this study required an interpretative paradigm, and the design provided an approach to investigating that question by outlining a way to explore

and discover participants' experiences. In this current study, the focus of the research question had not been adequately understood within the context of professional counseling. Therefore, a phenomenological design provided a method of uncovering the essence of clinical intuition as it was experienced by LPCs.

Prior to embarking on other courses of investigation of this phenomenon, the concept itself had to be discovered and described. Consequently, a researcher needed to have a grasp of the essence of the clinical intuition before, for instance, attempting an investigation that sought to find connections that explained or predicted clinical intuition (e.g., a study of the interactions of supervisors and supervisees) or an exploration that provided a concentrated focus of one counselor's experience over the course of her development. Therefore, a phenomenological approach provided the method to extract the core qualities of clinical intuition.

Moustakas (1994) explained that phenomenology was a process of seeing a phenomenon for what it was, continually looking and describing the nature of the experience, discovering and clustering invariant constituents, clustering the clusters into themes, forming composite textual and structural descriptions, and then synthesizing those composites. It was a process of illuminating the essence of a phenomenon as described by the experiencing individual.

The focus of a phenomenological study was on the intrinsic properties of an experience explicated by individual perspectives (Thompson, Locander, & Pollio, 1989). Phenomenological research was set apart from other qualitative designs through the process of the Epoche, which provided a way to set aside my biases and presuppositions about clinical intuition so that, rather than creating what I expected to find, I discovered

the essence of this phenomenon as it was experienced by LPCs. Furthermore, the focus of phenomenological research remained on the "appearance of things, a return to things just as they are given" (Moustakas, 1994, p. 58). That focus was necessary before studying the myriad facets of clinical intuition within the context of the clinical situation (i.e., supervisors, counselors, clients, and the counseling relationship). The essential core of clinical intuition needed to first be discovered.

Institutional Review Board

The University of North Carolina at Charlotte's Institutional Review Board (IRB) approved this study (see Appendix A). The protocol was amended in order to clarify the possibility of a second interview. The amendment was approved and is included in Appendix A. The accepted research procedures were maintained through the course of this research. The informed consent form provided details on those guidelines and was located in Appendix B**.**

Participant Selection

The participants in this study were comprised of a purposive and snowball sampling of LPCs in North Carolina. Ritchie and Lewis (2003) noted that this sampling procedure allowed researchers to select participants based on known experiences and characteristics. Given the purpose of this study and the nature of the qualitative design, the belief in the existence of the phenomenon presupposed the perception of what it was. Additionally, the interviewees' ability and willingness to verbally express their responses to the questions of this study was vital to the process of a qualitative investigation. Moustakas (1995) explained that the process of phenomenological analysis was

dependent upon the act of reflecting on an experience. Therefore, the participants in this study had to be able to reflect on their experience of clinical intuition.

The sampling strategy allowed me to initially utilize my direct relationship with the first group of professional counselors who believed in and could articulate their experience of clinical intuition. Following each of the interviews with those counselors, I asked for the name of another LPC who believed in and could describe their experience with clinical intuition. I followed the same process of acquiring referrals for this study with each participant.

Generally, the initial interviewees' recommendations of other participants were based on a more intimate relationship than I had with them. Therefore, participants had access to more information about those they identified for this study, and they had a better understanding of whether the counselors met the inclusion criteria.

To further the likelihood of accessing participants who believed in the existence of intuition and could verbalize their experiences of clinical intuition, more stipulations on the selection criteria were established. Consequently, a minimum of clinical and supervision experience and specific educational requirements were included in participant selection. Those stipulations were based on North Carolina licensure requirements for professional counselors (see Appendix C).

Experience as a counselor as an inclusion criterion was supported by the link between a counselors' ability to form judgments based on experience-based patterns (Skovholt & Ronnestad, 1992) and the pattern recognition model of intuition (Welling, 2005). That connection underscored the need for counselors to amass a level of clinical experience in order to base whether the presenting client situation feels as if it matched or

was incongruent with their previous work. Additionally, counselor development models suggested that a more complex and articulated sense of clinical abilities would correlate with more advanced levels of integrated experience and knowledge (Skovholdt & Ronnestad, 1992; Watkins, 1993).

Those models proposed that supervision was a forum for that integration to occur. Therefore, experience as a supervisee was another criterion in the participant selection process. According to developmental models, supervisors facilitated the movement of counselors through progressive stages of awareness, ability, and skills. Given the impact of supervision on the development of counselors, this stipulation supported the likelihood that participants in this study had the opportunity to integrate theory and clinical practice (Loganbill et al, 1982; Stoltenberg et al., 1998).

The minimum of experience for inclusion in this study was determined by the established standards of the North Carolina Board of Licensed Professional Counselors (NCBLPC). Therefore, only LPCs in North Carolina were included in the sample. The licensing criteria for counselors were different from that of clinical social workers, marriage and family therapists, or psychologists. First, the licensing board for counselors in North Carolina required that clinicians earn a master's degree in counseling (see Appendix D for a description of sample coursework from a master's level counseling program). This advanced degree was set apart from similar fields in terms of coursework (e.g., a class devoted to the development of technical skills) and philosophy (e.g., developmental and multicultural perspectives).

While the board stipulated that related degrees do not customarily meet the standard for licensure, the board would review applications on an individual basis. In this

study, two of the nine LPCs received their licensure in North Carolina through this case-by-case review process. These two participants had earned master's degrees in allied fields. One of these two counselors also held licensure as a Marriage and Family Therapist (MFT), a Licensed Psychological Associate (LPA), and as a LPC. She had been practicing as a LPC for 18 years.

Secondly, the board stipulated that practitioners acquired 2,000 hours of supervised professional practice in counseling. Furthermore, a minimum of two years post-graduate supervised experience was required in North Carolina before licensure was awarded. Those requirements ensured that participants in this study have amassed a minimum of two years of clinical work following their practicum and internship experiences. Additionally, the supervision mandate established a minimum of supervisory contact.

The length of experience required by NCBLPC was aligned with the exploration and integration stages of Skovholt and Ronnestad's (1992) theory of counselor development. When counselors have amassed two to five years of practice after graduate school, they were better able to integrate clinical knowledge with personal awareness, were less dependent on external sources of knowledge (manuals or supervisors), were more reliant on internal sources of knowing (increased self-awareness), and were developing their counselor identities. The description of professionals in these stages paralleled the pattern recognition models of intuition. Thus, counselors at this level of development were able to detect patterns in the clinical presentation, made meaning of that picture, and used that understanding to guide their behavior. Therefore, the LPC credential supported the possibility that participants had experienced clinical intuition.

The size of the sample in this study depended on when new invariant constituents or clusters no longer emerged. Lincoln and Guba (1985) explained that sampling size was determined by redundancy of data. That criterion specified that the sample did not need to continue expanding when participants were repeating similar responses. In order to determine when redundancy occurred, I transcribed the interviews and analyzed the data throughout the data collection process. Similar and repeating clusters and themes were apparent as soon as the second interview. However, novel clusters continued to emerge until the eighth participant. During the analysis of the ninth interview, it was evident that there were no new clusters and data collection stopped.

Profile of Participants

The following depiction of the participants in this study was presented to highlight who they were, while maintaining their confidentially as stipulated in the informed consent. Thus, their names were changed to pseudonyms and identifying information, such as personal history, had been excluded. Moreover, all of the participants had supervisee experience as stipulated by licensure requirements. All but Vicki had experience as supervisors.

Lou held a master's degree in community counseling and a bachelor's degree in music therapy. He had amassed 36 years of clinical experience in psychiatric hospitals and Hospice settings. Lou received his LPC credential 21 years ago.

Barbara earned a master's degree in community counseling and had been licensed in North Carolina for eight years. Her clinical experience included spiritual, bereavement, and private counseling. She had clinical experience that spanned 21 years. She was

certified in Eye Movement Desensitization Reprogramming (EMDR) work, and she worked with survivors of trauma.

Vicki received a master's degree in community counseling and had been licensed in North Carolina for eight years. She had nine years of experience in a rape crisis agency, private practice, substance abuse program, and a therapeutic boarding school. Additionally, she was certified in EMDR.

Ophelia received her master's degree in community mental counseling and had been practicing for five years in a community mental health agency. She, like Barbara and Vicki, was certified in EMDR. She had experience working with families and children.

Karen earned a master's degree in guidance and counseling and had 27 years of clinical experience in private practice and in-patient hospital settings. She was trained in energy healing and dance therapy. She had been a LPC for 15 years and specialized in working with individuals with eating disorders.

Gertrude received her graduate degree in community counseling and had five years of clinical practice and four years of work as a LPC. She was trained in Internal Family Systems (IFS) and had worked in college settings and private practice.

Sally graduated with a master's degree in educational psychology and had been practicing as an LPC for 10 years. She was trained in Somatic Experiencing (SE) and had worked in community mental health and private practice. She worked primarily with survivors of trauma.

Andy earned his master's in agency counseling and had been working as a LPC for 7 years. He had worked in a bereavement center and private practice. Andy was trained in cognitive-behavioral techniques and in hypnosis.

Terry was unique among the participants as she was the only counselor in this sample to hold more than one license. In addition to her LPC credential, Terry was a Licensed Marriage and Family Therapist and a Licensed Psychological Associate. She received a master's degree in clinical psychology in the 1970s. The NCBLPC reviewed her education and training history and determined that she met the criteria for LPC in North Carolina. Terry was a LPC for 18 years and had 33 years of clinical experience in psychiatric hospitals, community mental health agencies, and private practice. She now primarily provides couples counseling.

Data Collection Procedures

As a means of understanding the individual perspectives of counselors within this qualitative research study, in-depth interviews were conducted. Ten face-to-face interviews took place with nine LPCs. One participant was interviewed twice following the initial analysis of that counselor's first interview. I deemed it necessary to clarify that counselor's responses and contacted the participant to arrange and conduct a second interview. The interviews of all participants ranged from approximately 60 to 90 minutes.

I initially contacted potential participants by phone and utilized the recruitment script, approved by IRB, to provide information to the counselors about the study. I contacted 12 LPCs for inclusion in this study. One participant returned my call after the data had already reached saturation, one participant did not return my call or follow-up

calls, and one participant declined. Nine LPCs agreed to describe their experiences of intuition.

In the beginning of the interview with each participant, I reviewed and answered any questions regarding the counselor's informed consent to voluntarily participate in this research. The participants signed the informed consent form and were offered a copy. Participants were also asked to complete a survey to capture background information that might not be described in the interviews (Appendix E). Several participants opted to provide a resume and included additional information about their supervision experience instead of completing the survey. Additionally, a list of counseling referrals was available to participants in the event the interview questions activated an issue that they wished to further explore. None of the participants asked for a referral for counseling services.

In adherence to Glesne's (2006) instruction regarding the necessity of finding locations that were preferred by the participants, individuals in this study were asked to identify the location best suited for them and the interview purpose. Eight participants asked to meet in their counseling offices. One participant did not have available office space as she conducted counseling services in clients' homes, and so I offered my counseling office as an option. She agreed and we met there. Consequently, all interviews took place inside counseling offices. That environment provided the necessary privacy for counselors to describe examples from their clinical work. A comfortable and private interview location and a semi-structured interview format supported participants' ability to provide rich descriptions of their experience of clinical intuition.

The interview structure followed Patton's (1990) description of a general interview guide approach. The general interview guide allowed me to explore relevant

issues with each counselor without relying on a strict adherence to structured questions (Appendix F). Patton (1990) explained that the guide served as a way to ensure that particular areas were explored in a manner that was specific to each participant. Consequently, the wording of my questions and the sequence of their presentation depended on the context of each interview.

That type of structure provided counselors with an opportunity to elaborate on any question or provide additional insights. The interview structure invited them to respond in such a way that their perspectives guided the process, rather than the questions dictating the direction and scope. Participants were encouraged to expound on their answers to the basic guiding questions of the interview. Through their unfolding narratives, a description of counselors' perceptions of clinical intuition emerged.

Patton (1990) stated that an interview guide ensured that focus areas would be covered while the interviewer was free to deepen or widen exploration in any area. Given that purpose, the interview guide in this study was comprised of three sub-sections: (1) relevant experience and education; (2) experiences and perceptions of clinical intuition; and (3) opinions on development of intuitive ability.

While the interviews with each participant were guided by that framework, I utilized active listening skills to invite participants to expand on answers and to explore relevant areas. Active listening included open questions, reflections (paraphrasing content, feelings, and thoughts), nonverbal communication (eye contact, body position, voice tone), and summarizing (Young, 2005). My reflections served as a way to engage in member checking throughout the interviews. Thus, I continually verified my understanding of their responses through my active listening. My clinical experience,

supervised practice, and education contributed to the formation of reflections and questions that deepened the interviewees' responses.

Prior to beginning the interviews, I engaged in the process of the Epoche. I attempted to hear their descriptions with naïve and open ears. I met the participants with curiosity about their experiences with clinical intuition. During the interviews, I continually moved myself back into this space of receptive clarity.

Generally, I began the interviews by asking for their definitions of clinical intuition. This question served to establish a clear focus of the interview. Then, I asked for specific examples of their experiences so that they were telling their own stories rather than reporting their opinions about intuition. Based on the work of Petitmengin-Peugeot (1999), I attempted to ask questions that would allow them to talk from a perspective of re-experiencing rather than remembering. That distinction was elaborated in a forthcoming section of this chapter.

The interviews were digitally-recorded and transcribed. The transcriptions took place prior to the following interview with another participant so that an ongoing analysis of the data occurred. This analysis informed the way I asked questions so that I elicited more responses of re-experiencing rather than remembering in subsequent interviews. Interviews continued until no new emerging clusters or themes were evident. Data collection reached saturation with nine participants.

Data Analysis Methods

A phenomenological analysis was utilized to discover the essence of counselors' experience of clinical intuition. As this study was not a case analysis of counselors who experienced clinical intuition or a grounded theory investigation of this phenomenon, the

interviews were not analyzed based on participants' years or types of experience. Rather than matching years of clinical practice with their descriptions of clinical intuition, I focused on the emergent essence of their experience of intuition and examined it with regard to other counselors' descriptions.

I utilized a modification of the phenomenological method outlined by Moustakas (1994). I remained close to his framework by moving through the Epoche, phenomenological reduction, imaginative variation, and creative synthesis. I varied the phenomenological reduction phase through my incorporation of Charmaz's (2006) initial and then focused coding process. I presented my analysis in the manner I engaged in it: I began in the Epoche phase and then entered into phenomenological reduction. Next, I created textual descriptions of each participant and then formed a composite textual description. After engaging in a process of imaginative variation, I composed individual structural descriptions and then a composite structural description. Finally I synthesized the composites into a rich description of LPCs' experience of clinical intuition.

Epoche

The Epoche was an initial and continual process and was characterized by my awareness of assumptions and biases regarding clinical intuition. Moustakas (1994) explained that the Epoche was a process of examining things as they were without the filter of expectations and judgments. He wrote that we were freed to see a phenomenon from a novel perspective without ascribing our meaning to it. The Epoch existed prior to judgment and reflection.

Moustakas (1994) compared this process to meditation. During this period, I acknowledged and allowed my habitual judgments and biases about clinical intuition to

emerge as thoughts. I then noted the thoughts, labeled them for what they were, waited until my mind detached from them, and then returned to the phenomenon. I was receptive to the emergent phenomenon throughout the data collection and analysis, and I continually returned to view it with eyes that were free from predetermined judgments. Moustakas made the point that perception that was completely void of assumptions, expectations, and judgments may not be possible. However, the process of attending to those biases while I explored clinical intuition allowed me to see it more clearly for what it was and not for what I expected to see. In the Epoche, I cleared my mind of my literature review, my thoughts about this topic, my own experiences of clinical intuition, and my suspicions about the nature of counselors' experiences of intuition. I broadened my perspective and created a receptive state of mind to receive the essential meanings that the data revealed.

Phenomenological Reduction

Phenomenological reduction was a process that began with raw data and culminated in a composite textual description. As outlined by Moustakas (1994), the process involves the Epoche, horizonalization, delimiting horizons, discovering invariant constituents, clustering the constituents, and then clustering the clusters into themes. I utilized an initial and focused analysis to uncover the invariant constituents and themes before capturing those codes in the individual and composite textual descriptions.

Horizonalization

I began with the process of horizonalization with bracketing. It was a time of exploring the material as it was, without preconceived ideas about intuition intruding on the process. The Epoche had prepared the ground for this phase. During bracketing, I

identify phrases that illuminated the concept of clinical intuition. I considered these statements for what they meant about the essential nature of this phenomenon. As I explored those descriptions, I bracketed my preconceived ideas about intuition. In other words, I continually brought my attention to how predetermined ideas were intruding on what I observed in the data. My methodological log and peer debriefers were vital to this ongoing process. This process allowed me to discover meanings rather than inject them.

Bracketing made horizonalization possible by allowing the descriptions of clinical intuition to be equally examined. In this phase of analysis, Moustakas (1994) explained that each statement was considered and uniformly valued. This type of evaluation of participants' descriptions became the ground for the relevant statements to emerge.

Initial Analysis: Invariant Constituents

Following this process, recurring and irrelevant statements were removed so that only the invariant constituents remained (Moustakas, 1994). I continued to enter into the Epoche process so that I was continually aware of my predetermined opinions about clinical intuition. I was alert and receptive to the emergent qualities of the data. At moments, I became conscious of my own use of intuition when I 'knew' what were relevant statements without always knowing why. Upon reflection, I understood their pertinence. Moustakas used the term 'horizons' to describe those constituents and the textual meanings which surfaced from the descriptions of the experience.

This process resulted in varied descriptions of the experience of clinical intuition from the perspectives of the participants. In this initial analysis, I labeled these horizons by remaining close to the description. These codes did not involve a high level of abstraction so that the label strongly corresponded with the content. As I worked with the

data, it was clearer to me that the coded invariant constituents were grouping into clusters.

Initial Analysis: Clustering the Invariant Constituents

During this next stage, the invariant constituents were grouped according to themes (Moustakas, 1994). Thematic clusters captured the essence of the experience. While these clusters conceptualized more of the emergent qualities of the data, they continued to remain close to the initial codes.

I conducted an analysis of each transcript prior to the next interview or analysis of the next transcription. I utilized this initial analysis with the first 5 interviews with the first 4 co-researchers. I then used the focused analysis to reexamine the first 5 transcriptions and to guide the examination of the next 5 interviews.

Focused Analysis: Invariant Constituents

As a way to of examining and verifying my emerging themes, I incorporated Charmaz's (2006) process of a focused analysis of the initial analysis. Through this second wave of examination, I compared the raw data to the labeled invariant constituents (codes). This dynamic process entailed checking and rechecking the data with the codes and the codes with the data. I used the same method to explore the invariant constituents with each other.

Focused Analysis: Clustering the Invariant Constituents

As I explored and verified the initial codes through my focused analysis of the invariant constituents, the initial clusters began to morph. In this phase, I compared the clusters to each other and looked for how the clusters made sense of the initial codes. These clusters became actively involved in synthesizing the data as they continued to be

sensitive to the content. The focused analysis gave rise to conceptual clusters rather than descriptive codes. What I saw became the basis for the larger groupings of these clusters of invariant constituents.

Thematic Portrayal: Clustering the Clusters

Those groupings of clusters became the overarching themes of the experience of clinical intuition. The themes that manifested from the conversations between the clusters presented a story of LPCs' experience of clinical intuition. At this point in the analysis, I evaluated the themes in relation to the relevant statements that had risen as a result of the horizonalization phase. I examined participants' verbatim accounts of their experiences in view of the themes as way to verify their relevancy.

An open coding table was utilized to organize the clusters and to bring clarity to the emerging findings (see Appendix G). The table was arranged according to participants' experience, influencing factors, and participants' opinions about clinical intuition. Codes that remained close to the data were organized in relation to the clusters that emerged in the focused analysis.

Individual and Composite Textual Descriptions

I based the individual textual descriptions on the invariant constituents, clusters, and themes that emerged in individual participants' descriptions of their experiences (see Appendix H for a sample individual textual description). Moustakas wrote that textual descriptions comprised the feelings, thoughts, psychological reactions, and moments when the phenomenon occurred. These descriptions described *what* the experience was.

Prior to composing the composite textual description, I engaged in the process of the Epoche so that I maintained a broader and clearer perspective. I then compiled a

portrayal that included all of the counselors' individual accounts of their experiences. The result of that process was a rich composite textual description of the themes of the experience of clinical intuition for all of the participants.

Imaginative Variation

Moustakas (1994) unwittingly connected his explanation of imaginative variation to the focus of this current study. He wrote, "Variation was targeted toward meanings and depends on intuition as a way of integrating structures into essences" (p. 98). This process illuminated what had previously been hidden, and it exposed the essential structure of the phenomenon. Moustakas wrote that the focus of imaginative variation was on meanings and not on facts.

Individual and Composite Structural Description

The move from a textual description to a structural description was a move from the *what* of the experience to the *how* of it. Structural descriptions described the underlying meaning of the textual representations of the phenomenon. First, individual structural descriptions were created (see Appendix I for a sample individual structural description), and then a composite structural description was formed.

This was a process of discovering the precipitating factors that caused the feelings and thoughts of the clinical intuitive experience. It comprised the task of examining the horizons from varying and divergent perspectives. Through that discovery of potential meanings, the core essence of the underpinnings of clinical intuition emerged.

Synthesis

During this final phase, the composite textual description of invariant constituents and the composite structural description of textual meanings were integrated. The *what*

and the *how* came together in a synthesis of meaning. The essence of clinical intuition emerged from the descriptions and underlying meanings.

Trustworthiness

The issue of trustworthiness was based on whether the findings of a study were valuable and how that value could be established or confirmed. Lincoln and Guba (1985) suggested four questions that moved researchers closer to ascertaining the worthiness of a study's results. First, I asked how I would demonstrate the authenticity of my investigation (the truth of the essence of clinical intuition). Next, I examined the degree to which the findings could apply to other contexts (the extent to which counselors' perception of clinical intuition applied to other therapeutic schools). Third, I questioned whether my findings could be duplicated in a similar study (the same description of clinical intuition would arise in another phenomenological investigation of counselors' experience of clinical intuition). Finally, I considered the extent to which my worldview interfered or impacted the findings of this research.

Four areas of consideration were helpful in answering those questions about the trustworthiness of a study. In qualitative research, those criteria were termed credibility, transferability, dependability, and confirmability (Lincoln & Guba, 2005). Credibility referred to the extent to which this was an investigation of the true essence of clinical intuition and not any other concept. Transferability was the degree of applicability to contexts beyond the field of counseling. Dependability concerned whether my findings would be duplicated in a similar study. Confirmability was the amount of influence that my worldview and biases had on my findings. Those four criteria were the qualitative version of internal validity, external validity, reliability, and objectivity.

Procedures to Establish Trustworthiness

This investigation of counselors' experiences of clinical intuition included measures to establish credibility, transferability, dependability, and confirmability. First, the use of my methodological log applied to all four criteria. Second, I maintained an audit trail as a way of supporting confirmability. Third, this study's utilization of purposive sampling was important to the concept of transferability. Finally, the inclusion of member checks, peer debriefing, and an audit trail applied to the establishment of credibility and confirmability.

Methodological Log

The utilization of a methodological log moved a researcher closer to establishing trustworthiness in each of the four criteria. This log was a record of my assumptions, hunches, and thought processes through each phase of data collection and analysis (Lincoln & Guba, 1985). During the interviews and analysis, this record allowed me to record necessary information in order to monitor my own biases and my reasoning. I utilized this forum to reflect on my preparation prior to each interview, my experiences during the interviews, and my reactions afterward. I used the log as a type of personal diary of my own awareness and interests relative to the study. It also tracked my rationale about decisions that were made through the data collection and analysis. Finally, the methodological log included reflections of my involvement with peer debriefers.

The Audit Trail

I have maintained an audit trail through this study as suggested by Lincoln and Guba (1985) in order to establish confirmability. My detailed record keeping provided a method to examine the degree of my objectivity. The audit trail offered a transparent way

for any observer to see how methodological decisions were made and how findings were obtained. Verbatim transcripts, every phase of analysis, every phase of synthesis, electronic correspondence with participants, and IRB information composed the audit trail. My previously described methodological log added to that account.

Purposive Sampling

Although the transferability of qualitative findings was limited, the use of a purposive sampling strategy contributed to the likelihood of gathering a breadth and depth of information that could be used to base judgments concerning applicability (Lincoln & Guba, 1985). The inclusion of LPCs who believe clinical intuition existed and who were also able and willing to articulate their experiences contributed to a rich source of data. Lincoln and Guba asserted that the qualitative researcher's responsibility was not to statistically express whether the findings applied to another context. Rather, he or she was obligated to establish detailed information so that individuals could discern whether the findings might transfer. The comprehensive reports from participants in this study supplied that kind of information.

Member Checking

Member checking throughout the interviews and in the analysis helped to ensure that an interpretation of the data was in accordance with participants' perspectives. Additionally, this feedback was a way to identify where and when my bias filtered their understandings. Member checking was solicited during the interviews through my continual reflection of content and feeling. Those restatements, paraphrases, and summaries ensured that the meanings of participants' statements were understood.

Additionally, an effort was made to establish trustworthiness during the analysis phase. First, each participant was offered a copy of their transcription and an opportunity to meet again to discuss their verbatim report. Each of the nine participants declined both offerings. I contacted one of the nine counselors and requested a second meeting after the initial analysis of the first interview revealed a need for clarification. That participant agreed to meet a second time.

In my motivation to ensure that participants believed that they had described their experiences in the ways that they intended, I extended another opportunity for member checking. I emailed or mailed copies of their transcriptions to them and requested that they review, clarify, or expound on their responses. I emailed transcriptions of both interviews to the participant who met twice for this study. The reports maintained confidentiality as stipulated in the informed consent form. All identifying data was removed and their names were not included in the transcript. Three participants contacted me to extend their approval of their verbatim transcripts and the remaining counselors did not respond.

Peer Debriefing

In addition to participant review, peer debriefing was utilized to establish trustworthiness. Colleagues who were involved in counseling or related fields were consulted in an attempt to identify potential bias during the interview and analysis process. The addition of peer debriefing challenged the assumptions and biases that might influence my analysis.

I enlisted the perspectives of four professionals to review select transcriptions and provide feedback regarding emerging themes. A LPC who was not a participant, a

clinical social worker, a college student involved in a counseling field experience, and a music therapist composed the group of peer debriefers in this study. The LPC and the college student, who was interested in pursuing a career in counseling, were provided access to my codes prior to reading the transcripts. The codes provided these debriefers with a way to check their thinking against my own my so that discrepancies would be readily apparent. The clinical social worker and the music therapist were provided handouts from one of my presentations on this topic. The handouts created a frame for the social worker and music therapist to begin to formulate their own understanding of the data. The feedback from all four colleagues affirmed emerging themes in the data and it stimulated my thinking about particular areas.

Role of the Researcher

The feelings, beliefs, biases, and assumptions of the qualitative researcher informed and influenced the questions that were asked in the study and the meaning made out of the answers (Denzin & Lincoln, 2005). That impact was evident in Patton's (1990) description of the researcher as the instrument in both the collection and analysis of data. Patton went on to note that the humaneness of the instrument required that biases and assumptions were continually reflected upon.

Furthermore, researchers were responsible for engaging in a qualitative investigation without a pre-set theory to prove. Therefore, I was constantly reflecting on my own influence and motivation in order to understand clinical intuition as it was experienced by the participants. In addition to self-reflection, Moustakas (1994) noted that researchers must utilize reflection to examine the perspectives of the participants.

Through this consideration of self and others, new aspects of the experience emerged that changed my understanding of clinical intuition.

In this phenomenological investigation, I was the instrument. I was responsible for the questions that were asked during the data collection, the transcription of the interviews, the meaning derived from counselors' responses, and the report of the study's findings. Therefore, I was responsible for reflecting and monitoring the ways my worldview and my experience as a counselor guided my questions and influenced my understanding of participants' experiences.

The concept of empathy was an important part of a qualitative researcher's ability to make sense of lived experiences of individuals (Patton, 1990). Empathy was the ability to make sense of the emotional experience and implicit expressions of an individual. Patton noted that empathic understanding was vital to a phenomenological investigation. Consequently, in order to make sense of counselors' responses about their experiences of clinical intuition, I was empathic. My counseling training and experience in this area fostered my ability to detect interviewees' unspoken communication. Additionally, my training in a doctoral program with a multicultural focus added to my continual reflection of the impact of my biases and assumptions.

Ethical and Political Consideration

Prior to participation in this study, counselors were informed of the research purpose, voluntary nature of their participation, the risks and benefits of this study, and their rights and responsibilities. Participants signed an informed consent form, indicating their understanding of the research process and purpose. Disclosure about the use of a

digital recorder during the interviews and the ways that confidentiality would be maintained were explained and included in the informed consent form.

As issues of anxiety and competency were inherent in counselor development (Stoltenberg et al., 1998), participants may have experienced concerns about how their responses reflected on their clinical ability. Therefore, participants were assured of confidentiality. To maintain confidentiality, no identifying information was attached to the digital recordings. Further, all names were changed to pseudonyms during the transcription process so that no identifying information was attached to the transcriptions. In the verbatim reports, I only utilized the initial of the pseudonym for the purpose of efficiency. Prior to sharing data with peer debriefers, all names were changed to pseudonyms and other identifiying information (e.g., places or agency names) were deleted. All information was secured in a locked file cabinet. I alone had access to the information in the locked file cabinet. All recordings were destroyed before the expiration of this study.

Interviewees had an opportunity to meet and discuss their interviews and their transcriptions. Finally, counselors were assured that their participation in this research was completely voluntary. They were informed of their right to not answer questions and to stop the recorder at any time. Participants were informed of their right to withdraw from the study at any time without penalty. Furthermore, I had a list of referrals and resources available for any participant who was interested in processing any thoughts and feelings that were stimulated during this process. Participants were informed that the list was available to them.

This study adhered to the guiding principles of Institutional Review Boards (IRBs) as outlined by Glesne (2006). Principles included a requirement that participants had enough information to possess informed consent prior to engaging in the research. Another principle demanded that participants could disengage from the study at any moment.

Reflections of the Research Process

As the researcher, I entered this study with my own experiences with clinical intuition. I am a LPC, and I have been aware of what had seemed to me, prior to this research, a mystical and ineffable understanding of the clinical picture. My endeavor to develop my own intuitive ability and to facilitate conditions for the growth of intuition in supervisees led to the creation of this investigation. As I immersed myself in the literature, I combined my growing knowledge of this topic with my reflections and efforts in my clinical practice.

Consequently, the process of the Epoche was a fundamental component of my experience before and during the interviews, the analysis, and the synthesis. I developed a habit of noticing how I was engaged in the data collection and analysis. If my thoughts held preconceived ideas about intuition, I cleared my mind and reengaged with the data with naïve wonder. Through the analysis, a theme emerged that seemed to parallel the Epoche process. That theme described the moments before intuition arrived and it shared a similarity with the Epoche. Consequently, an attitude of open and alert receptivity imbued the gathering of observations for both this research study and the emergence of clinical intuition.

During the interviews, counselors were asked to recall their experiences of intuition. I attempted to guide participants from recalling those moments to re-experiencing them. I based that intention on Petitmengin-Peugeot's (1999) reflection that a here-and-now description yields richer data than a there-and-then account. As participants were less removed from their experiences, they seemed better able to describe their own clinical intuition rather than talk in general terms about it. Additionally, when participants appeared more in-touch with their experience, their speech slowed and they frequently broke eye contact. Those observations correspond with how Petitmengin-Peugeot wrote about this process.

During the analysis, I felt as if I were picking up the puzzle pieces of clinical intuition and watching them morph in my hands. With every wave of analysis and reflection, new facets and variations of those qualities seemed to shrink or expand to either merge with or disconnect from the picture that was forming. The process of the Epoche was vital to my ability to clear my mind, step back from the data, and view it for what it was.

I was surprised to experience the synthesis as an intuitive moment. The arrival of an image of a dynamic intuitive wave described in future chapters came unbidden. It emerged following this two year process of acquiring knowledge and reflecting on this topic. The significance of the wave was described in future chapters.

I ended every interview in the same way I completed my analysis and synthesis: I was filled with gratitude for the counselors who found the words to describe a seemingly ineffable experience. As one participant stated, this study was "kind of like nailing Jell-O to a wall" (Gertrude). Given that reflection, this phenomenological investigation was

merely a process of opening the refrigerator so that the gelling could begin. Future studies were responsible for hardening it to the point that it could be nailed to the wall.

CHAPTER 4: FINDINGS

The purpose of this study was to examine the essence of LPCs' experiences of clinical intuition. Although many counselors maintained that intuition was a facet of their clinical practice, the experience of clinical intuition had not been fully explored in the literature (Welling, 2005; Williams & Irving, 1996). This study was designed to contribute to that fund of knowledge. In this chapter, I presented the findings of this phenomenological investigation of LPCs' experiences of clinical intuition.

The themes, textual descriptions, structural descriptions, and synthesis were based on ten interviews with nine participants. The sample was comprised of two men and seven women, ranging in age from 31 to 62-years-old. Their years of counseling experience ranged from 5 to 36 and their years of practicing as LPCs ranged from 3 to 21. They had worked in diverse settings: rape crisis agencies; community mental health agencies; inpatient and outpatient psychiatric hospitals; bereavement departments; college counseling centers; therapeutic boarding schools; residential facilities; and private practices. They had diverse training in eating disorders, Somatic Experiencing (SE), grief counseling, Eye Movement Desensitization and Reprocessing (EMDR), Internal Family Systems (IFS), marriage and family counseling, music therapy, and dance therapy. Individually and as a group, the participants in this study brought a rich background to their experiences of clinical intuition.

After obtaining IRB approval, I contacted each participant, described the nature of this study, and if they agreed to be a part of this study, I scheduled an interview time. Then, I met each counselor in a counseling office, and prior to beginning the interview, we reviewed the informed consent form. After the consent forms were signed, I followed an interview guide to make sure that the research questions were explored while the participants and I were free to expand and deepen any area.

Throughout my data collection, analysis, and synthesis, I maintained a methodological log of my personal reactions about the process and my thoughts about the emerging codes and themes. My approach to the interview process was captured in an excerpt from that log. After the third interview, I reflected upon the richness of data when participants re-experienced their clinical intuition rather than simply recalling it. I wrote that I noticed when the third participant's speech tended to slow and she paused more often. I also noted that at one point in her depiction of an intuitive moment, she became much less articulate, and she admitted that "I keep looking there because that's where he (the client) was sitting" (Terry). That behavior seemed to indicate that she was reliving the session. Also, her language seemed to change when she was in a space of re-experiencing. I noticed when she used language such as "I thought" or "It looked to me," rather than "you see the deeper meaning." It seemed that her shift from the general "you" to the personal "I" indicated that she was describing her intuition from her own experience instead of from her preconceived conceptualization. Changes in language and speech patterns were also evident in other participants.

The ten interviews resulted in ten verbatim reports. Through a modification of the phenomenological process outlined by Moustakas (1994), I performed an initial and

focused analysis of those reports. My initial analysis remained close to the content of the raw data. However, my focused analysis required more abstraction in order to capture the deeper essence of participants' experiences. At that point in the process, I was guided by Charmaz's (2006) description of the purpose of focused coding. In my methodological log, I wrote that during my initial analysis, I had been hesitant and uncomfortable about changing codes to reflect what I was seeing because I feared that what I saw was rooted in theory, and therefore, reflected my bias. However, Charmaz's description of the coding process freed me to make broader and deeper sense of the data. She wrote:

> Coding forces you to think about the material in new ways that may differ from your research participants' interpretations. Your analytic eye and disciplinary background lead you to look at their statements and actions in ways that may not have occurred to them. By studying the data, you may make fundamental processes explicit, render hidden assumptions visible, and give participants new insights. (p. 55)

The initial and focused coding resulted in the appearance of relevant statements, invariant constituents, clusters of invariant constituents, and larger themes.

Those clusters and themes became the basis for the development of individual and composite textual descriptions. In turn, I engaged in a process of imaginative variation with those descriptions in order to create individual and composite structural descriptions. Finally, I synthesized those composite textual and composite structural descriptions. The synthesis integrated *what* the experience of clinical intuition was with *how* counselors experience it. It was a depiction of the essential features of the experience of clinical intuition.

During the process of synthesizing the textual and structural descriptions, an idea appeared to me like a "bolt of the blue" about the essential nature of clinical intuition. This idea appeared as an image and it seemed to integrate the material that emerged from

this study. It arrived in the same way that some participants described the appearance of their clinical intuition. It manifested as an image that depicted a complete pattern and was imbued with a quality of certainty. Therefore, it seemed that I had an experience of intuition about the essence of intuition. The intuition appeared to me in the form of an intuitive wave that carried affective and cognitive material as it flowed through the unconscious and conscious realms. This wave was described in detail in subsequent sections.

In this chapter, I introduced the themes that were revealed in counselors' accounts of their experience. Furthermore, composite textual and composite structural descriptions were presented. Finally, a synthesis of those narratives was provided. The following themes portrayed the experience of clinical intuition rather than the factors that influenced it. However, those conditions were later incorporated into the structural description. The experience itself was a development of associations which formed in counselors' unconscious and conscious awareness. That associational information created a pattern that appeared as intuitive knowledge.

Themes

Although participants described unique aspects of their own experience of clinical intuition, common themes emerged from their depictions. The following six themes surfaced in LPCs' portrayals of their experiences of clinical intuition: unconscious associations; conscious associations; the moments preceding the arrival of intuitive knowledge; its initial appearance; the manifestation of intuitive knowledge; and the nature of the intuitive information. Each theme represented a different facet of

professional counselors' experience of clinical intuition. Additionally, the clusters that comprised each theme were also presented.

Theme 1: Unconscious Associations

This theme captured participants' reports of the connections they made on an unconscious level. Eight participants described these previously implicit associations from a place of consciousness. Given that unconscious processes were inherently not conscious at the time, counselors surmised when unconscious information was operating in their experience. Consequently, they made links with the information in the form of inferences or as observations that were visible only after the intuition appeared. Participants described their process of linking unconscious information about the clinical situation:

> It's not as if I'm consciously waiting to hear oh, okay, this person was experiencing rage, now let me listen to their language and identify what kind of rage it is. It's not conscious on that level, it's simply, ah, I start to put two and two together. (Barbara)

> As I think back on it, there were some behavioral signals from them that might have been supporting this notion that something more was going on here. (Andy)

Two clusters within this theme emerged from participants' interviews. Shared descriptions surfaced of participants' recognition of how their clinical knowledge and countertransference reactions were unconsciously operating during their sessions with clients.

Cluster 1: Unconscious Clinical Knowledge

Counselors' unconscious awareness of their clinical knowledge was evident in the information contained in their intuitive knowledge. This cluster contained the theoretical or diagnostic information that participants were not cognizant of in the intuitive moment.

All but two participants articulated their awareness of clinical knowledge that was unconsciously operating in their work.

> There's a trust that I'm going to know what's needed rather than having to struggle and start flipping back in my developmental textbook about what stage you know (laughs) I mean or what theory fits, which I never do cause you know on some level I don't think I really remember any of that but of course I do. (Gertrude)

The preceding excerpts depicted a part of the experience of intuition: a general progression from unconscious awareness to consciousness. Counselors also recognized how the reverse might happen. One participant reflected upon the movement of clinical theory into his unconsciousness.

> When you're in grad school and you're reading the book about I don't know Jung or something, you understand the words and you understand the concept, but its only till you actually have to practice that for a few years that you really understand what's underneath all of that stuff, so, um, so its just kind of strange that its almost like you have to learn what you need to learn in order to be able to successfully forget and have it be supplanted by the by the greater growth it came from to begin with, but you couldn't connect with that before because you didn't have the experience of what it was all about. (Andy)

In his description, the knowledge was not fully conscious until it became relevant to him.

Cluster 2: Unconscious Countertransference Reaction

Countertransference had been defined as: "The feelings and reactions that therapists have towards their clients as the result of a therapeutic relationship" (Dass-Brailsford, 2003, p. 57). These reactions were rooted in both counselors' personal histories and their professional experiences. Only three participants intimated that countertransference reactions were occurring outside of conscious awareness:

> It's not like I hear a voice in my head that says 'you're a bad therapist.' You, you know there's just this anxiety or…I'll notice that my voice was getting louder or I'll notice that I'm leaning forward, you know, cause I'm trying to, you know, fix things or so there's all these cues that I could get if I'm open to getting them….I mean it's changing every, every second…you know with every word that comes

> something internally was shifting….I don't think it's possible to catch all of those….or it's not possible for me to catch all of them. (Gertrude)

Based on a self-assessment of countertransference reactions, one participant drew an inference about its occurrence in the unconscious:

> It was unconscious because I could look at how I am much more conscious about what the person was doing, what the meaning of it is, and what my reaction was to it….I would not have been able to really tell you why I was doing it [clinical intervention at the beginning of participant's career] except that look, this was how we, you know, this was what people do, you know, with this type of situation, um, but now I would be able to tell you quite a bit more about why, you know, doing it just cause of the clinical experience and things have gotten more, more conscious about responding to what did the situation need. (Lou)

When the level of conscious awareness of countertransference reactions at the beginning of a career was compared to a later point, it appeared that these reactions had been operating unconsciously.

Theme 2: Conscious Associations

This theme captured participants' descriptions of their observations, noticed in the moment that they occurred. While counselors *become* aware of previously unconscious observations, they were always aware of conscious information. All nine participants noticed and formed connections between what was occurring in them and what was happening with clients. Those associations were also linked to their clinical knowledge. That developing pattern was part of the clinical intuition experience.

Contrasted with the two clusters that emerged in the theme of unconscious associations, the interviews were replete with descriptions of conscious observations. Seven clusters were relevant to this theme. In participants' illustrations of this theme, the ways that observations developed into associational patterns within and across each cluster were evident.

Cluster 1: Client Nonverbal Behavior

Counselors described how they attended to clients' body language and nonverbal communication. Every participant in this study was aware of and made connections with clients' voice tone, voice volume, posture, and body position. The pattern that formed out of the nonverbal behavior was then linked to other associations:

> I think he's depressed even though he doesn't say that he is, but the blunted affect, the kind of, the eye contact that I had with him, was kind of, he looked to me like he was kind of searching for something. (Terry)

> It's kind of way she's sitting, it's kind of the way she's, um (pause) covering up her lower torso with her clothing its um her lack of eye contact, it's she doesn't really have anything to say to me but you could tell there's a lot going on um (pause) she was I just know her I know her and um she was she was holding back I could tell. (Karen)

Participants also noticed unspoken communication in the interactions of couples:

> They were meeting each other without judgment…you know and the way that shows up was just, um, you know, a facial, the facial muscles just relax, the body relaxes, there's no, there's no rigidity, the voice softens and slows and um and it's just miraculous to watch, you know, and there're tears a lot of times. (Gertrude)

Cluster 2: Client Verbal Communication

In this cluster, seven participants recalled consciously listening to what their clients were saying and relating that to previous statements. Furthermore, they linked that developing pattern to other observations. Some participants described the connections that formed between nonverbal and verbal communication in order to find the link to the client's feeling:

> I would go with nonverbal cues but I'd would also go with just how, the content of what they were talking about….there would be some tension in their face when they talked, when they said this phrase, and these would all be cues that there's um, there's some significant emotion underneath, underneath there that they may not be talking about directly. (Andy)

Counselors also directly made the link between what was said and the underlying feeling:

> If the person was raging in terms of impotence, then um that person might express language such as 'I felt, I felt such a loss of control. I feel so helpless'….with shame I would associate that with feelings of inadequacy, low self-esteem, um, low self-worth, um, he makes me feel as if I'm worth nothing, he makes me feel worthless, um, he makes me feel undesirable. (Barbara)

Some participants connected clients' verbal response with previous clinical experience. The following passage depicted the moment a connection was made between what the client said and an association to a time when the counselor worked closely with clients with borderline personality characteristics:

> It was just talk with someone about here's what our plan was … yet she was leaping to 'so you're saying I'm crazy' or 'you're rejecting me' and it was all this kind of, you know, very emotionally laden and stuff and I recognized that immediately. (Lou)

Counselors listened to what and how clients talked in order to know how a client was processing information:

> I saw her relax and then the statements she began to make were more of an identification of about her instead of that externalizing it to a god….She brought it more into her present experience … like 'oh, yeah, I know that and oh, yeah, I've experienced that and oh, yeah, this was me and oh, yeah,' so there was more, she became more in her own being and more in her own experience. (Vicki)

Participants linked nonverbal behavior to spoken words in order to then connect those associations to clinically meaningful issues.

Cluster 3: Presenting Clinical Issue

Five LPCs talked about their conscious awareness of the salient clinical issue. Their attention to that issue was in association with other observations. The following passage was a portrayal of the recognition that the clinical issue was about unresolved and unexpressed anger:

> I could recall that her, um, um, her identity as a pleaser and as a doer for other people even if people walk on her, now that was clear before that moment and I

> think that um, clinical insight about people in that place that yeah, they do have underlying anger but they cannot allow themselves, so I think that definitely that came into play in the situation with her. (Lou)

In the following passage, the clinical issue was a client's prognosis. The participant recognized a pattern based on her work with clients with similar issues that manifested differently:

> She was barely getting through… in terms of functioning…as opposed to this other client who, um, was feeling primarily under control with his OCD, um, until he went back to the university….I mean there would be very few things than maybe a family emergency….ah, that would prevent him from finishing….he well exceeds what's going to be required of him…So I base it on that and I base it on having worked with him for a year now…and seeing that whatever his weekly anxiety is….[it's] gonna pass as well. (Barbara)

The clinical issue could also leap out of a pattern:

> There was that, kind of that existential struggle of I'm supposed to have faith and I'm supposed to believe, but this hurts too bad and why would god do this to people…. so that dissonance was going on within her. (Vicki)

In that example, the issue was the client's existential struggle. The counselor's ability to identify the existential anguish was indicative of a link to clinical knowledge.

Cluster 4: Clinical Knowledge

In their counseling sessions, four participants articulated their conscious awareness of counseling theory, diagnostic information, and previous clinical knowledge. They were aware of what was clinically salient. In this passage, the counselor was attending to a client's behavior and lining it up with diagnostic criteria for a particular disorder:

> It's just years…of working in psychiatry full time and in-patient, you know where you just see the broad diagnostic symptomtology, and so when I'm across from someone and that, those symptoms were being, even if they were subtle and it's just that the radar was just exquisitely tuned to that. (Lou)

Some participants actively searched through their clinical knowledge for associations that informed the emerging clinical picture:

> I have a couple now and the client was the says he's a 6 [Enneagram personality type] and he had a huge controlling part that's driven, I think in his words by anxiety...by this huge anxiety and fear that she, his partner's his wife's, gonna leave and um so, what I find myself doing was listening to him um (pause) trying to understand and to remember the motivation for a 6 [referring to the Enneagram] and why he's doing what he's doing so because that informs my knowing him. (Gertrude)

Counselors linked what they were seeing during a counseling session to what they learned outside of that room. They also connected associations with information gleaned from their identification with clients.

Cluster 5: Identification

Five participants described their conscious awareness of identifying with their clients. They were often aware during the session of how they were similar to their clients. For some counselors, that awareness provided the intuitive knowledge that moved clients into deeper work:

> How could I ask them to be someplace that feels really like a natural reaction to pain and trauma, challenges, and feeling stuck? 'Cause I've been there. I'm a fabulous yes butter sometimes…I don't stay there very long and I know it so I could sit with their yes butting and also still hold this knowing that there was the opportunity for them to do something different…. there's that self-determination piece, ah, because I have. (Vicki)

When counselors were experiencing identification, they saw themselves reflected in their clients. That reflection provided associational material that guided their clinical work:

> I've owned a, well we have something in common: he started a business and it's not doing well…is that like for you that you have this new business and you know how the economy was rather depressed and you're not doing well in the moment and he started um his eyes started changing when we started talking about that, it didn't look like he was searching for something as much as he was just feeling

> the, the discouragement about it, and then he started telling me how hard he had been working. (Terry)

When counselors recognized a facet of themselves in their clients, identification led to an association with a clinical issue:

> I had an eating disorder in college and um I feel a kinship to college girls with eating disorders and so a lot of times I feel and this was where it gets tricky because I don't want to be projecting my own stuff onto people….but I feel like I could pick up when especially around sexual, sexuality um when young women were struggling with that you know bodily and energetically and with food and um (pause) so I would often just get hits, I call them hits of you know someone was um struggling in a relationship um with their body acceptance. (Karen)

In the preceding excerpts, counselors were identifying *with* their clients rather than experiencing a countertransference reaction *to* them.

Cluster 6: Countertransference Reactions

When counselors were cognizant of their experience of countertransference reactions, they connected those thoughts and feelings to previous associations. Seven counselors in this study expressed their awareness of their countertransference reactions. Those reactions provided a compass to aid their quest to find clinical relevance:

> When I was on the personality disorders team, it was mostly borderlines, it was a couple of others, but it was mostly borderlines, and every time I would go into group, the activity therapy group, every day, every time I'd go in I'd get that same, um, stomach tightening, you know because it was the onslaught of um, demands, misperceptions, and just, just the stuff, you know the challenges that they have to work with, you know, in terms of the dia, the diagnosis that they have …. But it would all get externalized, and then it's your problem kind of thing, so it was that, and I know that, that gut tightening was just that putting up a shield to try to, you know, keep that stuff away, you know, so that same gut tightening was starting. (Lou)

The awareness of countertransference provided counselors with the ability to disentangle their own issues from their clients' issues:

> I could tell, if my (pause) if your heart was heavy about something you know because you know that you've been through that experience and your, and your

> heart, you're feeling that heaviness then, you know, what that was like, what that experience did for you… you know whenever and then I think you could be clear as a clinician that you're cooking on your own stuff. (Terry)

> The practice that I use was really trying to become vigilant, the parts of me that were getting triggered … um like there might be a person who might have characteristics of a maybe a friend I have that I have in an argument with, or maybe a partner that I'm having a difficulty with and um so I could feel all different kind of anxieties about that, and so to be able it's it's hard when you're in session cause you you kind of gotta be checking in checking you know looking at all at the same time but to to check in and see if that part was just willing to step back and let you come back to being…the therapist. (Gertrude)

> That's where you have to differentiate between 'am I following my own fear and calling that my intuition' and maybe the difference was when it's my intuition, its calm, it's subtle. (Sally)

Conscious awareness supported counselors' discernment process. Counselors were better able to detect when they were interacting with a client in ways that indicated that the client represented someone else in the counselor's life. They were also more able to identify when they were experiencing an empathic response to the client. Their awareness clarified the presenting clinical picture, and they were no longer reacting without cognizance. Consequently, they had the power to respond with intention.

Cluster 7: Resonance

Counselors described a deep understanding of clients' lived experience. Their descriptions did not indicate that they were feeling as their clients felt. Rather, participants talked about experiencing a sense of 'as if' rather than a sense of 'I am' the client. This difference provided clinicians with the ability to resonant with clients while remaining therapeutically objective.

Five participants experienced empathy when they were resonating with clients on an emotional level. This empathetic response was then associated to clinical assessments:

> I listen to that internally, with me, you know how hopeful do I feel based on what I'm what I'm hearing and how, and how they're relating, what how, how hopeful do I feel that they could work things out. (Terry)

In this description, the counselor made a connection from her feeling to an assessment of depression:

> I don't know if I feel it so much in my body I just feel it in the room I feel like it's really the whole energy of the room just dropped…Everything was darker and (pause) more more heaviness in the room, in the room, in the air, something…It's more a feeling than a than a something I see. (Karen)

In contrast to participants' descriptions of their empathetic understandings of clients' emotional experiences, four counselors talked about their sense of clients' phenomenological worlds. This attunement between counselor and client was broader than and incorporated empathetic understanding:

> An ability to hear things underneath statements, to feel and hear emotion in statements, to be more tuned into verbal cues….and lack or connection or lack of connection between them [emotion and verbal cues]. (Gertrude)

> *I could feel in him* this shift because in the in the moment he's realizing in a in a ah felt-sense in a sensation way oh, wow, I'm actually bigger than her, I don't need to have my childhood fear. (Sally)

Counselors also experienced attunement in a somatically:

> I could feel what's going on in their body like if they're having um if the leg was starting to release energy I would often feel that in my leg. (Sally)

Theme 3: Moments Preceding the Arrival of Knowledge

This theme captured the time period directly before participants experienced an intuitive knowing about the clinical situation. All nine participants described those moments just prior to their intuitive awareness. Participants described a state of openness during this period. This facet of their experience was imbued with a quality of effortless "being." Counselors felt calm and were exquisitely aware of the present moment. They

were simultaneously relaxed and keenly alert to developing associations. Participants described this moment as quiet, without the usual mind chatter. One participant stated, "Intuition was a very soft knowing and if there's chaos it you can't hear it" (Gertrude). This was a time when counselors were very tuned in and receptive to their experiences in the 'here and now.'

Cluster 1: Acceptance

Eight participants articulated their experience of a quiet stillness and receptivity which was devoid of self-denigration about their competency. Their self-judging and critical superegos were silent. Counselors trusted themselves and their abilities. During this facet of the experience of clinical intuition, counselors were not worried about doing it "right." They were in a place of self-acceptance where they felt comfortable and at ease with the therapeutic process:

> It's a just a constant um awareness, really not vigilance, vigilance sounds more efforting, but it's just this awareness…intuitively sometimes you know that this this isn't working…we don't need to be going there so what else could we do, and and what I find was when I could trust myself as being in self, then it I don't have to think of anything they [what to do] just come. (Gertrude)

> There wasn't any of that anxiety, it's like oh this would be perfect for this time, um, so I think I feel I have enough tools in my toolbox um to not feel any anxiety and just kind of go with it (Ophelia)

> If I'm really following the inner like the core of the heart (pause) well for one I'm working much less, it's not me efforting, I mean if I'm just trusting my heart, I'm not efforting at all. (Sally)

Cluster2: Presence

A sense of presence was closely allied with the effortlessness previously described. The defining feature of this cluster was an acute awareness of the present

moment. It was a time when eight of the participants felt “present” and “connected” to their clients:

> It’s a presentness…of what makes sense, cause I know my brain was working…and so it’s not just a feeling ….there was definitely some cognitive wheels turning ….I guess the distinction that I’m making was like intuition doesn’t feel like after I’m out of the session….thinking about well you know, what would my teacher say about that or what would have, what would the theories say about that…or what would I think now that I’m not sitting with my client. (Vicki)

Some participants described intentional practices that brought them more fully into this state of presence:

> I think it helps just me on a number of levels to be able to be in touch with myself, and to um be steady, and to be present I mean that’s what meditation was all about was to be present so…I feel like I bring the presence from my [meditation] practices you know as much as I could into my work. (Karen)

> I’m ah, very relaxed, my entire body relaxed but I’m very alert which was a state that um someone who’s had many years of meditation could achieve….alertness, alertness with a very relaxed physical body. (Barbara)

That alert receptivity hinted at the expectancy that participants experienced immediately before the intuitive knowledge was revealed.

Cluster 3: Expectant

At the verge of intuition’s appearance, four participants experienced a feeling that heralded their intuitive knowledge. It was a sense of the imminence of that knowledge. It was a feeling of expectancy:

> It’s an expectation, It’s an anticipation was is sort of the, that’s the impulse that’s occurring … It was as if he’s he’s talking to me, he’s engaged me, my client’s engaged me in something fascinating, and I’m trying to figure out how to help him and I’m hyper-alert and paying such keen attention to what he’s doing and all of a sudden, all of a sudden there’s this picture of chopsticks [chopsticks were used in therapeutic intervention] and so it’s as if it’s time to jump up and receive my hardboiled egg and run so it’s a feeling of I’ve been at rest in my chair yet I’m very engaged and I’m ready to start my run around the track any second as soon as it comes to me I’m going to receive my image and take action. (Barbara)

> There was an energy inside of me…I felt charged. There's a difference between I could feel charged with anxiety and I know that feeling, that's really icky, um but it was charged with this ah kind of extra um (pause) exuberance was too much, but like just extra umph…That (pause) yeah, there was just an extra umph, there was, there was flow to it and it was exciting…like the pieces were fitting together in my brain. (Vicki)

Theme 4: Initial Appearance

Eight participants described the quality of the initial appearance of the clinical intuition. Counselors explained that their intuitive knowing arrived whole and suddenly. The descriptions of certainty and sacredness warranted two additional clusters in this theme.

Cluster 1: Holistic

The information contained in the intuitive knowledge was a complete picture of the associational material that came before it. Five counselors described intuition's appearance as a whole configuration:

> There's no figure ground, it was just a panorama and everything was equal and the only thing I could think of which people have talked about was when your life comes in front of you, you know, and it looks like I'm going to die, and they talk about there's just no figure ground, it's like everything was equal and everything was just right there in it's enti…everything was a figure. (Lou)

> It's a not thinking …. there's a part that's like 'of course this was what we're doing…my brain doesn't even think, of course this was what we're doing …It's just there….I don't have the search the files, I don't have the search the brain files. (Vicki)

> It's like a light bulb….you know that just goes on inside and you're like oh, no wonder...no wonder he did that or she did that or….no wonder that's so frustrating to her because da da da…you know its like things just kind of you have all this information. (Gertrude)

Cluster 2: Immediate

A characteristic mark of the arrival of information contained in clinical intuition was a sense of suddenness. It appeared without warning in the experience of six counselors:

> Whatever she was talking about was certainly related but it wasn't that related….but this was like a lightning bolt out of the blue. (Lou)

> All of sudden I was struck with the impulse…and I followed the impulse and it made sense to him. (Barbara)

> It's a flash in during a session …. it's like suddenly you just have the don't know where it came from but the idea to ask a question. (Andy)

Cluster 3: Certain

All but two participants described their conviction about the truth of the intuitive knowledge. Although counselors often tentatively presented the information to clients for verification, the rightness of the intuition felt certain.

> I couldn't predict the future and a part of me, the core part of me knew that there was there was change there was absolutely the possibility for something different in her life. (Vicki)

> You just know something's true…. and you do, I mean there was no doubt in there, there's just well, of course it's true you know it … it's so difficult to explain that to people who still only have the rational logical understanding you know, well, what was that, well I don't know how to tell you cause you have to have the experience. (Gertrude)

Cluster 4: Sacred

For four participants, a sacred quality pervaded the intuitive information. They described experiences of a spiritual nature:

> There's that sacredness but that's not really an emotion you know but it was kind of it's just kind of a holy experience when something happened that just kind of blows you away or that you know or you or you say something or ask something and all of sudden you just you know. (Gertrude)

> What I was seeing was some, was um, I was seeing something that was ineffable…It was of a spiritual nature…not religious, but spiritual nature…It was my guide to know where to go in terms of the therapeutic interaction with her. (Lou)

The distinctive mark of this cluster was a sense that the intuition was connected to something bigger than the participants.

Theme 5: Manifestation of Knowledge

This theme was a facet of clinical intuition that captured *how* the appearance of intuitive knowledge was experienced. This presentation of intuitive information revealed itself along a dynamic continuum that undulated through unconsciousness and consciousness. That flow was a general progression from an affective sphere to a cognitive realm. The development of associations propelled the movement from a felt sense to a symbolic representation. All nine counselors experienced the appearance of intuitive knowledge at different points along this flowing continuum.

Cluster 1: Felt Sense

All but two participants described the way they received the intuitive information in somatic terms. The intuition was experienced on the level of sensation. The 'knowing' was felt viscerally and anchored in the movement of emotions:

> Often times when people dissociate … I might start to feel a little lighter, like woa, woa, woa, and I'll feel this like lightness in my legs. (Sally)

> I get impatient, I could sit all day with a couple that was talking well but when people start to get nasty with each other I get impatient… it probably shows because I'll squirm or I get you know sit on my feet. (Terry)

Participants described the quality of their felt sense:

> What I could feel inside was a softening that everything had just soften you know everybody had both of them or one of them had just gotten to a different place or opened to something that it then feels like we could move. (Gertrude)

Two participants described their felt sense of something in the room:

> It was almost like, it was almost like a heaviness in the room, I don't know it, I don't know that I … really remember feeling it as a specific sensation in my body I don't, I don't recall that, I recall it more more being just like a heavy presence in the room that maybe something that would something that wasn't being said. (Andy)

> I don't know if I feel it so much in my body I just feel it in the room. I feel like it's really the whole energy of the room just dropped…. you know everything was darker and (pause) more more heaviness in the room, in the room, in the air. (Karen)

Cluster 2: Gut Feeling

For seven participants, the gut feeling was a keener awareness of their physical sensations. A more conscious quality was attached to counselors' emotional experiences. The somatic awareness was now closer to a cognitive awareness as counselors had a fuller sense of the 'I' who was experiencing the emotion. The experience of visceral sensations was now an awareness that 'I feel' the affective associations.

> It was like just being carried, shoved into this awareness place where everything was apparent all at once and there was an absolute a surety that this was reality. (Lou)

> I listen to that internally with me, you know how hopeful do I feel based on what I'm what I'm hearing and how, and how they're relating, what how, how hopeful do I feel that they could work things out. (Terry)

When counselors were conscious of their experience at this level, they were able to be intentional about their responses. One participant described how her gut feelings informed her:

> When I feel some kind of um physical any kind of sensation, anxiety, sadness, judgment, anything like that's manifesting in my body then I know immediately that something was going on….I'll notice that I'm leaning forward you know cause I'm trying to you know fix things. (Gertrude)

That participant had the ability to intentionally redirect her therapeutic work once she was aware that she was motivated to “fix things.”

Cluster 3: Pattern Recognition

Six participants described seeing the emergent pattern in the clinical picture. The defining characteristic of this cluster was the presentation of coalescing connections which required more development or translation before the knowledge was completely understood. Some participants recognized a pattern of associations that were contained within pictures or analogies:

> It’s often visual…or abstract as if I’m seeing a picture, in fact I see things quite a bit in pictures and I would communicate about the pictures I see and especially in the last year, the intuitions seemed to come forward in the form of an analogy…for that individual, that, an analogy that I have never heard before. (Barbara)

> It’s not image like TV image, it’s not that concrete, I think it’s a way of translating perhaps what I sense in my body into something that was slightly more cognitive so then I could take the next step with it or something like that, yeah, but it’s not like I see a real concrete image, some people are, some people were maybe more visual, but it’s more this ah well, I don’t know, I mean if you feel what it’s like on a sunny day, you’re going to also see a sunny day. (Sally)

Cluster 4: Symbolic Representation

This cluster contained the experiences of every participant in this study. This grouping contained their explicit comprehension of intuitive knowledge. Participants described two orders of this cluster: One involved words as symbols and the other involved a deeper understanding that emerged from the integration of affective and cognitive associational material. When the intuitive knowledge took the form of words, participants experienced thoughts, questions, or instructions:

> It’s just a knowing, I don’t get it necessarily in a physical, I get in more in just like a thought. (Karen)

> That's what my intuition tells me: 'go out, let them have a chance to process it themselves.' (Terry)

> It goes more quickly to a thought for me … I'm that thinking girl who over analyzes everything and whatever else and don't necessary know exactly where you know feelings were in the body I think I experience it more as thoughts…thoughts like the words. (Ophelia)

> It's like suddenly you just have the, don't know where it came from, but the idea to ask a question. (Andy)

Clinical intuition also manifested as an integrated thought and feeling:

> It was visceral in the same way but words concepts, constructs got…hooked on. (Lou)

> I felt it, but it turned itself into a thought….and you get that feeling and then it goes my thought yeah, then, kind of articulates it and then I just go a different direction. (Ophelia)

The Intuitive Flow from a Felt Sense to a Symbolic Representation

Participants' descriptions of their experience of clinical intuition indicated that the clusters of theme 5 existed along a continuum that began in the unconscious and affective realm. The continuum seemed to reflect a developing awareness of the clinical issue and a cognitive understanding of how to respond. While counselors' portrayals revealed that clinical intuition manifested along a continuum, their experiences were not uniform.

While six participants described separate intuitive moments that presented in each of the four clusters, only two counselors shared examples that began in a felt sense, moved into a gut feeling, flowed into pattern recognition, and ended in a symbolic representation. In other words, four participants experienced intuitive knowing in each of the four clusters when more than one instance of clinical intuition was described. Two counselors needed only one occurrence of intuition to reveal all four clusters. Nonetheless, those four counselors who provided different examples of clinical intuitions

did reveal instances that fell into more than one category and supported the finding of a continuum.

For instance, Gertrude described two occurrences of clinical intuition that manifested in different clusters and indicated a flow. Taken together, her examples fell into each cluster. In one situation, Gertrude described a sense that something had shifted with the couple she was working with. That sense quickly moved to a feeling of softening and then the question to ask (symbolic representation) appeared. Although she did not articulate an experience of pattern recognition, her description did support the notion of an intuitive flow. In another example, Gertrude discussed her intuition about a woman in an abusive relationship. In that instance, her intuitive knowledge did manifest in the pattern recognition cluster and then quickly moved to a symbolic representation.

Three counselors did not have experiences that manifested in all four categories. However, two of the three described instances that reflected more than one cluster. For example, Karen shared how she sensed what a client was feeling and then the "thought comes in that this is really about her…fear of…not wanting to be like mom." Although she did not provide an example of a gut feeling or pattern recognition, her experience intimated that a flow existed. Therefore, while clinical intuition appeared in different clusters for different counselors and in different instances, the pattern of manifestation supported the picture of a continuum from a felt sense to a symbolic representation (see Figure 1).

	Affective	**Cognitive**
Conscious	Cluster 2 ***Gut Feeling***	Cluster 3 ***Symbolic Representation***
Unconscious	Cluster 1 **Felt Sense**	Cluster 4 ***Pattern Recognition***

Figure 1. Continuum of clusters from theme 5.

Theme 6: The Nature of the Information Contained in Clinical Intuition

The previous theme captured *how* clinical intuition manifested in participants. Theme six extracted the nature of the information contained in intuitive knowledge. Every participant in this study described the information that was contained in their intuition. The degree and quality of that information were critical to counselors' experiences of intuition because the knowledge dictated or influenced how they responded. Thus, the intuitive experience corresponded to the data it provided to clinicians.

The nature of the information contained in clinical intuition seemed to correspond to the way it manifested. When intuition emerged as a felt sense, counselors experienced a stirring of emotions. As that affective movement increased, counselors became more conscious of it until clinical intuition emerged as a gut feeling. At that point, counselors were more aware of the affective connections that were forming and were closer to a cognitive manifestation of the information.

When intuition took the form of pattern recognition, it had a more cognitive appearance. Counselors experienced a development of cognitive associations that remained attached to affective connections. This growing mass of connections hovered between unconsciousness and consciousness. When it fully erupted into consciousness, it appeared as a symbolic representation. At that moment, the counselor had a meaningful comprehension of the affective and cognitive associations.

Cluster 1: Affective Movement

For six participants, the information presented through a counselors' felt sense was formed by emotions and sensations. Generally, the information contained in these intuitions alerted participants that something relevant was happening:

> Like a pull or a…a 'hey, there's there's an issue here I want you go pay attention to you know…… it as sort of the heart saying like, cause it's so much softer, its like (she whispers)'hey Sally sweetheart.' (Sally)

> I felt that that was that there was something bigger in the room than than I mean the stated problem….It was almost like, it was almost like a heaviness in the room, I don't know it, I don't know that I, I don't know that I (pause) really remember feeling it as a specific sensation in my body I don't, I don't recall that, I recall it more more being just like a heavy presence in the room that maybe something that would something that wasn't being said. (Andy)

The following passage depicted affective movement as it developed toward consciousness. This participant had a felt sense that it was not time to explore a core issue with a client. The felt sense increased into a gut feeling which brought more conscious awareness to the moment:

> It was clear that whatever I was seeing was not to go in that direction. In other words, don't explore what you were seeing…. [The feeling] was so intense, it was so deep…. I think that part of the reason that I did not go there was, was I didn't know how, I could not articulate it….I knew I shouldn't go there and I was thinking it was coming from her but now, it was, it was, that was true, but I also did not have a frame for it, I did not have words for it, so even if she had given some other, even if I thought that she could have gone there, I would not have

> known what to do, and that was later being able to do that…because the intuition was there but it was not conscious. (Lou)

As the movement of emotions quickly grew, the participant experienced:

> This kind of falling into this consciousness, awareness place…. a falling into….When I was doing the elevated log in the ropes course and you had to fall off backwards…you had to fall off backwards and it was just that falling, you know, and not necessarily being caught but just that…there's absolutely no control, I did not, I did not have any fear…kind of being swept up in as if this river came through and picked me up and deposited me, you know downstream in this much higher conscious state….but no fear at all….carried, being propelled, being carried....It was like just being carried, shoved into this awareness place where everything was apparent all at once and there was an absolute a surety that this was reality. (Lou)

Cluster 2: Affective Associations

As counselors continually connected emotionally-laden material, a more conscious awareness of an affective pattern emerged. Consequently, the information contained in their gut feeling was composed of conscious feelings. Thus, for six counselors, their conscious awareness of sensations allowed them to initiate a chain of associations that led to an *intentional* response:

> You know when like when you start to feel dizzy, wow, well I wonder if they did a 360 in the crash….when I start to feel dizzy….and also then when they when they say oh, I feel dizzy, I don't panic and go oh, no, what's wrong with my client, I'm like yeah, okay I need to orientate them to time and space, I need to orientate them to the present cause that's what's so huge, you gotta keep them present, so the safe, adult self could process what happened in the past. (Sally)

> I just kind of start watching for little openings or feeling when their when the anger might be lessening or softening just a little bit…that that would be a time that they might be willing to um try to hear that there's a part of them that feels very angry right now. (Gertrude)

Cluster 3: Cognitive Associations

The affective associations then attached to cognitive awareness before flowing back into the unconscious dimension. The developing cognitive connections incubated

until the pattern reached the critical mass that marked its full return to consciousness. This level of intuitive understanding paralleled the pattern recognition cluster in theme five. Every participant made cognitive associations at this point in the intuitive flow:

> I was talking to one client who's got some um fears about going back home, and how he perceives his mom as bigger than him and dangerous, and I said well, what kind of dog would she be, I'm thinking like where, where was this coming from, and in my head I'm thinking, she's a Chihuahua, you know and he's going to see now perhaps that she's small, he was now bigger than her and he says and I'm like what kind of dog would she be, he says a Chihuahua… and you're just like yeah, and he could feel, I could feel in him this shift because in the in the moment he's realizing in a in a ah felt-sense in a sensation way oh, wow, I'm actually bigger than her, I don't need to have my childhood fear. (Sally)

> What my intuition was telling me about that couple was that he felt like an inadequate partner, the business was not doing well, he was working like a dog trying to make it happen, um, and he felt inadequate, inadequate, and … his solution to that was to leave the relationship. (Terry)

> It's something that sort of *grows and develops* as you know I have an inkling about something and I state it…and then the person would say 9 times out of 10 yeah, that's that's kind of what I'm feeling and this was more about it and so then that adds to it and then I'll say well have you thought about it from this perspective and then they'll you know it's a building…. I just get kind of a little glimpse of mmm let me ask her about this and then she'll give me a little bit more and then it you know it grows. (Karen)

Cluster 4: Cognitive Constructs

The manifestation of intuitive knowledge also emerged completely understood in the experience of all nine participants. The information contained in this cluster corresponded to symbolic representations and provided counselors with the ability to be more intentional in their work. These cognitive constructs surfaced on one level as explicit instructions and on another level as a fuller realization of the underpinnings of the intuitive knowledge.

In the first level, the information contained in the intuition was housed in counselors' questions, thoughts, and directions. At this stage, counselors were able to

comprehend the intuitive instruction but were unable to detect the underlying dynamics of that knowledge:

> I would look at her and I would be like this this was going to change. You would not be here forever. There were solutions. You were doing them and then I would point out the action that she's taking and um that's like a huge promise to make to somebody when…like I don't know, and the truth is, I did know. (Vicki)

> What was clear to me was that this was a truth telling that needed to happen, you know, and she, by this time, she was sobbing and so I said I'm just gonna, I'm going to go out for a few minutes and just sit on the top of the stairs and let you comfort her and then I'll knock on the door before I come back in because I really felt like they just needed some time you know to kind of process some of what was going on. (Terry)

As associations continued to develop, a more complete integration of thought and feeling occurred. Counselors had a deep understanding of the meaning of the intuition:

> I felt this word come up inside of me and the word was betrayed I said this may not fit for you but I get a sense that you felt betrayed….in that case it was a feeling deep inside my heart and, and it came up inside of me like a burp…like, something I didn't think about, but it was visceral feeling of this word that just moved through my heart and my chest and up into my throat and just tumbled out of my mouth. (Barbara)

Just as the clusters of theme 5 seemed to flow from a felt sense to a symbolic representation, the clusters of theme 6 appeared in a similar fashion. Both the nature of the information and the way it manifested were depicted in a wave form that moved through the dimension of unconscious to conscious awareness and the dimension of affective to cognitive material (see Figure 2).

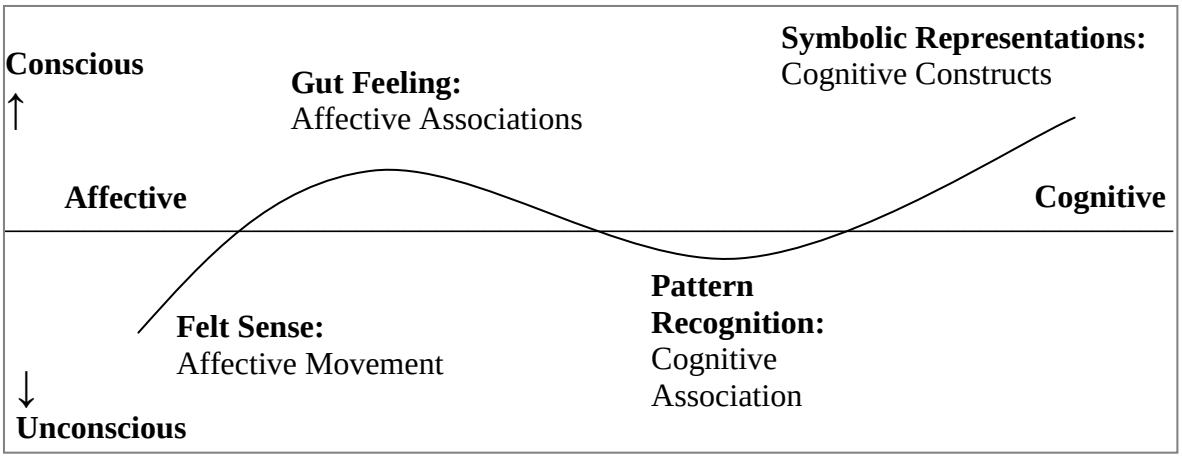

Figure 2. Intuitive wave.

Summary of Themes

Participants' narratives resulted in 6 themes and 23 associated clusters. Unconscious associations, conscious associations, the moment preceding the intuitive knowledge, its initial appearance, the way the intuitive information manifested, and the nature of the information contained in the intuition represented the essential features of counselors' experience of clinical intuition. These categories represented the core of LPCs' experience of clinical intuition. Graphic depictions of the flow of intuition from a felt sense to a symbolic representation have been presented. A comparison of those pictures demonstrated the flow of the intuitive wave through different dimensions (see Figure 3).

The result of the extraction of relevant statements, invariant constituents, clusters of invariant constituents, and larger themes was presented. The remaining sections of this chapter provided progressive levels of synthesis of that analysis.

	Affective	**Cognitive**
Conscious	Cluster 2 ***Gut Feeling*** **"**Affective Associations"	Cluster 3 ***Symbolic Representation*** "Cognitive Constructs"
Unconscious	Cluster 1 **Felt Sense** "Affective Movement"	Cluster 4 ***Pattern Recognition*** "Cognitive Associations"

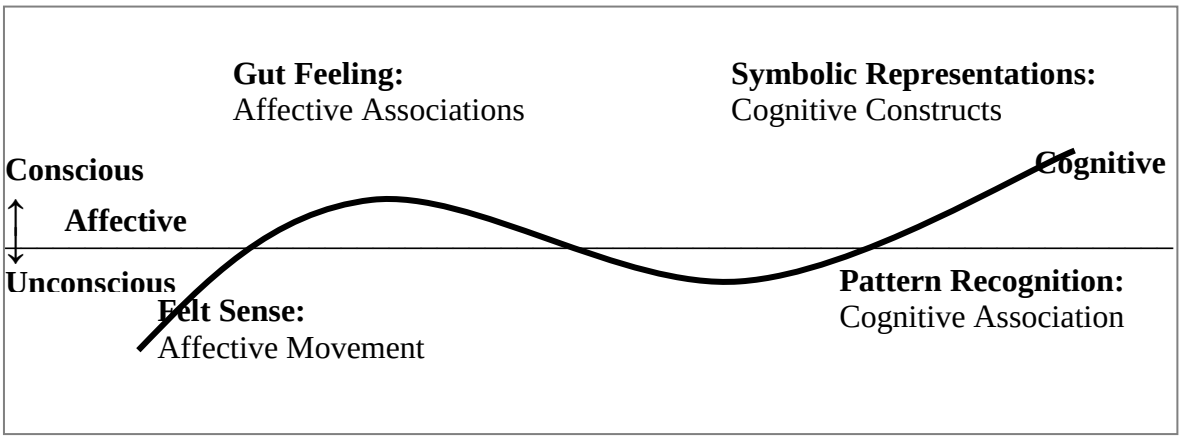

Figure 3. Comparison of intuitive flow in two depictions.

Composite Textual Description

The composite textual description was a recapitulation of the findings that have been presented in this chapter. It was based on the individual textual descriptions from each of the nine participants. Those nine pictures of the experience of clinical intuition integrated into a composite image of LPCs' experience of clinical intuition. The entirety of the experience contained the development of unconscious and conscious connections, the moments prior to and the instant those associations were understood, and the information contained in that knowledge.

Clinical intuition was partially comprised of associations that seemed to form outside of conscious awareness. Some participants inferred from the information contained in their intuitive understanding about the existence of forgotten clinical information. Counselors were not conscious of their theoretical or applied knowledge during the counseling session, but it was evident in the intuitive information. Using a participant's words, clinical intuition was the connection of a "commonality among people" and a "commonality of themes" to a "base of knowledge" (Terry). Through hindsight, participants were aware of patterns that indicated how their clinical knowledge operated outside of their consciousness. Those patterns were apparent across clients or across sessions with the same client.

For some participants, unconscious countertransference reactions were apparent in their interactions with clients. The implicit reactions appeared to be "catalyzed" by conscious attention to their internal sensations or to their client's communication. When they focused on those observations, their unconscious associations surged forth.

Counselors were also consciously aware of associations as they formed in the moment, rather than becoming aware of them only after something triggered their appearance. This conscious awareness was a significant facet of the experience of clinical intuition. Counselors observed and found patterns in clients' nonverbal behavior and verbal communication. They formed connections between presenting clinical issues and their clinical knowledge. The ways they were reacting to, identifying with, or resonating with their clients further contributed to the emergent clinical intuition. Clinical intuition was the experience of forming connections between what clients were saying, how they

were saying it, and the emotions that were apparent within, behind, and under what was visible.

Prior to the emergence of the intuitive knowledge, participants were in a state of nonjudgmental acceptance of themselves and their competency. There was no need to "prove" their skill or do it right. Participants described feeling confident while giving themselves permission to be imperfect. A relaxed acceptance was pervasive and counselors felt receptive to the intuitive information.

Participants described a sense of "presentness" in which they were very aware of the current moment. In this state, they experienced a heightened awareness of feelings and thoughts about what was happening in the session. A "go with the flow" quality, a "content" feeling, and an effortless awareness permeated this place of unstructured time. A feeling of connection with the client was correlated with this sense of presence. Some counselors sensed a quieting of the "emotional and physical chatter" (Vicki) while in this place of intuitive incubation. It was in this state that participants were keenly aware of the pattern emerging from observations of themselves, their clients, and the counseling relationship.

A sense of expectancy preceded the arrival of the intuitive information for some participants. Just prior to the moment of intuitive understanding, participants experienced a feeling of "excitement," "an extra umph," a "push," and "anticipation." Terry described a "possibility of excitement" that heralded the emergence of clinical intuition. This preceding moment was marked by a state of heightened arousal.

For some, the intuitive knowledge presented itself all at once just "like a lightning bolt out of the blue" (Lou). The phrase "all of sudden" was widely used in participants'

descriptions of the appearance of clinical intuition. The intuitive information arrived suddenly and from “out of left field.”

Although the quality of not knowing “where it came from” pervaded the arrival of intuition, a common element of the intuitive experience was the certainty of the knowledge contained within it. While many participants presented the intuition as a hunch to be explored, they were convinced that it was “right.” Clinical intuition felt like “truth,” “surety,” and “right.”

In the instant that intuitive knowledge appeared, it was fully formed. One participant described it as having “no figure ground, it was just a panorama and everything was equal.” Clinical intuition revealed itself with a sense of completeness. Some participants described the appearance as having “a spiritual nature.” A “sacredness” and “holy experience” depicted the holistic, sudden, and certain characteristics of clinical intuition.

Moreover, the participants described different ways in which they registered the intuitive knowledge. Some experienced clinical intuition as a felt sense or physical sensation. Others registered their intuitive awareness as a cognitive understanding. The clinical intuition also appeared as an integration of feeling and thought.

The ways that the “bolt out of the blue” were experienced seemed to fall along an undulating continuum with a felt sense anchoring one end and a symbolic representation grounding the other end. The range of experiences could be viewed as a progression that began with a felt sense (comprised of emotions), developed into a gut feeling (awareness of feelings), moved into a recognition of a pattern (cognitive associations), and culminated into a symbolic representations (meaning was made of prior associations).

While some experiences did not fall into every category and some fell into different categories, the pattern of clusters described by participants indicated that a continuum existed. That continuum appeared to be a dynamic flow that moved in and out of full conscious awareness (see Figure 4).

The beginning of that continuum was experienced as a felt sense and developed into a gut feeling. Those sensations were felt in the body and infused the experience with "an absolute a surety." Participants described feeling "propelled," "swept up," "clear," "lighter," "a softening," or "a shift." Two participants expressed intuitively feeling something "in the room" that turned their attention to something clinically relevant. When the intuitive information revealed itself as a somatic awareness, participants knew that something was salient.

When the experience of the intuitive information became primarily cognitive, it was recognized as a developing pattern. Intuition often appeared as images or words. For some participants, the intuitive knowledge took the form of pictures and analogies. Counselors had to make sense of those images in order to understand the significance. For others, the intuition was a configuration of connections that required additional associations before the design was fully comprehended. Whether it was an image or a nascent pattern, the explicit message was not yet directly apparent.

As the associational information increased, "an internal dialogue" was perceived that provided a therapeutic direction in the form of statements, questions, or instructions. Counselors experienced this type of intuitive manifestation as a symbolic representation that took the form of language. The words were symbols that explicitly represented the intuitive information. The intuition was "speaking" to them in ways that were more

explicit than the cognitive pattern that appeared as a picture. Participants did not need to make sense of the analogy because they were plainly informed by “what my head tells me” (Terry).

Clinical intuition contained varying amounts of information. The intuition was a sense of something important, an identification of what it was, or an assessment of what was required in the counselors’ response. This movement was characterized by a “hint” or “inkling” of something at one end of the continuum and a knowing “what question to ask” at the other. Clinical intuition informed participants to pay attention, to assess what was happening, and to provide a therapeutic response.

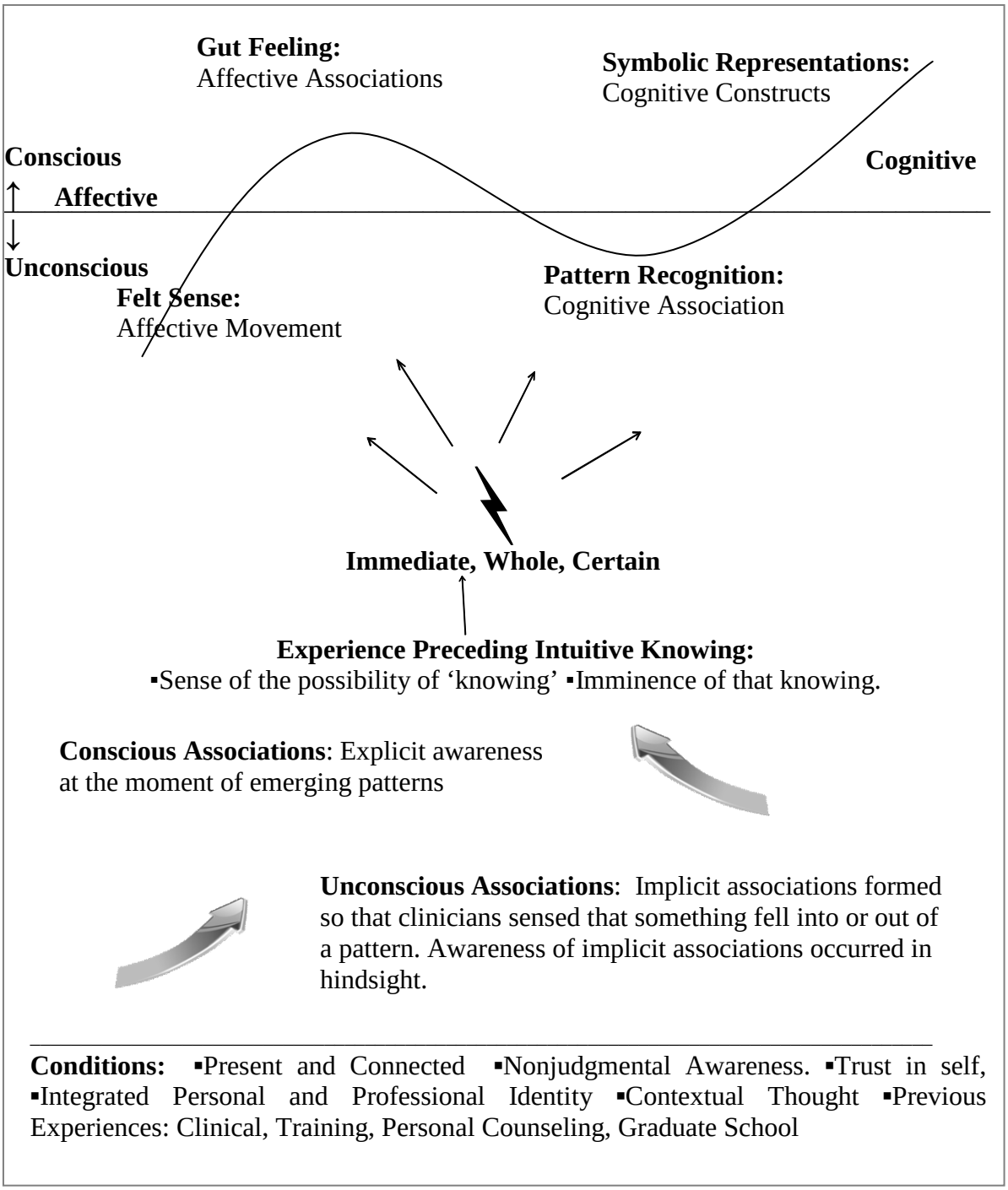

Figure 4. The experience of clinical intuition.

Imaginative Variation

Participants' textual descriptions were transformed into structural descriptions of the experience of intuition through the process of imaginative variation. Imaginative

variation allowed me to walk around the picture that emerged from the phenomenological reduction process. As I imagined different perspectives of the descriptive data, the underlying structures of the experience of clinical intuition were illuminated. Through this process of imagining possibilities, I watched for the 'how' that addressed the dynamics underlying the 'what' of the experience of clinical intuition.

Composite Structural Description

The dynamics that underlie the experience of clinical intuition were inherent in participants' histories and developmental issues. The formation of intuition was influenced by personal and professional experiences. It was also impacted by factors that existed in the evolution of a professional counselor:

> My experience was that I had to step into an office with clients…I had to have a good supervisor who's willing to walk me through my own stuff and um I had to trip into that countertransference stuff and go why'd this feel icky, why'd this feel great, why'd this feel flat, you know, and, and honestly bring it to somebody and get that feedback and then again get some substance to what was given to me in graduate school. (Vicki)

Professional counselors made connections between their experiences in supervision, training, personal counseling and clinical work in order to form the patterns that facilitated intuition (see Figure 5).

Previous Experience

Previous experience provided the information that counselors used to form associations. Those connections were made in a particular session, across sessions with one client, or through sessions with innumerable clients. That picture was based on personal therapeutic work, professional counselor experience, graduate education, post-graduate training, supervisory experience, validation of their intuitive ability, and non-clinical intuitive experiences.

Personal Counseling

Counselors who became clients had a heightened awareness of their emotional reactions to their own clients. Furthermore, counselors credited their personal counseling for their ability to recognize when and how their countertransference reactions were triggered. The increase in self-awareness prompted a concomitant increase in awareness of the counseling process. Participants grew more aware of what was happening with clients and in the clinical session.

Participants also credited their "own work" for their ability to remain present in clinical situations. Personal counseling also fostered a sense of self-acceptance that was conducive to a receptive environment for the emergence of clinical intuition. Additionally, personal work gave counselors the experiential knowledge that deepened their understanding of theoretical concepts. Their therapeutic process seemed to provide a language that bridged theory with actual clinical practice. One participant reflected, "You get to do your own work and in the process you begin to have a not just a vocabulary like a theoretical vocabulary but this experiential vocabulary you could then share with your clients" (Vicki). Therefore, experience with the counseling process as clients gave participants a way to talk about psychological concepts.

Clinical Practice

Experience as a professional counselor further contributed to an increase of awareness of the counseling situation. Clinical practice filled long-term memory with case examples that could be compared with current clinical pictures. The storage of those associations created the patterns that stimulated the appearance of clinical intuition.

Experience also provided counselors with "the structure in your head of what you're doing" (Karen). This sense of competency encouraged the emergence of intuition because counselors felt a greater self-acceptance. They were more likely to feel open and receptive to intuitive awareness. Furthermore, clinical practice provided counselors with the experience of acting on intuitive knowledge and receiving confirmation from clients of their "hit." Those moments encouraged and reinforced their trust in their intuition.

Graduate School and Post-Graduate Training

Graduate school for some participants was a time of theoretical curiosity, exploration, and self-discovery. Counseling programs provided courses that became "a path of personal growth at the same time there was that learning" (Gertrude). Those programs also taught the value of the therapeutic relationship. One participant stated, "LPC was what I was raised in, you know if I wanted the medical model I could have gone to a different school…I was raised in was this idea that it's the human relation that did the work" (Vicki).

Participants spoke of their post-graduate training as a time when their "gift" of intuitive awareness was validated and encouraged. One participant stated that her training gave her "carte blanche to let my intuition come out" (Barbara). Through continued training, professional counselors felt more trust in their intuitive abilities.

Some counselors participated in training that integrated personal therapeutic work with supervision. Connections were facilitated between their awareness of themselves and their awareness of the clinical situation. An integrated training experience allowed counselors to more readily generalize their personal work to their professional work.

Supervisee Experience

Supervisory experience also had a significant impact on the counselors' awareness of their clinical work. Supervisors encouraged or instructed participants "to work on your own issues" (Lou). This urging led counselors to engage in personal counseling and to increase their self-awareness.

Other supervisors were able to integrate instruction and counseling in their supervision of participants. Those counselors were then able to make connections between their personal and clinical work. Supervisors were instrumental in facilitating an exploration of participants' countertransference reactions to clients. Counselors examined the ways they were triggered and what those reactions meant about themselves and their clients.

Some participants described feeling supported in their self-exploration through their supervisory process. Supervisors encouraged self-acceptance and the discovery of "who I am as a counselor" (Ophelia). Some counselors also felt that their intuitive abilities were fostered and "applauded."

Confirmation of the Validity of the Intuition

Participants often tentatively presented intuitive knowledge. When clients validated that intuitive awareness, counselors felt encouraged to trust their intuition. Also, "if you nail it, you know, later on I'll think how did how did I know that or where did that come from" (Gertrude). The confirmation from clients stimulated a search to discover the origins of the intuitive information.

Non-Clinical Intuitive Experience

For some participants, childhood experiences demanded an aroused, alert, and sensitive state of being. As children, they had to attune themselves to "minor…nonverbal cues" (Lou). In this place of childhood awareness, "intuition was honed by being aware of um small behaviors and what they meant" (Lou). As adults, those participants continued to give attention to subtle environmental stimuli.

Developmental Issues

Issues that pertain to counselor development also influenced the experience of clinical intuition. For participants, these were matters that they had moved through, were newly experiencing, or had returned to. These developmental issues exerted a large influence on counselors' experience of clinical intuition. Issues that appeared to reduce or decrease the possibility of the experience of intuition included context-free rules, critical self-consciousness and concerns about competency. Factors that seemed to enhance the clinical intuitive experience were contextually based responses, nonjudgmental awareness and an integrated counselor identity.

Context Free Rules to Contextually Based Response

Participants described a shifting away from a need to follow a predetermined way of providing counseling and a movement toward a sense of responsiveness to what was required in the present moment. It was a process of "folding back I think my intuition into my clinical experience because when I was first post graduate I was very, I think by the book" (Barbara). Motivated by an "awful wonderful need to excel at what you're doing" (Terry), counselors made decisions based on their search for the "right" intervention. During a session, they directed their attention to their memories of

coursework, textbooks, and supervisors' instructions, failing to maintain an awareness of everything else that was happening in the session.

As counselors developed, they experienced a growing ease with the structure of counseling and a concomitant willingness to do what was required without first identifying the "right" technique. One participant stated, "I'm realizing it takes some intuitiveness to know how to use that protocol and um I haven't been doing it long enough so that's where I really um feel less capable to roll with the punches" (Ophelia). As participants moved away from context-free rules, they were less constrained by manualized plans-of-care.

When counselors were not focused on following a predetermined script, they were more likely to enter into a clinical environment that was conducive to the experience of intuition. A participant reflected that "intuition doesn't feel like after I'm out of the session….thinking…what would my teacher say about that or…what would the theories say about that…or what would I think now that I'm not sitting with my client" (Vicki). Participants felt "present" and "connected" when attending to what was happening in the moment as it occurred. When they were not actively trying to "figure it out," their awareness broadened to incorporate more of the clinical picture. "When I could just let it sit back there then I'll get that hit of well this was what I need to do" (Gertrude). They trusted that the information was there and they could relax enough to allow it to form into clinical intuition.

Critical Self-Consciousness to Nonjudgmental Awareness

The movement from a critical appraisal of their clinical abilities to an accepting self-awareness facilitated the emergence of intuition. At the disparaging end of this

continuum, participants doubted their skills, questioned whether they had the knowledge to do this work, and wondered if they were good enough to deserve their credentials. Participants described how they relied "more on my intellect than on my heart" (Karen) when in this place of self-judgment.

However, when they worked from a place of self-awareness, the barriers to intuition, erected by self-consciousness, were lowered. Counselors monitored what they were doing and what was happening in the session without the need to be perfect. Their acceptance of how they "don't have to be right" (Karen) decreased their anxiety to a point where the clinical intuition could present itself. Furthermore, they were more likely to trust themselves "to go with it" when the intuitive information was there.

The uncritical self-awareness that came about through their personal counseling and supervision experiences provided "a clearer map of what to do [in session] and therefore the times I might not have been on target, there were less of those times" (Lou). It also allowed counselors to work from a place of intention:

> I would use more discrimination whereas before I just go ahead you know just kind of crashing through…. you know and it was like I wouldn't realize that you know probably the client was not ready for that..kind of thing. So I got more discriminating. (Lou)

Therefore, the detection of what to do and when to do it was enhanced with self-awareness.

That ability to be intentional was vital to counselors' therapeutic responses. They examined their own reactions and discerned whether their feelings or thoughts were of a countertransference nature or an empathetic ilk. When it was determined that it was a countertransference reaction, counselors intentionally explored their reaction to find the nugget of gold within their reaction. When counselors accepted that their unresolved

issues were activated, the golden nugget informed them about the client behaviors that triggered their reaction.

Competency Concerns to Counselor Identity

Clinical intuition was more likely to surface when participants felt secure in their identity as counselors. One participant stated that “the better you get at the technical, the clinical stuff, the less it becomes necessary or as important for you to have it because it was kind of all morphing together into a more general awareness about how you need to be” (Andy). As confidence in their abilities increased and trust in their role deepened, counselors seemed better able to attend to the salient information that formed the basis for their intuitive knowledge.

As participants developed, their experiences of intuition transformed along with their sense of competency. A level of confidence about “having some tools in your toolbox” (Ophelia) provided some participants with an experience of intuition comprised of knowing “which one to pick out in the moment” (Ophelia). As confidence in their competency increased, other participants had a sense that “I could just sit and be an instrument” (Sally). The birth of a counselor identity was a time when participants felt that they were themselves at the same time they were in a professional role. They merged their clinical knowledge and experience into their self-awareness of their personal reactions.

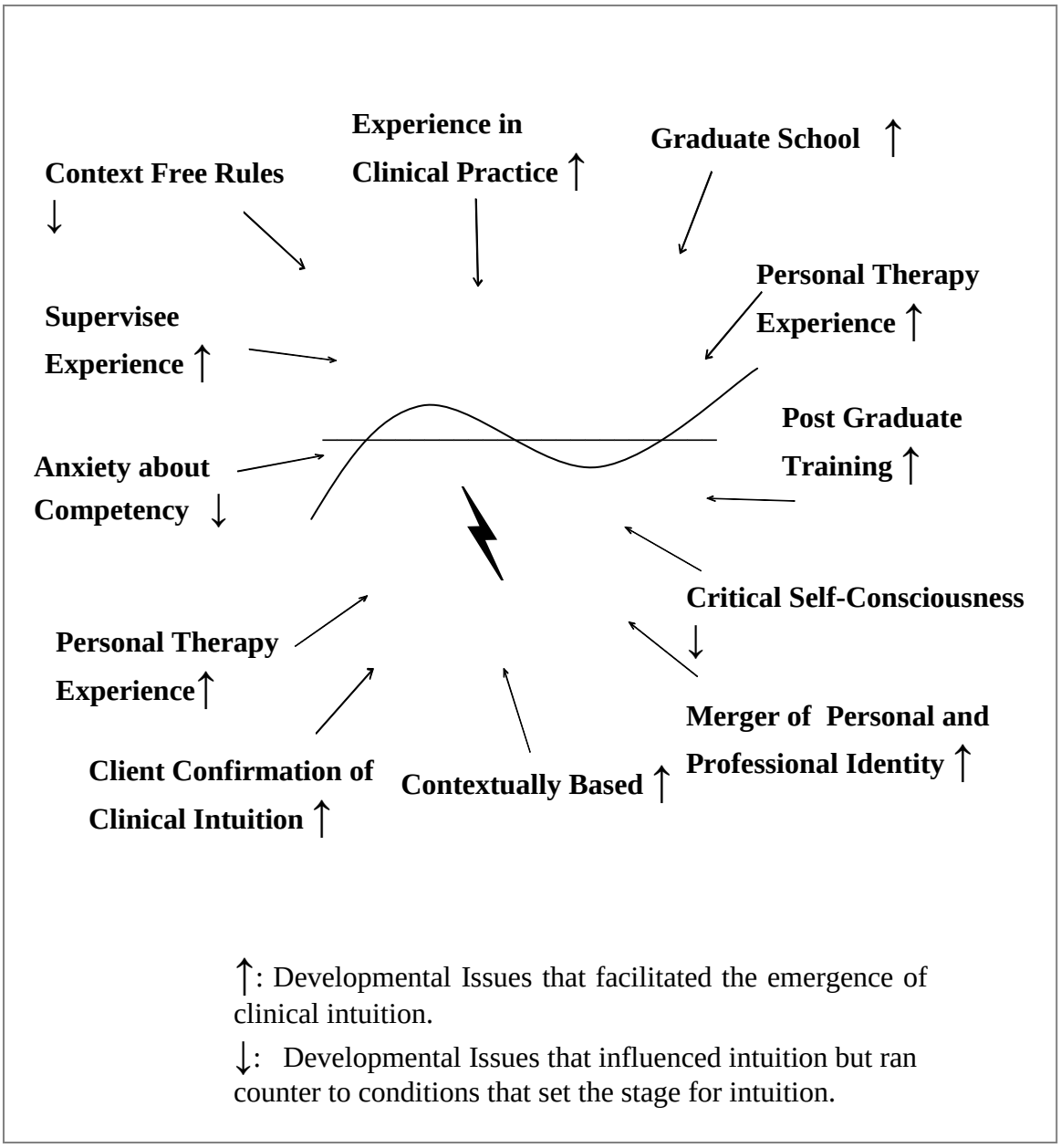

Figure 5. Conditions and influencing factors of clinical intuition.

Synthesis of the Composite Textual and Composite Structural Descriptions of the Experience of Clinical Intuition

Clinical intuition appeared suddenly and was imbued with a sense of certainty. It was a revelation of a complete clinical picture which was not seen a moment before. For some, the arrival of intuitive knowledge held a sacred quality.

While the presentation of intuitive information happened abruptly, the entire experience was a slow progression of developing associations. Its appearance prompted counselors to ask “where did that come from” (Gertrude)? The experience of clinical intuition was comprised of the answers to that question, the instant it appeared, and the nature of information it contained.

The “bolt out of the blue” (Lou) was more like a bolt out of the collision of past experience and the current clinical situation. An occurrence in the present moment catalyzed a pattern of connections which appeared as intuition. Those associations were linked through the unconscious and consciousness in a dynamic, fluid, and undulating flow. The clinical dots were connected over time, across different clients, and across multiple sessions with the same client. Furthermore, the developing associations moved through affective and cognitive realms.

In the domain of the unconscious, a storehouse of forgotten clinical knowledge and experience existed. That depository was created when counselors moved some or much of their knowledge of counseling theory, graduate coursework, professional trainings, and clinical experience into their long-term memory. That knowledge seemed to be retrieved either at will or unintentionally.

The unconscious was also an apparent repository of present-moment awareness that had not fully reached a counselor’s conscious attention. Outside of their consciousness, counselors were connecting their countertransference reactions to clients’ nonverbal behaviors and to clients’ verbal expressions. Once in consciousness, more time was needed for that burgeoning collection of associations to take form. Counselors gave their attention to what clients were saying and what they were not. They were aware of

the ways they were reacting to clients and how they were identifying with them. A sense of resonance with a client's phenomenological world was experienced. Those areas of awareness were linked to associations in the unconscious in an intuitive design that seemed to arrive "out of no where" (Barbara). Once the intuitive knowledge appeared, counselors were able to intentionally explore and assess the clinical situation.

The ways that counselors made sense of the pattern of developing connections was dependent upon their degree of awareness of what made up the associations. That awareness seemed to increase with experience. Previous and continuing personal counseling, supervision, clinical practice, and training were wellsprings for the enrichment of attention to themselves, their clients, and the therapeutic relationship.

Through their personal therapeutic work and clinical supervision, counselors learned to turn inward and examine the thoughts and feelings which underpinned and motivated how they were in the world. This process of self-exploration sensitized their clinical antennas to the subtle nuances of their felt-sense reactions. Consequently, when working with their own clients, counselors received the emotional and somatic messages that may have otherwise occurred unconsciously.

Cognizance gave clarity to previously unconscious associations and it provided intentionality to counselors. It allowed counselors to disentangle their activated personal issues from their empathetic or attuned understanding of clients' lived experiences. Consciousness also gave counselors the ability to detect when the dots were actually their own unresolved issues. Moreover, sensitive antennas could identify the clinical significance of the pattern of those dots. Counselors attended to the ways they were identifying with and experiencing countertransference reactions to their clients. They

could sort out the specific client behaviors that were triggering their responses and then connect that information to other clients who activated similar reactions.

Furthermore, professional counselors linked their clinical knowledge to those associations that formed out of their self-awareness. Their clinical knowledge included counseling theory, coursework, clinical practice, and training experiences. Information was pulled from both long-term and working memory. This process facilitated the emergence of a cohesive pattern that was experienced as clinical intuition.

That design seemed to appear when counselors were in a state of receptivity. Their antennas were freely roaming and picking up information in the present moment. Internal messages and external cues were perceived without an active effort to do so. When counselors were not grasping for proof of their competency, they trusted that "the information would come" (Gertrude). When their energy was not spent on doubting their abilities, they had it to give to the associations that were forming.

Out of this relaxed and alert state came a feeling of expectancy. An excited energy announced the coming of the intuitive information. That knowledge suddenly emerged and was infused with a quality of certainty. An apparent correspondence existed between the way counselors registered that appearance and the nature of the information it contained. That relationship was in keeping with the dynamic flow of intuition through the dimensions of affect, cognition, the unconscious, and consciousness.

Intuitive knowledge appeared along an undulating continuum that encompassed two dimensions: (1) affective and cognitive material and (2) unconscious and conscious awareness. Generally, intuition was expressed along a continuum that revealed affective and cognitive elements and dynamically moved in and out of conscious awareness.

Counselors' felt sense was experienced as an affective movement. The felt sense was generally experienced somatically and counselors had a growing sense of something significant in the session. This level of intuition was often characterized by physical sensations created by the movement of emotions. In this phase of the wave, counselors experienced a felt sense that something was happening.

As the affective movement propelled the wave of intuition along, counselors sometimes experienced a gut feeling. In this phase, counselors were conscious of their feelings and were more able to intentionally link their affective associations. They detected and made sense of their feelings and somatic experience.

Then, the flow from a felt sense (affective movement) to a gut feeling (intentional connections of affective associations) dynamically moved into the cognitive realm. This progression returned some counselors' experience of intuition to the realm of the unconscious. This return was not total and it was not static. In this phase, intuitive knowledge was perceived as pattern recognition. Cognitive associations were developing and moving again toward conscious understanding. During this process, the pattern of associational material was recognized but was not yet understood. In this phase of intuitive knowledge, some counselors imagined pictures or analogies. They still had to make meaning from the images in order to fully comprehend the intuitive knowledge.

When the intuition flowed into the conscious and cognitive realms, the assembly of associational material was clearly understood. At this phase of symbolic representations, meaning was attached to the recognized pattern. During the development of comprehension, some counselors experienced their intuition in the form of words,

statements, directives, or questions. They intuitively knew what was relevant and determined a degree of therapeutic direction.

CHAPTER 5: DISCUSSION

The purpose of this study was to investigate the essence of the experience of clinical intuition through the perspectives of LPCs. A phenomenological research method was utilized to explore the essential core of professional counselors' experiences of clinical intuition. Ten interviews with nine participants resulted in verbatim reports of their intuitive experiences in a counseling context. Transcripts of those interviews then provided the raw data that was utilized in a process of phenomenological reduction, imaginative variation, and synthesis (Moustakas, 1994).

That method produced six thematic areas that captured the essence of the experience of clinical intuition for these participants. Those themes were detailed in Chapter 4 and were relevant to the purpose of this investigation and four corresponding research questions. The guiding research question was: How do LPCs experience clinical intuition? The ensuing questions were:

How did counselors define clinical intuition?

How did they describe their intuitive experience in a counseling context?

How did counselors perceive and understand their development of the ability to use clinical intuition?

How did counselors relate their professional and personal experiences to their development of the ability to use intuition?

Six themes organized the findings of this study: unconscious

associations, conscious associations, the moments preceding the arrival of intuitive knowledge, initial appearance, manifestation of intuitive knowledge, and the nature of the intuitive information. This chapter explored the key findings of the current study relative to the literature that was reviewed in Chapter 2. Then, implications for clinical practice, counselor supervision, and counselor education were examined. Finally, limitations and suggestions for future research were offered.

LPCs' Experience of Clinical Intuition

Although all six themes were components of the overall experience of clinical intuition, three areas most captured the core experience for counselors in this study. First, counselors described distinct characteristics that seemed to herald the arrival of the intuitive information. Second, participants experienced the quality of the intuition information in particular ways. Finally, the way the intuitive knowledge manifested in each counselor was a major facet of the experience itself.

Moments Preceding the Arrival of Knowledge

During the moment just prior to the appearance of the intuitive knowledge, counselors experienced a state of calm arousal. Participants' descriptions of this moment were reminiscent of Moustakas's (1994) conceptualization of the phenomenological Epoche. Both were a time of quieting the mind's "chatter" so that what remained was heard from the present moment rather than previous judgments or biases. Counselors softened their grip on predetermined therapeutic directions and were open to contextual cues that guided interactions and interventions.

Their minds' eyes were watchful but not fixated, and Reik's (1948) third ear was tuned to a multitude of frequencies. Similar to the Epoche, this was a time when internal

and external messages were heard only as they were communicated rather than heard through a filter of counselors' expectations. Subtle messages were brought into prominence, and the "soft knowing" of intuitive knowledge was registered.

Reik (1948) compared that position of alert receptivity to a light: When the light was not fixed in a particular spot in anticipation of something expected, it was able to illuminate the entire area. Thus, the intuitive knowledge waiting in the shadows was made visible. His searchlight analogy had implications for the use of intuition and was explored in a forthcoming section.

If the time before the arrival of intuitive knowledge was characterized by a field of light where everything had an equal chance of detection, then the instant before was marked by sound. Participants related a sense of expectancy that could be compared to bells and whistles echoing from the field. Therefore, the intuitive information emerged from a glowing field amid the sound of music.

Initial Appearance

Clinical intuition was not summoned, it arrived unbidden. Its appearance was complete, certain, and often sacred. It was not doubted for truth, nor was it partial. Although counselors often worked to fully comprehend the intuition, its arrival was experienced as a complete amalgam of information. Furthermore, counselors sensed that the intuitive knowledge was imbued with something greater than themselves, their egos, or their cognitive capacities.

Manifestation of Knowledge

This theme reflected the ways counselors experienced the manifestation of intuitive knowledge. The information flowed from a felt sense to a gut feeling to a

recognized pattern and then, finally, to a symbolic representation. In contrast to the overview of implicit to explicit awareness presented in Chapter 2, the clusters that emerged in this theme seemed to suggest less delineation between unconscious processes and conscious awareness. It appeared that the actual experience of intuition for professional counselors in this study was more aligned with a dynamic wave that flowed through the dimensions of unconscious to conscious awareness and affective to cognitive material. The intuitive flow illustrated the development of associations that continually influenced counselors' understanding of the current clinical situation.

The identification of a pattern and the construction of the meaning of that pattern were primarily cognitive processes. This finding was similar to the pattern recognition model proposed by Welling (2005). The resemblance was also apparent in the idea that intuition contained increasing amounts of information. The findings of this current study suggested that the available information grew as the intuitive flow moved toward the cognitive and conscious spectrum. In Welling's model, more data were also available at each progressive level.

Another major point of correspondence was found in the concept of pattern recognition. Although Welling (2005) was not alone in his view that individuals made sense of the world through the formation and activation of patterns (Gobet & Chassy, 2008; Eisengart & Favier, 1996), his model did stand out as a way of conceptualizing the experience of intuition. In comparison to the current study, his model was similar to the pattern-recognition cluster.

In his model and both clusters, associational material formed patterns that were used to cognitively and consciously understand the presenting situation. In this study,

participants' experience of clinical intuition as a recognized pattern occurred in the form of images. This cluster corresponded with Welling's (2005) metaphorical solution phase, when intuition appeared as pictures or metaphors. Both the pattern-recognition cluster from this study and the metaphorical solution phase from Welling's model required further interpretation from the counselor. Complete comprehension was not reached until the symbolic representation cluster from this study and the explicit verbal understanding phase from Welling's theory.

A point of divergence between the findings of this investigation and Welling's (2005) model was discovered among the dimension of affective and cognitive associations. While correspondence existed between Welling's model and this study's cognitively-based clusters, the affective dimension of this current investigation was not as developed in his theory. His model presented a cognitive theory of intuition, while this study offered an integrated affective and cognitive theory.

How Counselors Defined Clinical Intuition

Participants provided general definitions of clinical intuition which seemed to provide a frame for their descriptions of their experience. Several participants described clinical intuition in terms of feeling connected to their clients in the present moment. Others noted that clinical intuition was a way of quickly understanding deeper and unexpressed clinical issues: "The intuitive mind can slice through cognitive beliefs and cognitive levels and get to the heart of the matter" (Barbara). Counselors also acknowledged that attention to subtle nuances in clients' behaviors were a part of clinical intuition.

Although participants articulated their *opinions* about what clinical intuition was, their descriptions of their *experience* provided a rich source of information about the essence of clinical intuition. The themes that emerged from the data captured the core of what clinical intuition was. The following definition surfaced from those findings: Clinical intuition was the emergence of unconscious and conscious associations of counseling theory, clinical practice, and personal experience into an awareness of the current clinical situation.

How Counselors Described Their Intuitive Experience in a Counseling Context

LPCs' experience of the moment before and the arrival of intuition were also enfolded into their experience in a counseling context. Moreover, additional themes were relevant to the intuitive experience in a counseling context. Two of those areas consisted of the associations that were formed unconsciously and consciously. Those connections were comprised of clinical knowledge, countertransference, the presenting clinical issues, counselors' resonance with clients, and clients' nonverbal and verbal communication. The third area consisted of the information that was housed within the clinical intuition. That knowledge was related to the associations that had formed in the unconscious and consciousness.

Unconscious Associations

Participants speculated that their clinical knowledge and countertransference reactions were operating unconsciously in their clinical practice. First, the existence of implicit clinical knowledge was supported through the apparent connection of what counselors did in session and what they learned in school, training, and practice. This relationship suggested that clinicians' knowledge and skill base continued to exist even

outside of their conscious awareness. That finding supported the template theory, proposed by Gobet and Chassy (2008), which explained the ability of professionals to create templates of information based on their experiences. Relative to the findings of the current study, the template theory suggested that clinical knowledge was stored as patterns in long-term memory and was retrieved when activated by something in the present moment.

Secondly, support for unconscious countertransference reactions was surmised from incidents when clinicians *did* notice their thoughts and feelings about clients. Counselors sensed that countertransference reactions did not always wait for the light of awareness in order to operate. Moreover, counselors' intentional process of disentangling a personal reaction to clients from an empathetic response implied that personal reactions (countertransference) may have occurred and were not always detected. That finding supported Dass-Brailsford's (2003) suggestion that these reactions might have been present even when counselors were not conscious of them. That researcher examined the impact of awareness on these unconscious processes.

As participants described their experiences, they made inferences about their unconscious awareness. Therefore, counselors' reflections were imbued with a quality of tentativeness. From the standpoint of a conscious rendering of a remembered experience, it appeared difficult for participants to discern the moment when unconscious processes moved into their consciousness. It was possible that counselors were unconsciously aware of more than what they explicitly noticed and, consequently, reported during their interviews. That idea was supported by Kihlstrom's (1987) theory of the cognitive unconscious. His review of automatic processes, subliminal perception, and implicit

memory supported the notion that the unconscious was actively involved in an individual's experience of the world.

Furthermore, some participants realized that their awareness of discrete observations had been growing at different rates. That development suggested that a clear delineation between unconscious and conscious awareness of the clinical picture may not have existed. Therefore, a counselor may have had disparate levels of awareness about different aspects of the clinical situation.

Those varying degrees of awareness were depicted in one participant's case illustration (see Appendix J). Andy's increasing awareness of nonverbal behavior seemed to parallel, but not match, his awareness that the presenting issue did not warrant either the referral to counseling or "the level or the intensity…of emotion." That finding was supported by Kihlstrom's (1987) work on unconscious cognitive processes. His model of memory challenged the theory that information processing happened in a series of stages. He proposed that information could be processed in a network of parallel activation. Thus, as in Andy's experience, a growing awareness of nonverbal interactions occurred at a different rate than a burgeoning knowledge of the clinical issue.

Nascent Clusters

Given that both unconscious and conscious awareness of clinical knowledge and countertransference appeared in the data, it was logically possible that counselors could unconsciously attend to other types of observations. McKinnon's (2005) examination of neural science and intuition led to his suggestion that unknown processes may be "unrealized rather than absent" (p. 44). Therefore, for instance, although unconscious identification was not revealed in this investigation, it was plausible that it existed.

Other clusters in this theme began to form but failed to fully emerge. Participants' unconscious attention to clients' nonverbal behavior, verbal communication, and the presenting clinical issue were described by only two participants. Unconscious attunement was also reported by one counselor in this study.

Conscious Associations

This theme encompassed the essential nature of counselors' observations that were made with their conscious awareness. Participants described what they attended to and were aware of in the moment that it occurred. Apparent cues were linked and then associated with connections in the unconscious. Some participants noted that they were cognizant of "becoming conscious" of those associations.

Participants were conscious of their clinical knowledge, the presenting clinical issue, their identification with clients, their countertransference reactions to them, their resonance with them, and clients' nonverbal and verbal communication. Embedded in their descriptions were connections within and between each cluster.

The Nature of the Information Contained in Clinical Intuition

Counselors' awareness of themselves, their clients, and clinical situations were tributaries that led into the intuitive flow of information. The stream gained in momentum as associational bonds propelled the current in and out of consciousness. It began with a movement of emotions and culminated in cognitive constructs.

The affective movement, characterized by sensations and emotions, grew toward consciousness as connections of affective information increased. The dynamic flow, still carrying the affective material, then hovered in the realm of the unconscious as it journeyed toward the cognitive sphere. As affective and cognitive associations merged, a

recognizable pattern formed. When the pattern was clearly visible in consciousness, counselors made meaning of it in the form of a cognitive construct.

Conscious awareness distinguished affective associations from affective movements. Thus, when the unconscious movement of emotions joined other affective material in the intuitive current moving toward consciousness, counselors were able to be more intentional in their responses. Gendlin (1978) purported that an intentional focus brought that felt sense more clearly into consciousness. Consequently, when counselors were cognizant of what they were feeling, they could be responsive rather than reactionary (see Figure 6).

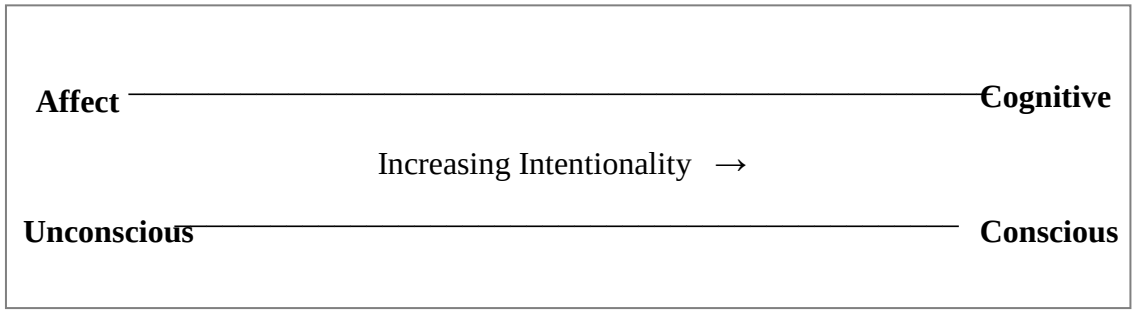

Figure 6. Intuitive volition.

That intentionality was also true of cognitive constructs. In that cluster, the degree and quality of intuitive information provided counselors with the ability to identify the clinical issue and to comprehend the meaning of it. That capability was reflected in Welling's (2005) final phase of pattern recognition when clinicians made sense of the clinical situation. Counselors then purposely responded to what was required in the moment rather than blindly reacting to what was unclear in the situation. The clinical significance of intention was further explored in the implications of this study.

How Counselors Perceived and Understood Their Development of the Ability to Use Clinical Intuition

Counselors' development of the ability to use clinical intuition seemed to correspond with an integration of their intuitive guts and their clinical minds. Some participants noted that clinical intuition contained their "highly analytical" processing skills and the insight gained from clinical training. Barbara stated that she considered that "logical deduction was a subset of intuition" and that her "analytical, critical thinking skills" occurred quickly and were based on patterns formed through her clinical experience. Another participant reflected:

> Intuition was larger than insight….The insight comes from training…um information you know when a client looks this way, think of depression, blah, blah, any of those kinds of things….I'm seeing insight, how I'm looking at it as more a cognitive. (Lou)

That belief implied that intuition contained affective elements, insight was primarily cognitive, and clinical intuition seemed to be a merger of both.

Those participants entered graduate school with pre-existing intuition that had developed through their childhood experiences. In their youth, they learned to adapt to their environment by acquiring highly alert and observant behaviors. Then, during their counseling programs and continued training, they developed clinical insight. Ultimately, as their personal and professional identities merged into a counselor identity, their intuition and clinical insight also integrated into clinical intuition.

The emergence of a counselor identity and clinical intuition seemed to be impacted by the softening of the voices of their internal judgers. When participants were preoccupied with whether they were using the right intervention or moving in the right direction, they were less able to utilize their intuition. Terry remarked: "I think we're so

bogged down in just trying to do it all right…that we can't at that point have the luxury of developing any intuition, clinical intuition, because we are trying to do it by the book." Terry's reflection corresponded with Stoltenberg's et al. (1998) description of counselor development. Those authors noted that a decrease in performance anxiety was necessary for a clearer conceptualization of the clinical situation.

Moreover, participants noticed that they were better able to use their intuition when they were no longer operating by context free rules. That notion was reflected in the novice stage of Benner's et al. (1992) model of clinical intuition in the nursing field. When clinicians were utilizing preconceived interventions and techniques, they were more likely to miss the deeper presenting issues. Stoltenberg's et al. (1998) early stage of counselor development also echoed that idea. They wrote that a preoccupation with a perfect delivery of a technique obscured the broader clinical picture. In this current study, Terry noted:

> 30 years ago I think I would have taken what they [clients] said at sort of face value and and just gone with that….I think when you're a younger clinician, you, you don't, have the um, well, this is what I observe in my supervisees , you have that that awful wonderful need to excel at what you're doing……but you don't yet have the clinical intuition that goes along with it so you're very much I think you're very much operating on the face, the surface of it, what they're saying….. you're not looking for any kind of deeper meaning, you're responding to what they're telling you.

As counselors gained more clinical experience, the ability to intuitively respond to what was required in the moment also seemed to increase.

Another core component of counselors' understanding of the development of their ability to use intuition was their perception of the impact of their growing ability to be present to their clients. Earlier in their careers, their concern of what others would think of their performance and their dependence on textbook knowledge seemed to pull them

out of the moment and into the classes they had taken in graduate school or the supervision they were able to receive. The more counselors felt present and connected to their clients and the therapeutic process, the more they were to access their clinical intuition.

How Counselors Related Their Professional and Personal Experiences to Their Development of the Ability to Use Intuition

Counselors' personal and professional experiences provided the raw material contained in their unconscious and conscious associations, increased their awareness of that information, and deepened their trust in their ability to respond to clients based on that awareness. Their experiences were comprised of their pre-clinical intuition, personal therapy, supervision, clinical education, and clinical practice. Personal therapy and supervision provided the contexts for their increased awareness; and counselor education and clinical experience gave them a storehouse of information and the trust in their intuitive ability.

Several participants described childhood and adult experiences that occurred prior to their clinical training and deepened their propensity for keen observation. Their heightened awareness was carried forward into their work with clients. Before entering graduate school, they had already honed their senses to the world around them.

Participants then described personal therapy and supervision as arenas to explore unexpressed issues that were influencing the therapeutic encounter. Dass-Brailsford (2003) purported that clinicians must be aware of themselves in order to fully actualize the potential of therapy. In this study, participants noted how their own therapy and

supervision increased their awareness of themselves and the issues that were activated with clients. Sally noted:

> It's so important that I've done my own work, I don't think I can sit with terror in a client if I haven't sat with my own terror because their terror is going to come up and I'm going to check out.

Supervision seemed to create a bridge between personal therapy and clinical work. Supervisors facilitated counselors' generalization of their self-awareness to their awareness of the clinical situation.

Counselors' education, training, and clinical experience were also pivotal to their development of intuition. Their education and training provided a map of expectations and a guideline of how to be in the counselor's chair. Participants described that framework as the foundation of their work. Their experience was built upon that ground:

> I think the more you do it and the more you um work with people the (pause) the more you see the more patterns you notice the more you know that you can be yourself in in a counseling session that you have certain things that you need to follow and and you have the structure in your head of what you're doing….but yet within the context of that you can you can just be a human being with another human being….and but that's really where the healing is if they feel that their there, that you're there with them you hear them. (Karen)

Several counselors in this study acknowledged the impact of their continued training on their ability to use their intuition. Influential training models provided supervision that connected didactic instruction, experiential learning, and personal exploration.

Finally, counselors attributed their increased trust in their intuition to the development of the ability to use it. Their trust emerged from their sense of competence as clinicians. When participants recognized that they had honed their skill sets, they felt freer to risk listening to and responding from their intuition. Furthermore, the continued validation from clients and the support from supervisors deepened that trust. When

counselors knew they had “nailed it,” they had more assurance in their ability to see deeply into the clinical situation. Supervisors contributed to that confidence by encouraging counselors to listen to themselves and respond accordingly.

Implications

The themes and associated clusters of the essence of clinical intuition had implications for counselors. The overarching contribution of this study was the credence it gave to the possibility of teaching the intuitive ability. One participant aptly reflected on whether it could be learned:

> If intuition really comes from someplace other than the data…it’s just the way it was and you tap into it or you don’t and its either as big as it or its…. as small as it was for you, because of the the gift or or was it…other skills that we have in our life where the the more we practice then the more we’re open to them, the more different ways we try to apply them that we do get better at it. We we could open the door up wider or invite the flow to be more full. (Andy)

The findings from this study seemed to ‘open the door up wider.’ The extracted essence of clinical intuition suggested that increased awareness provided more information in counselors’ intuitive knowledge. Moreover, the degree and quality of that intuitive information seemed to enhance counselors’ ability to be intentional and timely.

Furthermore, this study revealed the conditions that seemed to support the use of intuition. The “very soft knowing” (Gertrude) of intuition was audible when counselors felt present and connected with the clients, when counselors’ felt more confident of themselves, and when counselors had integrated their professional identity.

Therefore, the impact of awareness and the conditions that support the use of intuition had implications for the clinical work of counselors. The findings from this study supported the use of interventions that increased counselors’ awareness of themselves, their clients, therapeutic relationships, and clinical situations. Furthermore,

the information that emerged in this study could be applied to the creation of environments that were conducive to the appearance of clinical intuition. Consequently, this study was relevant to counseling practice, clinical supervision, counselor education and clinical training. The following overview was delineated among the areas of practice, supervision, and education.

Counseling Practice

Clinical intuition appeared to be an important part of how counselors worked. These findings had implications concerning the creation of case conceptualizations. This research was also relevant to the different ways intuition could be applied in the formation of those clinical judgments.

Case Conceptualization

Clinical intuition provided a sudden and complete picture of the salient issues in a client's life. That conceptualization was based on associations that formed through observations of clients, knowledge of the history of a particular client, and knowledge of clinical theory and practice. A case conceptualization formed through clinical intuition incorporated a broad range of sometimes disparate information into a thorough rendering of the clinical situation.

Although the associations that formed the clinical picture required education, training, and experience, the formation of intuitive knowledge appeared suddenly. When counselors experienced a sudden understanding of the clinical picture, they were able to quickly and intentionally respond to what was required in the moment. Their clinical intuition provided counselors with a comprehension of the clinical situation which allowed them to purposefully take action.

Applications of Intuition

One participant suggested that clinical intuition had implications regarding the purpose of a session: Andy described the difference between the use of intuition when he made a formal assessment compared to when he was in a completely receptive state. He stated that with "the conscious use of intuition, hmm, you're still utilizing a lot of the same kinds of data collecting ability, mechanisms…but you're actively searching for something rather than being more receptive." In his view, the use of intuition during assessments involved more focused attention.

The distinction was further developed with Gobet and Chassy's (2008) template theory. Gobet and Chassy proposed that attention to particular cues activated corresponding patterns stored in memory. Therefore, the recognized templates were limited to specific and conscious observations. Such conscious attention to cues seemed analogous to the focused attention required when counselors were making a clinical assessment.

Alternatively, the findings from this current investigation suggested the possibility of an unconscious awareness that activated other connections stored in long-term memory. That unconscious knowing seemed comparable to the receptive openness that counselors adopted when searching for specific cues.

That difference was also akin to Reik's (1948) searchlight analogy described previously. In an intake interview, rather than flooding the field with light, counselors scanned the field in search of information about diagnostic criteria or treatment planning. They might have also focused their light on a particular area. That narrowed perspective did not seem to preclude the experience of intuition. Rather than flooding the entire field,

the light seemed to be scanning during an assessment. Nevertheless, clinical intuition presented itself, but the quality of its appearance was experienced differently.

The participant who articulated that distinction further explained that while he made intuitive judgments in his assessments, he was “never completely…confident.” However, his intuition felt certain when he entered a counseling session without the expectation that “the end product was going to be some assessment.” Although his reflection suggested that the use of intuition in making a formal assessment constricted the potential that appeared evident in another context, intuition continued to operate.

Clinical Supervision

Supervision was important to counselors’ continual development. Developmental theorists viewed supervision as an opportunity to hone skills and abilities, explore themselves in relation to their clients, and connect theory with application (Loganbill et al., 1982; Stoltenberg et al., 1998). The findings of this study applied to supervisees’ reflective practice and enhanced awareness. Furthermore, the data suggested that supervisors fostered the conditions that supported the use of intuition.

Reflective Practice

The notion that intentional awareness of particular cues might restrict the fullness of intuition had implications concerning the self-reflective propensities of counselors. This self-reflection was different from the use of intuition while making formal assessments. While self-reflection had to do with an increase of overall awareness, the application of intuition in an assessment was related to a focused attention to diagnostic criteria. This point was particularly important in view of several participants’ descriptions

of the impact of self-reflection on their experience of clinical intuition. According to the findings of this study, reflection appeared to increase awareness of the clinical situation.

Although some research suggested that conscious analysis interfered with intuitive judgments, those studies did not examine the real-world laboratory of counseling practice (Reber, 1989; Wilson and Schooler, 1991). In the counseling setting, clinicians acquired a wellspring of clinical information and experience through years of practice. The incubation process of associational information, which occurred through experience, seemed to produce conceptualizations that appeared suddenly (Hodgkinson, Langan-Fox, & Sadler-Smith, 2008). That conceptualization of the slow development of connections and the instantaneous expression of understanding conformed to one participant's reflection: "It appeared to come out of nowhere; it appeared to be….this mysterious intuition" (Barbara). It might have appeared mysterious because the pattern seemed to form quickly and was based on information that had moved out of conscious awareness.

Schon (1991) explored the process of conscious attention through his examination of reflective professionals. He distinguished reflection-on-practice from reflection-in-practice: The first type occurred outside of the situation that was reflected upon, and the second type happened during the situation.

He suggested that the ability to reflect-in-practice enhanced an individual's creative potential through a process of broadening one's perspective on the current situation. Schon (1991) noted that without that 'in-the-moment' consideration, seasoned individuals might unwittingly fail to notice information that did not match their existing templates. The suggestion to experienced counselors was that reflection-in-action may increase their awareness of themselves, clients, therapeutic relationships, and the

counseling process. Given that a core element of clinical intuition was awareness, this implication was meaningful to both counselors and clinical supervisors.

Further Development of Awareness

The findings of this current study contributed an understanding about the need for counselors to develop their awareness. Schon (1991) wrote about ways to enhance awareness through counselors' reflection-on-practice. He suggested that these exercises improved their ability to reflect-in-practice. He noted that when counselors reflected on their work when they were not actively involved in a session, they were freed to explore their reactions and behaviors in ways that would otherwise be difficult to do in session. Outside of session, the processes could be slowed down, and potential performance anxiety might be lowered. Consequently, if reflection increased awareness and awareness was a core component of clinician intuition, the implication was that counselors could strive to increase their awareness in order to develop their clinical intuition. That logic indicated that supervisory practices designed to increase awareness were important to counselors' intuitive abilities.

The therapeutic session was slowed down and processed in several established ways. Interpersonal Process Recall (Kagan & Kagan, 1990) was a supervisory intervention that provided reflection-on-practice. Supervisors and supervisees watched videotapes or listened to audiotapes of the supervisee's counseling sessions. The tape was stopped at particular points so that the counselor could process what he or she was feeling, thinking, or doing at that moment. That type of supervision provided an opportunity to attend to the myriad levels of awareness which quickly passed during a counseling session.

The use of role-play combined reflection-on-practice with engagement in an experiential exercise. It was plausible that the movement of 'popping-out' of role to process a particular interaction and then going back into the counselor role strengthened counselors' ability to reflect-in-session. That type of supervisory intervention might have fostered the development of "internalized supervisors."

"Internal supervisor" was a term I adopted in my own clinical work that provided another way of describing a counselor's in-the-moment self-reflection or "self-supervision." This reflective ability instructed counselors to notice their own reactions as well as clients' behaviors. Furthermore, that attention to their reactions moved their felt sense into greater consciousness. Consequently, counselors had more awareness of their gut feelings.

The internal supervisor also facilitated a search to discover the answer to "where did that come from" (Gertrude)? When clients provided confirmation of their counselors' intuitive awareness, counselors began to trace their way back through the web of connections that led to the intuitive knowledge. This type of reflection-on-practice might have heightened or increased intuitive responses as counselors could have been more readily conscious of particular cues that signaled the "hit."

The awareness that strengthened clinical intuition seemed to be enhanced through modeling. One participant credited her supervisor for modeling how he was using his intuition. She felt she had access to the inner workings of his skills. He provided an answer to her question of how he knew what he knew.

Another intervention involved supervisees' reflections of the ways they identified with their clients. This process involved describing similarities in physical appearance,

behavior, life experiences, emotional responses to the world, and thought patterns. Following that description, supervisees reflected on the ways they experience countertransference. To facilitate that process, counselors first identified a transference issue that may have been operating in the counseling relationship. They then described the specific client behaviors that indicated that particular issue. Finally, counselors reflected on their personal thoughts, feelings, and actions in response to the client's behaviors. As Schon (1991) suggested, that type of exercise provided counselors with a way of slowing down interactions and processes so that the meaning of a transference issue was uncovered.

The themes and clusters from the data reflected the importance of awareness in the experience of clinical intuition. It seemed evident that increasing awareness would benefit counselors' intuitive ability. In counselor development models (Loganbill et al., 1982; Stoltenberg et al., 1998), the facilitation of an increase in awareness was also vital to a counselor's growth. To that end, clinical supervisors impacted the development of clinical intuition through facilitating an increase in awareness.

Other Conditions of Intuition: Acceptance and Presence

In addition to increased awareness, other findings in this study suggested that certain dynamics were conducive to intuition. Some conditions served to facilitate clinical intuition while remaining intrinsic parts of the experience itself. For instance, awareness and presence were inherently in the intuitive experience, and they also comprised the fertile ground of intuitive information.

The favorable environment for the emergence of clinical intuition consisted of factors that corresponded with developmental issues (Loganbill et. al, 1982; Stoltenberg

et al., 1998). As counselors moved from the beginning to more advanced stages, they contended with several issues. This current study's discoveries of self-acceptance and presence were counterparts to the development models' findings of competency and awareness, respectively.

Acceptance provided counselors with a chance to tune in to internal and external information in the moment. That broad perspective was in contrast to how counselors restricted their focus when listening to self-critical judgments of their performance. Given that a participant noted that "intuition doesn't feel like after I'm out of the session….thinking about well you know, what would my teacher say about that" (Vicki), it was important to monitor when reflecting-in-session enhanced their intuition or disrupted it. Additionally, it seemed important to determine whether it was disruptive because of self-denigration or because it was a new skill that required more focus initially. If it was the later, then as counselors practiced, the information that was once new might have moved into procedural memory (Kihlstrom, 1987) and reflection would have demanded less conscious focus.

Moreover, when counselors were present, as one participant said, "The chatter, the emotional and physical chatter was quiet" (Vicki). Counselors were receptive and could listen with their third ear to the information in the intuitive flow. In contrast, beginning counselors were learning the fundamentals of counseling and tended to focus on finding the "right way." Consequently, they lost the broader perspective that allowed more information to feed into the creative stream of intuition. Therefore, receptivity to the clinical environment seemed to enhance their ability to detect emerging associations.

When counselors were self-accepting and present to the moment, they had an opportunity to experience clinical intuition.

Counselor Education

In counseling programs, counseling students were instructed in areas such as multicultural competencies, counseling theory, techniques, assessments, and ethics. In graduate school and continued training, students and practicing counselors learned to connect their knowledge with their clinical practice. The development of a counselor identity corresponded to the merger of knowledge and application. That integration paralleled clinical intuition's blend of knowledge and experience. Moreover, the findings of this study indicated that clinical intuition was facilitated through training experiences that connected a didactic approach with experiential learning.

Knowledge Base

Counselor education and training provided counselors with a base of information that became some of the associational material in their clinical practice. Even when counselors were not aware *that* the knowledge was operating, they could observe *how* it was operating. These findings suggested that counselors moved some of their declarative memory of facts to their procedural memory of how to apply that knowledge (Kihlstrom, 1987).

Counselor Identity

The quest to find the right way was a part of the process of integrating a personal and professional identity into a counselor identity. Several counselors noted that they were intuitive before going to graduate school. However, they needed to gain the clinical insight through education before they could integrate the two into clinical intuition.

The implications of the merger of the "intuitive gut" and the "clinical mind" were related to how didactic training was combined with experiential learning. Several counselors described post-graduate training that required personal counseling in conjunction with classroom instruction, clinical practice, and clinical supervision. For them, the net experience enhanced the work they did as well as their clinical intuition. The personal counseling seemed to enhance the connective tissue between counseling theory and clinical practice. Through that kind of integrated training, counselors were less able to distance themselves from what they were learning. They moved from "using tools" to being "the instrument."

Integration of a Didactic Approach and Experiential Learning

Another implication of this study involved the use of particular training practices. Clinical training that combined experiential learning with the presentation of knowledge seemed to facilitate the use of clinical intuition. Participants who engaged in such practices described how their awareness of themselves and their clients was organically integrated with their knowledge base. Those counselors were required to engage in supervision that bridged their personal therapeutic work with their learned and applied knowledge. That experience allowed them to bring their attention to themselves, to their clients, and to the theoretical constructs that informed what they were noticing. Those observations created the associations that emerged as clinical intuition.

Summary

The findings of this study suggested that intuition provided counselors with the ability to respond to what was relevant in the moment rather than restrict their interventions to predetermined treatment plans. The example of the participant who knew

to interrupt her client's pattern of obsessive compulsive behaviors by drumming a different rhythm with chopsticks was a quintessential example of responding to the moment. This ability to detect what was relevant was indicative of a counselor who had reached either the proficient or expert level of Dreyfus and Dreyfus's (1986) model of professional development.

The results also implied that clinical intuition provided counselors with the ability to conceptualize a clinical situation quickly and more thoroughly. They were able to detect more cues in the clinical moment because they had already formed templates that assimilated those new observations (Bohart, 1999; Gobet & Chassy, 2008). That ability was reflected in the example of the participant who intuitively knew that a client was angry based on knowing the client's interpersonal patterns and the general grief process that she was experiencing. Her nonverbal or verbal behavior catalyzed the counselor's intuition that the client was not dealing with her angry feelings.

The speed of the presentation of intuition was important to the timeliness of interventions. One participant described the intuitive knowledge that prompted her to orient a client to her surroundings. That intuition was an example of a technique that was effective at the time the client needed to pull herself out of a traumatic memory. Although that counselor's response was sudden, it was based on a slower process of learning about and working with traumatic reactions.

The implications of these findings were that the experience of clinical intuition allowed counselors to more effectively respond to what was relevant, respond in a timely manner, attend to more cues in the moment, and conceptualize a case. Therefore, clinical

intuition was a vital component of counselor development. Consequently, counselor education programs that supported conditions for its emergence were also important.

Limitations

This research study had several limitations that were related to its design and to its sample criteria. The purpose of a phenomenological study was to discover and explore the essence and meaning of an experience through the perspectives of individuals who have lived it (Patton, 1990). While this research accomplished that end, clinical intuition appeared in the context of a therapeutic relationship, involving the counselor and a client. Therefore, although the information may have seemed "right" to the clinician, the client's understanding was not verified through this design.

Further, the danger of describing past experiences was that counselors' recall may have been an issue. Participant's memory of the sequence of events and the way they experienced them may not be exact. For instance, information that may have been unconscious at some point might have seemed to participants that it was always conscious once they were aware of it. Also, cues that were not actually present may have been inferred as counselors made sense of their intuitive knowledge.

I believed that an inherent aspect of any investigation was the gift of further questions. This study added a small piece of understanding to the field of counseling. Based on these findings, future studies could continue to deepen and broaden the scope of that knowledge. Consequently, the limitations of this investigation were transformed into the possibility of future research.

Suggestions for Future Research

This study added a piece to the base of literature on clinical intuition. It contributed a small part to an area of research that could be further expanded. Future studies could incorporate different methods and designs, participant selection criteria, and research questions that have been raised through the current investigation.

A broadening of this research could include the experiences of clients in relation to the counselors who have intuitive "hits." Interviews with both counselors and clients would yield a deeper understanding of what this phenomenon was and how it occurred. To supplement those interviews, videotapes of those sessions could be viewed and analyzed. Observation of the actual sequence of events and the nonverbal and verbal communication could verify counselors' descriptions. For instance, if counselors inferred that they were probably noticing nonverbal behavior, the video tape would reflect whether the nonverbals were present prior to the arrival of the intuitive knowledge. Also, participants could watch the video during the interview and describe their experiences as the session progresses.

Furthermore, this research could be extended to encompass the development of the intuitive ability. While participants in this study talked about developmental issues that impacted their experience, this investigation did not compare the experience of counselors at different stages of their careers. Therefore, the ways that intuition presented itself, the degree and quality of the intuitive information, and the frequency of its occurrence at different developmental levels were not known. Consequently, future research could utilize sample criteria that would provide an in-depth examination of the development of the intuitive ability. The sample might include several counselors in

different developmental stages. Such a study could then be broadened to include the clients involved in the experiences of clinical intuition.

Alternatively, the sample could include supervisor and supervisee dyads. The implications of this current study were that clinical intuition could be enhanced through supervision, practice, and education. However, the design precluded an investigation of practices (e.g., role plays or reflecting-in-practice) that could be conducted in clinical practice to improve counselors' intuitive ability. Therefore, interventions designed to enhance intuition and the outcomes of those exercises were not known. That kind of study would explore the theory that intuition could be taught. It might also examine the interventions that were more likely to facilitate the development of clinical intuition.

Moreover, the results of this study applied to the experience of LPCs in North Carolina. The experience of clinical intuition for clinicians in allied professions was not explored or discovered through this investigation. Additionally, this study did not examine the experience of intuition in particular settings or from specific theoretical frameworks. Consequently, in future research, the sample criteria could be limited to counselors who work in particular settings. For instance, only LPCs working in hospices or in rape crisis centers could be interviewed. Furthermore, the sample could consist of counselors with the same theoretical orientation. Such a study may include only participants who worked from a Gestalt perspective or a Rogerian perspective.

Furthermore, a case-analysis approach to this topic could yield information that would have implications for the development of the intuitive ability. Several participants in the current study stated that they wanted to become more aware of the preceding moment and the arrival of intuitive information. Thus, multiple interviews with one

individual over time may uncover how conscious attention impacted the intuitive experience.

A possible correlation between learning styles and experiences of clinical intuition did not fully emerge in this study. However, this nascent finding did suggest a possible research question for a future study. An investigation of the connection between how people experience the appearance of intuition and how they learn could be explored. For instance, visual learners might see more images while kinesthetic learners may be more likely to experience a felt sense. The purpose of the study could center on whether a link existed in two different ways of processes information.

This study of LPCs' experiences of clinical intuition provided a stepping stone on a path of further exploration. Clinical intuition could be explored with different sample criteria, various designs, and a myriad of research questions. The findings from this study contributed to a base of knowledge that supported future research in this area.

Conclusion

The findings of this study suggested that counselors suddenly detected a felt sense, a gut feeling, a recognized pattern, or a symbolic representation. Based on that intuitive information, counselors responded in a timely and effective manner to what was relevant in the moment. While the presentation of intuitive knowledge appeared sudden, it was based on the incubation of previous experience and clinical knowledge. It most readily emerged out of certain conditions: nonjudgmental awareness, presence, and a counselor identity.

The fund of experience that contributed to the information contained in the intuition came from unconscious and conscious awareness of past clinical situations. Past

observations integrated with clinical theory to form the associations that gave rise to intuition. The experience of intuition suggested that clinical knowledge and past experiences grew until a critical mass of affective movement, affective associations, cognitive associations, or cognitive constructs were catalyzed in the current clinical situation. That sudden appearance of relevant information was based on a breadth of awareness and clinical knowledge that was accumulated over time.

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APPENDIX A: IRB APPROVAL

UNC CHARLOTTE

Compliance Office / Office of Research Services

9201 University City Blvd, Charlotte, NC 28223-0001
t/ 704.687.3311 f/ 704.687.2292 www.research.uncc.edu/comp/complian.cfm

Institutional Review Board (IRB) for Research with Human Subjects

Approval of Exemption

Protocol #	**08-11-22**			
Title:	**A Phenomenological Investigation of Licensed Professional Counselors' Perspectives of Clinical Intuition**			
Date:	**12/22/2008**			
Student Investigator	**Ms.**	**Melanie**	**Weis**	**Counseling**
Responsible Faculty	**Dr.**	**Lyndon**	**Abrams**	**Counseling**

The Institutional Review Board (IRB) certifies that the protocol listed above is exempt under category 2 .

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and

b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research, as well as any unanticipated problems that may arise involving risks to subjects. Amendment and Event Reporting forms are available on our web site: http://www.research.uncc.edu/comp/human.cfm

M. Lyn Exum — 1-6-09

Dr. M. Lyn Exum, IRB Chair — Date

UNC CHARLOTTE

Compliance Office / Office of Research Services

9201 University City Blvd, Charlotte, NC 28223-0001
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Institutional Review Board (IRB) for Research with Human Subjects
University of North Carolina at Charlotte

Approval of Amendment

Protocol #	**08-11-22**		
Title:	**A Phenomenological Investigation of Licensed Professional Counselors' Perspectives of Clinical Intuition**		
Date:	**1/26/2009**		
Student Investigator	**Ms. Melanie**	**Weis**	**Counseling**
Responsible Faculty	**Dr. Lyndon**	**Abrams**	**Counseling**

The Institutional Review Board (IRB) has approved the amendment of the protocol listed above for Research with Human Subjects.

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research, as well as any unanticipated problems that may arise involving risks to subjects.

Amendment Details: Participants may be asked to participate in a follow-up interview for clarification. Consent updated to reflect this change. Consent also updated to differentiate between the follow-up interview and an option 3rd meeting to review the transcripts of the interviews.

M. Lyn Exum 2-9-09

Dr. M. Lyn Exum, IRB Chair Date

APPENDIX B: INFORMED CONSENT FORM

Informed Consent for
A Phenomenological Investigation of Licensed Professional Counselors' Perspectives of Clinical Intuition

Project Title:
A Phenomenological Investigation of Licensed Professional Counselors' Perspectives of Clinical Intuition

Please read this consent agreement carefully before you decide to participate in the study.

Purpose of the Research Study:
The purpose of this research was to understand experienced counselors' perceptions of clinical intuition.

Need for Study:

The lack of attention to counselors' clinical intuition within models of counselor development was indicative of a deficient understanding of the concept of intuition in counseling practice. Although theorists studying the general concept of intuition have reached conceptual understandings of this phenomenon, researchers contributing to counselor development models have ignored the specific concept of clinical intuition in a counseling context. Furthermore, in spite of the parallel and overlap of clinical intuition and counselor development, the phenomenon of clinical intuition had not been explored through the lens of counselor development.

Despite this dearth of research on the nature of clinical intuition, counselors continue to assert that intuition was an essential component of how they work. To address that gap in the literature, it was necessary to explore the perspectives of counselors who have experienced clinical intuition in their counseling practice.

Investigator(*s*)

Melanie Weis, doctoral candidate at the University of North Carolina at Charlotte
Lyndon Abrams, chair of dissertation committee

Eligibility

Inclusion Criteria: You were eligible to participate in this study if you were a licensed professional counselor (LPCs) in the state of North Carolina, and if you believe that the phenomenon of clinical intuition exists.

Exclusion Criteria: You were not eligible to participate in this study if you have not yet earned your license, if you have a degree or license in a field other than counseling, and/or if you do not believe that clinical intuition was an actual phenomenon.

Overall Description of Participation

You would be asked to complete a survey about your demographic information, education, training, clinical, and supervision experience. You would be asked to describe your training and professional experience. You would be asked questions about your experience of intuition during your sessions with clients. You would also be asked to describe how you perceive of your development of your intuitive ability. The interview process was opened-ended, but I anticipate that the interview would be completed in one to two hours. You may be asked to participate in a follow-up interview in the event that clarification was necessary. I anticipate that this possible second meeting time would be completed in no more than thirty minutes. You have the option of receiving a copy of your transcription via mail or mail. You were encouraged to review the transcription to ensure accuracy of my report, and you were encouraged to meet with me again to review the transcript. I anticipate that the optional meeting time to review the transcript would be one to hours in duration.

In addition to your review, peer debriefing would be utilized to establish trustworthiness of the research data. Colleagues in the counseling profession would be consulted in an attempt to identify potential bias during the interview and analysis process. The addition of peer debriefing would challenge my assumptions and biases that may influence my analysis. Confidentiality would be adhered to in every phase of this study.

The interviews would be digitally recorded and transcribed by me. No identifying information would be attached to the digital recording. Further, all names would be changed to pseudonyms during the transcription process so that no identifying would be attached to the transcriptions. All information would be secured in a locked file cabinet. The tapes would be destroyed before the expiration of this study.

Length of Participation

The data collection consists of one open-ended interview process and a possible shorter second interview to clarify. I anticipate that the length of your interview would be between one to two hours. You may be asked to participate in a follow-up interview in the event that clarification was necessary. I anticipate that this possible second meeting time would be completed in no more than thirty minutes. You have the option of receiving a copy of your transcription via mail or mail. You were encouraged to review the transcription to ensure accuracy of my report. You were invited to meet with me again to review your transcript. I anticipate that the length of the optional meeting to review your transcript would be between one to hours.

Risks and Benefits of Participation

Risks: The project may involve risks that were not currently known. It was possible, as issues of anxiety and competence were inherent in counselor development, you may experience concern about how your responses reflect on your clinical ability. Therefore, you may experience increased anxiety or doubt about your level of competence. I would also have a list of referrals and resources available if you were

interested in processing any thoughts and feelings that were stimulated during this process.

Benefits: Benefits may include the therapeutic effect provided by the interview format. That possible result may occur because you would be given the opportunity to disclose and process your thoughts and feelings regarding the work you perform. The interview process could provided that forum for that kind of processing. This study may also allow you to describe a process which may have been previously implicit. Through verbalizing your understanding of clinical intuition, you may be more likely to articulate how you know what tyou know and why you act accordingly.

Volunteer Statement

Since you were a volunteer, the decision to participate in this study was completely up to you. Even if you decide to be in the study, you may stop at any time. You would not be treated any differently if you decide not to participate in the study or if you stop once you have started. You were free to not answer questions and to ask me to stop the digital recorder at any time.

Confidentiality Statement

Any information about your participation, including your identity, was completely confidential. The following steps would be taken to ensure this confidentiality: no identifying information would be attached to the digital recording. Further, all names would be changed to pseudonyms during the transcription process so that no identifying would be attached to the transcriptions. Prior to sharing data with peer debriefers, all names would be changed to pseudonyms and other identifiying information (e.g. places, agency names) would be deleted. All information would be secured in a locked file cabinet. I alone would have access to the information in the locked file cabinet. The tapes would be destroyed before the expiration of this study.

Statement of Fair Treatment and Respect

UNC Charlotte wants to make sure that you were treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-3309) if you have questions about how you were treated as a study participant. If you have any questions about the actual project or study, please contact Melanie Weis (828-279-2188, m.weis@uncc.edu) or Dr. Lyndon Abrams (704-687-8964, lpabrams@uncc.edu)

Approval Date

Original form was approved for use on *December 22, 2008* for use for one year. This was an amended form and was approved for us February 2, 2009 for use for one year.

Participant Consent

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at

least 18 years of age, and I agree to participate in this research project. I understand that I would receive a copy of this form after it had been signed by me and the principal investigator of this research study.

_____ _____

Participant Name (PRINT) DATE

_____

Participant Signature

_____ _____

Investigator Signature DATE

APPENDIX C: LICENSURE REQUIREMENTS

The North Carolina Board of Licensed Professional Counselors

http://www.ncblpc.org/HowToApply.html

The NCBLPC stipulates the following requirements for counselors to achieve an LPC credential:

- A master's degree in counseling from an accredited institution with a minimum of 48 semester hours. A graduate degree in a related field would be considered by the board if equivalent coursework had been completed.
- A minimum of two years of counseling experience after earning a master's degree.
- A minimum of 2,000 hours of supervised counseling experience with a supervisor who had been approved by the board.
- A minimum of 100 hours of face-to-face individual or group supervision. Group supervision could only count for one quarter of the 100 hours.
- A passing score on the National Counselor Examination (NCE).
- A Professional Disclosure Statement that was accepted by the board.

APPENDIX D: COUNSELING COURSEWORK

Example of Graduate Level Curriculum for a Degree in Counseling

Council for Accreditation of Counseling and Related Educational Programs

http://www.cacrep.org/2009standards.html

Section II: Professional Identity

G. Common core curricular experiences and demonstrated knowledge in each of the eight common core curricular areas were required of all students in the program.

1. PROFESSIONAL ORIENTATION AND ETHICAL PRACTICE—studies that provided an understanding of all of the following aspects of professional functioning:

    a. history and philosophy of the counseling profession;

    b. professional roles, functions, and relationships with other human service providers, including strategies for interagency/interorganization collaboration and communications;

    c. counselors' roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event;

    d. self-care strategies appropriate to the counselor role;

    e. counseling supervision models, practices, and processes;

    f. professional organizations, including membership benefits, activities, services to members, and current issues;

    g. professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;

    h. the role and process of the professional counselor advocating on behalf of the profession;

    i. advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and

    j. ethical standards of professional organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling.

2. SOCIAL AND CULTURAL DIVERSITY—studies that provided an understanding of the cultural context of relationships, issues, and trends in a multicultural society, including all of the following:

    a. multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;

    b. attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students' understanding of self and culturally diverse clients;

    c. theories of multicultural counseling, identity development, and social justice;

    d. individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;

    e. counselors' roles in developing cultural self-awareness, promoting cultural social justice, advocacy and conflict resolution, and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind, or body; and

    f. counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

3. HUMAN GROWTH AND DEVELOPMENT—studies that provided an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, including all of the following:

    a. theories of individual and family development and transitions across the life span;

    b. theories of learning and personality development, including current understandings about neurobiological behavior;

    c. effects of crises, disasters, and other trauma-causing events on persons of all ages;

    d. theories and models of individual, cultural, couple, family, and community resilience;

    e a general framework for understanding exceptional abilities and strategies for differentiated interventions;

    f. human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;

g. theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment; and

h. theories for facilitating optimal development and wellness over the life span.

4. CAREER DEVELOPMENT—studies that provided an understanding of career development and related life factors, including all of the following:

   a. career development theories and decision-making models;

   b. career, avocational, educational, occupational and labor market information resources, and career information systems;

   c. career development program planning, organization, implementation, administration, and evaluation;

   d. interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development;

   e. career and educational planning, placement, follow-up, and evaluation;

   f. assessment instruments and techniques relevant to career planning and decision making; and

   g. career counseling processes, techniques, and resources, including those applicable to specific populations in a global economy.

5. HELPING RELATIONSHIPS—studies that provided an understanding of the counseling process in a multicultural society, including all of the following:

   a. an orientation to wellness and prevention as desired counseling goals;

   b. counselor characteristics and behaviors that influence helping processes;

   c. essential interviewing and counseling skills;

   d. counseling theories that provided the student with models to conceptualize client presentation and that help the student select appropriate counseling interventions. Students would be exposed to models of counseling that were consistent with current professional research and practice in the field so they begin to develop a personal model of counseling;

   e. a systems perspective that provided an understanding of family and other systems theories and major models of family and related interventions;

   f. a general framework for understanding and practicing consultation; and

g. crisis intervention and suicide prevention models, including the use of psychological first aid strategies.

6. GROUP WORK—studies that provided both theoretical and experiential understandings of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society, including all of the following:

   a. principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;

   b. group leadership or facilitation styles and approaches, including characteristics of various types of group leaders and leadership styles;

   c. theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;

   d. group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness; and

   e. direct experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term.

7. ASSESSMENT—studies that provided an understanding of individual and group approaches to assessment and evaluation in a multicultural society, including all of the following:

   a. historical perspectives concerning the nature and meaning of assessment;

   b. basic concepts of standardized and nonstandardized testing and other assessment techniques, including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, psychological testing, and behavioral observations;

   c. statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;

   d. reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);

e. validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);

f. social and cultural factors related to the assessment and evaluation of individuals, groups, and specific populations; and

g. ethical strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling.

8. RESEARCH AND PROGRAM EVALUATION—studies that provided an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

a. the importance of research in advancing the counseling profession;

b. research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;

c. statistical methods used in conducting research and program evaluation;

d. principles, models, and applications of needs assessment, program evaluation, and the use of findings to effect program modifications;

e. the use of research to inform evidence-based practice; and

f. ethical and culturally relevant strategies for interpreting and reporting the results of research and/or program evaluation studies.

APPENDIX E: BACKGROUND INFORMATION SURVEY

Clinical Intuition Survey

Licensed Professional Counselors' Perspectives of Clinical Intuition

1. **Age** _____

2. **Gender** **Male**_____ **Female**_____

3. **Education Background**

Undergraduate Study:
University_____ Major _____Date of Graduation_____

Graduate Study:
University_____ Degree_____ Concentration _____
Date of Graduation_____

Post Graduate Training (Please include length of training and relevant certification) :

_____

_____

_____

_____

4. **Years of Clinical Experience (Total : _____years)**

The year you were first licensed as a professional counselor:_____
If you were first licensed in another state, what year were you first licensed in North Carolina?_____

Clinical Experience:

Population _____Years_____

Population _____Years_____

Population _____Years_____

Population _____Years_____

5. **Supervisory Experience**

Supervisee Experience:
From_____to_____

Supervisor Experience:
From _____to_____

APPENDIX F: INTERVIEW QUESTION GUIDE

Training and Professional Experience

1. Tell me about your clinical experience.
2. What had been the nature of your coursework?
3. What was your view of the counseling profession?

Description of Clinical Intuition

4. Describe a time when you 'knew without knowing' during a session?
    a. What was happening in the session before the intuitive moment?
    b. How did you know?
    c. What were you experiencing in your body?
    d. What was alerting you to pay attention?
    e. What were you paying attention to?
5. What words describe that moment?
6. How did you make sense of it at the time?
    a. What was your experience when you were first aware of your intuitive understanding?
    b. What did you see, hear, taste, or smell during that time?
7. How important was that kind of understanding to your clinical work?

Development of the Ability to Use Clinical Intuition

8. Tell me about a time, early in your career, when you intuitively knew what was happening with a client and contrast that experience to intuitive moments now.
9. What had contributed to how you experience intuitive moments now?
10. How comfortable were you discussing these experiences with your supervisor?

11. How do you process this understanding in supervision?

12. What role did your supervisor play in facilitating this ability?

APPENDIX G: OPEN CODING

		Lou	Barbara	Vicki	Ophelia	Karen	Gertrude	Sally	Andy	Terry
Experience	**Unconscious Awareness** of Countertransference	Compared his early-career countertransference reactions to current awareness					Acknowledged that she is not 'catching' all of her reactions			Not aware at the moment of her reaction—her behavior clued her in
	Unconscious Awareness of Clinical Knowledge	Inferred the connection between intuitive knowledge and past clinical knowledge	Inferred the connection between intuitive knowledge and past clinical knowledge	Inferred the connection between intuitive knowledge and past clinical knowledge	Inferred the connection between intuitive knowledge and past clinical knowledge	Theory provides a context even when not explicitly recalled	Does not explicitly remember theory but 'of course I do'		'to successfully forget [what we learn in school] and have it be supplanted by the greater growth it came from'	
	Conscious Awareness of Client Nonverbals	Nonverbals are 'clues'	Nonverbals as 'signs' and 'clues'	Watches nonverbals	Nonverbals are a source of information	Nonverbals are a source of information	Nonverbals are a source of information	Nonverbals are a source of information	Nonverbals alerted him that 'there was something more here'	Nonverbals communicate more than verbals

Conscious Awareness of Clinical Knowledge	**Conscious Awareness** of Countertransference	**Conscious Awareness** of Identification with Client	**Conscious Awareness** of Client Issue	**Conscious Awareness** of Client Verbals
His 'radar is exquisitely tuned to… diagnostic criteria'	Reaction to client was connected to other times when he felt that reaction	Recognized/identified with the feeling	Awareness of the deeper/true clinical issue	How they talked and discrepancy btwn what they said and nonverbals were sources of information
Awareness of pattern based on experienced-based knowledge			Awareness of the deeper/true clinical issue	The type of language informed her intuitive knowledge
	Awareness of visceral reaction to clients	Understanding client's experience because she had a similar experience	Awareness of the deeper/true clinical issue	Client statements informed her intuitive knowledge
	Awareness of when/how she was being triggered			Hearing what clients say informed her intuitive knowledge
		Common experience informed her intuitive knowledge		Awareness of the meaning of client verbal disclosures
Awareness of pattern based on experienced-based knowledge	Physiological reaction that informs her intuitive knowledge		Awareness of the deeper/true clinical issue	
	Physiological reaction that informs her intuitive knowledge			
	Awareness of feeling intimated in reaction to client	Common experience informed her intuitive knowledge	Growing awareness of the deeper/true clinical issue	Client verbals informs intuitive 'direction'
Awareness of clinical knowledge that informed intuitive knowledge	Awareness of feeling n reaction to client	Common experience informed her intuitive knowledge		What they said informed her intuitive knowledge

Experience Preceding: Expectancy	**Experience Preceding:** Acceptance	**Experience Preceding:** Present and Connected	**Conscious Awareness** of Resonance/Attunement	**Conscious Awareness** of Resonance/Empathy
Excited 'an oh, oh, kind of thing'	'there's nothing to prove'	Aware of what the client needed and when	Awareness of client's worldview	'Senses the deeper emotions' of the client
'its an expectation' 'its an anticipation'	Not 'worried' about what to say next		Awareness of feeling that informs her knowledge of the client	
'an energy inside of me…I felt charged'	Absence of self-criticism	Cognitive and affective awareness of present moment		
	'confident' low anxiety and willingness to try something new	No expectation that session will be a certain way; able to tolerate ambiguity in the present moment		Awareness of how she feels to inform intuitive knowledge of what client is feeling
	'I don't have to be right'	'more in tune or aligned' with herself and her clients		'I can sense… what people are feeling'
'a possibility of excitement'	A 'trust to go with' how she is making sense of the session	''feels natural and organic' 'not thinking about future or past'	'an ability to hear things underneath statements'	
	It is not an effort. It is a trust of the process	'its subtle, calm, present'		
	Confidence in his skill	'relaxed' The clinical direction 'presents itself'	Awareness of her physical reaction that informs her knowledge of client's worldview	Awareness of her physical reaction that informs her intuitive knowledge of what client is feeling
		Feels connected to clients		'Listens' to how she feels to inform intuitive knowledge

Experience of the Intuitive Moment-how it manifested: Gut feeling	**Experience of the Intuitive Moment-how it manifested: Felt Sense**	**Experience of the Intuitive Moment-quality of appearance: Sacred**	**Experience of the Intuitive Moment-quality of appearance: Certain**	**Experience of the Intuitive Moment-quality of appearance:**	**Experience of the Intuitive Moment-quality of appearance: Holistic**
Awareness of sensation that provided information about the clinical situation	Visceral	'I was seeing something of a spiritual nature'	No guessing; no conflict. An 'absolute a surety'	The intuitive knowledge was there immediately	'everything is present all at once'
Awareness of feeling that moved from 'heart to head'	A feeling in her physical body	Comes from her 'high mind or the higher mind'	'I knew' what to do	'all of a sudden I'm struck with an impulse'	
Feeling the depth of work without feeling the client's anxiety escalating	Sense of how 'it shows up in the body'		'the core part of me knew' what would happen	The opening presented itself	'its just there, I don't have to search the [brain] files'
			Knowing and feeling what is right to do		
	'I can sense what people are feeling'				
Awareness of feeling. Feeling something 'shift' that communicate something about the client	'a sense inside of me' a feeling inside	'kind of a holy experience'	A knowing that something is 'true'		'there is not a before or after…its just happening'
A more cognitive awareness of what had been a felt sense	Physical feeling	Her heart is 'connected to the divine' and is vital for her intuitive understandi		'all of sudden' I knew what to do	'a light bulb' Access to 'all this information'
Awareness of feeling that communicated something about the client	Felt 'something in the room'		'I felt like it was right'	'it's a flash' 'its like suddenly'	'Bigger than what I can think in my head'
She felt the rightness of her response			'I knew' what would happen	'all of a sudden it was clear to me'	

Experience of the Intuitive Moment-level of information: affective movement	**Experience of the Intuitive Moment-how it manifested:** Symbolic Representation	**Experience of the Intuitive Moment-how it manifested:** Pattern Recognition
Could not articulate his sense not to proceed in a particular direction. Responded from his emotions	'words, concepts' got hooked on to his visceral feeling	A knowing that was separate from language
Physical sensation of falling asleep when "there's a heaviness to the intensity'	A word appeared	Received intuition in the form of pictures and analogies
	'just knew' what to do and say	'the pieces were fitting together in my brain'
	Intuition 'moves quickly to a thought'	
Experienced a sense of what the client was feeling	'I get it more in just a thought'	
She senses when one member of a couple needs to be seen individually	'I just know what question to ask'	Consciously linking the situation together
Visceral reaction to clients…. Her awareness that early in her career, she unconsciously understood the	'the idea to ask a question' arrives	Intuition takes the form of images
Experienced a sense that something else was happening than what his clients were saying	Connected his feeling with his cognitive awareness that the couple needed marriage counseling	Growing awareness of the family dynamics—beginning to see the picture but not understanding it totally
	'hears' what to ask or what to say	

Experience of the Intuitive Moment-level of information: cognitive constructs	**Experience of the Intuitive Moment-level of information:** cognitive associations	**Experience of the Intuitive Moment-level of information:** affective associations
Emotional and cognitive Understanding what he is doing based on clinical situation	Awareness that he should not probe deeper but not aware of why.	A movement from 'reacting' to 'responding'
Understood the issue and responded effectively	Identified core issue—named it	
Knew the issue on an emotional and cognitive level and responded	Knew the core issue	Feeling that let her know they were in the 'therapeutic window'
Understoodthe issue and responding effectively	She put the pieces of the client's story together	
'then I just state' what she is seeing	'I have an inkling about something, a glimpse of something'	
Emotionaly and cognitively Knew what question to ask; knew how to respond	Conscious Linking one aspect of counseling situation with another	Her awareness of her feeling informs her about the clinical situation
'seeing the picture' and responding to the client based on that image—emotional resonance involved	Cognitive understanding of the clinical picture	The information in her physical sensation informs her
Offered effective intervention based on his emotional and cognitive understanding of issue	He consciously connected the dots of the story and had a growing awareness of what was only vague before	Felt 'something bigger in the room' that connected to his sense that the stated problem was 'smaller than the energy they were giving it'
Knew what the issue was and how to respond	Identified core issue—named it	Her feeling and her awareness of what was required supported her response
The following findings were not revealed as themes or clusters because they were not specifically about the intuitive experience. The findings that I labeled 'influencing factors' became the underlying structure and conditions of the intuitive experience.		

Influencing Factors				
Influencing Factors: Supervisee experience	**Influencing Factors**: Graduate School	**Influencing Factors**: Post Graduate Training	**Influencing Factors**: Clinical Practice	**Influencing Factors**: Personal Therapy
He was encouraged to examine how his personal issues were impacting his clinical work			Grew more consciously aware of clinical issues as he gained more experience	Helped him become more conscious of his issues and how they impacted his work
Encouraged her to listen and trust herself		Through clinical training, 'I ended up folding back my intuition into my clinical experience'	Her clinical experience of observation set up patterns of behaviors that she could see when they repeated	
Supervision helped her translate her self-reflective work into her clinical practice	Foundation of learning to connect with clients	Sensed a difference between integrating her training into herself and teaching the skills without integration	Experience allowed her to see patterns	Personal work deepened her understanding of the therapeutic process
Helped her integrate her personal and professional			Her particular clinical training is not as structured and requires that she not rely	
		Connects her holistic training (mind/spirit/body) to her current clinical work	Experience has given her a map of expectation of behavior	Her experience in her own therapy allowed her to understand an intuitive knowing that was beyond intellect
	Foundation of personal growth that was integrated with clinical theory	Her training integrated her personal therapy with her clinical practice	Sees patterns in relationship	
		Training allowed her to 'know what you're looking for'	Experience has given her a pattern of her own reactions to client that she uses in her intuitive judgments	She was not triggered when her clients were experiencing terror
Supervisor modeled 'intuitive knowing:' he explained how he knew		Training/research that focused on noticing patterns of behavior—identifying what we 'didn't want to name'	Could see patterns in people over the years	

Influencing Factors: **Developmental Issues:** Competency	**Influencing Factors**: **Conditions:** merger of personal and professional identity	**Influencing Factors**: **Conditions:** nonjudgmental	**Influencing Factors**: **Conditions:** Present and connected in the	**Influencing Factors**: Nonclinical	**Influencing Factors**: Confirmation of Clinical Intuition
When he was motivated by a need to appear competent, he could not grasp the full clinical picture	He no longer identities as 'I'm a therapist now and then I'm not' He bring himself into the role	I don't have to prove something	Became more aware of clinical picture	Highly 'sensitive to nonverbal cues'—not very conscious of his awareness	Positive response of his intuition confirmed his
Early in career, was afraid to use her intuition for fear of appearing incompetent	Merging her internal experience with her knowledge of clinical concepts	Allowed herself to relax and not worry about what she was about to say		Very sensitive—ability to viscerally feel the emotional experience of other children	Positive response from clients reinforced her trust in
She sometimes questions her intuition when faced with accounting for it	She knows her own struggles enhances her ability to work with clients in their struggles	Not self-conscious—not worried about her performance	The most powerful thing I have in a session is to be present		She knew her intuition was right on based on the client's response
Doesn't always trust intuition when she fears she is wrong	She does not slip into a role that is separate from who she really is	Not anxious about what she needs to do—more	Meets the moment—responds to what is	connection and understanding with a horse	Observed the client's positive response to
	Shifted from 'a heady approach to a felt presence approach'	Trusting herself as a counselor	Present with herself and with client	'picked up' others' experiences—'knew what they were going through'	Positive confirmation from client reinforced her intuitive knowing
When she is stressed, she doubts her competency and doesn't trust herself	Not trying so hard to be in the role of therapist and allowing herself to be herself	'pick up cues and trust myself to go with it'	The session just flows—not thinking about past or future		When she 'nailed it' she reflected on 'where did that come from?'
		Trust in herself	Knowing what is required in the moment—it is bigger		Learned to trust herself
	Connects his own experience with the clinical theory	More confidence and trust in himself	Relaxing into the moment and then seeing what is required		Confirmation of intuition reinforced his intuitive knowing
	Times of personal crisis have deepened her clinical work		Feels connected to clients		The consequence of acting on her intuition confirmed her intuitive knowing

											Influencing Factors: **Developmental Issues:** self-consciousness	**Influencing Factors**: **Developmental Issues:** Context Free Rules
												Intuition is impeded when he s not conscious of what the situation requires
												Early in career, used preformed techniques to guide treatment
											Has difficulty feeling present when she does not feel genuine l	When she relies on preformed techniques, she does not feel intuitive
											When she is frustrated with herself and the situation,	When she's bogged down with the agency's
											struggles when she is more in her head than in her heart	
											When she is not present, she is less likely to experience intuition	
												When guided by technique, she feels she misses the bigger picture
											When he is preoccupied and not present, intuitive awareness is less likely to occur	When guided by technique, he feels his work is 'awkward' and 'artificial'
												'operated on the surface' early in career: 'took things at face value'
The following findings were not revealed as themes or clusters because they were not specifically about the intuitive experience. The findings that I labeled 'Opinions' were relevant to the focus of this study and informed how I made sense of the data in Chapter 5.												
Opinions												
Opinions: integrated cognition and affect origins	**Opinions:** cognitive origins	**Opinions:** Metaphysical origins										
Integration of insight from training and awareness of visceral reaction to client	Intuition is larger than insight											
'my cognitive skills have interwove with my intuitive skills' to the point that its hard to separate out'	Logical deduction is a subset of intuition	It comes from the unconscious or the collective unconscious or the higher mind										
		It may defy language—ineffable										
you are getting your clue internally that something is happening' based on what you are observing externally		I Sometimes I don't know where it came from—hard to know it came from another plane										
		It's a divine gift emanating from the heart										
He calls it intuition when he must rely on something more than cognitive deduction to make a discernment	Could be a highly developed information processing process	It may be a gift										

Opinions: Development of Intuition in Supervisees	**Opinions:** integrated unconscious and conscious origins
students assimilate what they learn, they learn to apply it,	
Supervisees must learn to trust the ‘clinical insight coming in a different form’	‘blending of cognitive deductive reasoning and a wellspring of unconscious material’
Novices need to ‘get their skill set down,’ ‘gain experience,’ and then ‘trust themselves’	
Supervisees would need to be aware of their emotional reaction to the clinical situation and learn to trust themselves	
Supervisees need to be aware of their feelings and their reactions and trust themselves	
He would ask supervisees to pay attention to what they notice	Unconscious awareness grows into consciousness
Recognizes that novice counselors are focused on facts and ‘don’t have the luxury to listen to what their gut’s telling	

APPENDIX H: SAMPLE INDIVIDUAL TEXTUAL DESCRIPTION

Gerti's experience of clinical intuition was comprised of associations that were formed both out of and in her conscious awareness. The connections that occurred unconsciously involved clinical issues, her countertransference, and her clinical knowledge. She also articulated the relationships that she was conscious of in a client's nonverbal language, their verbal expressions, clinical issues, her countertransference, her clinical knowledge, and her attunement with a client.

Gerti described her awareness of implicit connections that were only apparent to her after they reached consciousness. In the movement of unconsciousness to consciousness, she experienced a trust that her memory of clinical knowledge and her ability to see patterns across clients would inform her awareness of the current clinical issue. "It's just trusting that I'm going to know what to do you know I had the training, I've had the experience. I might not have had this particular couple before but yet you know there's that commonality among people and you know and and most couples there's a commonality of themes about you know what the problem was and so it I but I don't think I don't think I would have the confidence um (pause) to do what I do without that base of knowledge."

In her unconscious awareness of her countertransference, Gerti would "notice that my voice was getting louder or I'll notice that I'm leaning forward you know cause I'm trying to you know fix things or so there's all these cues that I could get if I'm open to getting them ….It's changing every every second…you know with every word that comes something internally was shifting….it's not possible for me to catch all of them." She described the clinical knowledge that she was not attending to at the time in terms of

"there's a trust that I'm going to know what's needed rather than having to struggle and start flipping back in my developmental textbook about what stage you know (laughs) I mean or what theory fits, which I never do cause you know on some level I don't think I really remember any of that but of course I do."

She also experienced an awareness of the associations that were apparent to her in the moment they occurred. She knew when "there was an acceptance of the other they were meeting each other without judgment …..you know and the way that shows up was just um you know a facial the facial muscles just relax, the body relaxes, there's no, there's no rigidity, the voice softens and slows and um and it's it's just miraculous to watch you know and there're tears a lot of times." Gerti consciously attended to her countertransference reactions. She was aware of the "physical sensations that go along with it and those were the those were the triggers for me when I feel some kind of um physical any kind of sensation, anxiety, sadness, judgment, anything like that's manifesting in my body then I know immediately that something was going on… you know it's not like I hear a voice in my head that says 'you're a bad therapist.'"

Just prior to the moment of intuitive understanding, Gerti felt "it's like there's a possibility of excitement or it's not it's not even excitement it's (pause) there's a possibility of that." Then, the intuitive knowledge presented itself all at once: "Just all of sudden I'll I'll just know what question to ask….. you know it's like a light bulb….you know that just goes on inside and you're like oh, no wonder…. there was no doubt in there, there's just well, of course it's true you know it."

She experienced the intuitive knowledge as a sensation: "In my work with couples was that there's um, it's it's more of a sense inside me that um that something had

shifted." Her intuitive experience also could take the form of language in that the "the questions come or the um the words just come."

The amount of information contained in her intuition was related to a developing pattern in the clinical situation. Her experience was one of awareness of a relevant issue, knowing when the issue was presenting itself, and knowing how to respond. Initially she "probably got some hint a little controlling I didn't necessarily get that he was emotionally abusive until she came in." She knew how to "start watching for little openings" that told her when it was "time that they might be willing to um try to hear that there's a part of them that feels very angry right now." She knew how to respond when she had "a sense with a couple especially when um even if one of them was seeing another therapist um that that it would be helpful for for that person and I to have a private session so that we could work with that part of them that they don't trust their partner enough to work in front of them."

APPENDIX I: SAMPLE INDIVIDUAL STRUCTURAL DESCRIPTION

The dynamics that underlie Gertie's experience of clinical intuition were expressed through the circumstances and factors of her development as a counselor. The influence of previous experience and the impact of developmental issues created conditions that fostered or impeded the formation of intuition. Gertie's past experience included both a personal and professional history. The developmental issues that she had moved through or those she was currently in included factors that supported, diminished, or prevented the appearance of intuition. Those dynamics permeated and facilitated Gertie's experience of clinical intuition.

Previous Experience

For Gertie, previous experience was especially important for the associations that formed in her unconscious and conscious awareness. The attention she was giving to the client, the clinical situation, and to herself were associational because of patterns created in a particular session, across sessions with one client, and though her personal and professional history.

Personal Therapy & Post-Graduate Training

Gertie's post-graduate training incorporated personal work into its structure. Through her personal counseling in the training, she moved "to a place of compassion….with the part of me that's critical." This place loosened her self-imposed constraints and she grew more in touch with her intuition.

Clinical Practice

Her clinical work also contributed to her increased awareness of what was happening with the current clinical picture. She was able to see "the pattern in the

relationship." Based on previous experience as a counselor, she recognized that "relationships were built on one partner, one person you know triggering a part of another person…..you know which person's part so that you could kind of do the work there and then things ease a bit so then the other person was able to work."

Graduate School

Gertie's experienced her counseling program as a time of exploration and theoretical curiosity: "To have a certain level of competency and education and a a knowing on an intellectual level….I rarely felt there was any kind of rigid dogma you know established in any class. It was just about you know what do what did this mean….I also was able to take that and turn inside, well, what did that mean about me and how would I apply that to me and so it was it was really a path of personal growth at the same time there was that learning." Similar to the experience she had through her post-graduate training and personal work, Gertie's graduate school experience was a time of integrating her cognitive clinical information with her experiential learning.

Confirmation of Validity of Intuition

The verification from clients of her clinical intuition prompted Gertie to reflect upon how she knew what she what she knew. Based on "feedback you get it whether you nailed it or not… then if you nail it you know later on I'll think how did how did I know that or where did that come from?"

Developmental Issues

For Gertie, developmental issues influenced her intuitive experience. When she worked with context-free rules, critical self-consciousness, and concerns about her competency, her intuitive experience was diminished. She discovered that when she

worked contextually, with nonjudgmental awareness, and in an integrated counselor identity, clinical intuition was more likely to operate.

Context Free Rules to Contextually Based Thinking

Gertie was aware of her movement from working from a place of context free rules to working from what was required in the moment. “I feel like what I try to do if if I’m in a place where I’m not trying to grasp at things just so I have something to say was to um fall back and trust the knowledge that I have and to know that I’m gonna know what to say.” She recognized that while “I could spend all day up here [in her head] trying to figure it out, when I could just let it sit back there then I’ll get that hit of well this was what I need to do…or this was what I need to say.”

Critical Self-Consciousness to Nonjudgmental Awareness

Gertie was moving toward a more accepting awareness of herself in most of her work. However, “it’s very easy for me to slip into ‘I’m either in self or not’ you know and if I’m not there’s something wrong with me.”

She brought her attention to her critical self-consciousness and recognized it: “Wow there’s that part again you know that part that really really believes that I can’t help these people….and so I have a some kind of level of awareness that that’s happening so that I could just check in and just kind of breathe and go you know I know you’re nervous, you’re scared cause that’s what it was it’s some part of me that’s afraid I can’t help them.”

Her experience of intuition was more likely to happen “when you’re confident um you’re it doesn’t you don’t have anything invested in whether you’re right or wrong

about it, it's not you know it just it just feels right it just feels like it's the time to to put that out there."

Competency Concerns to Counselor Identity

As she developed, Gertie experienced a merger of personal and professional identities. "The truth when my life was chaotic it was much more difficult for me to access that cause I got managerial parts that were you know scrambling role you know 'what about this and you haven't done that'…you know so it's still easy just to get caught up in a part and you know and go out and be you know managing my life in a way that looks like it works….but I forget you know that there's this other sacred spot in there that was where I really want to live."

Gertie was no longer as motivated by a need to perform as a counselor. She was now driven to do effective counseling: "I'm you know I'm sure part of that was ego there's a part of me that likes to feel competent you know like I am good therapist so that you know that part gets triggered too but it's it seemed like it's it's more than that there's a (pause) there's a satisfaction I think of a peace and an acceptance of um the work that it's just going exactly the way it was supposed to and and then there's just that calm that you walk out of session with that wow that was you know amazing and and for me what the session when I walk out of those sessions, I I I honestly feel like I should be paying them."

APPENDIX J: THE ENTIRETY OF THE CLINICAL INTUITION EXPERIENCE: AN ILLUSTRATION

The following illustration provided another perspective on the emergent themes from the data. The subsequent passage was a portrayal of one experience of intuition in its entirety. This representation provided a method of examining the essential structure of clinical intuition through the temporal dimension.

In this illustration, identifying information was altered to maintain confidentiality. The criterion for altering this excerpt was based on a guiding question: Would any person involved in this clinical situation recognize themselves if they were to read it? I then sent a copy to the participant to further ensure that key information was sufficiently altered to protect confidentiality and to make certain that the integrity of the experience was maintained.

The Presenting Issue

Andy was contacted by a couple to provide counseling to their third grade daughter. The presenting problem was that their daughter, Rose, had been a very amenable girl until recently. She was now argumentative about issues such as doing her homework and completing her chores. Following two individual sessions with Rose, Andy met with her parents to talk about apparent generalities in his work with their daughter.

The Development of Unconscious Associations

During that parent meeting, it became clearer to Andy that the presenting problem was not the full clinical picture. In his description of that encounter, Andy depicted a burgeoning movement from his unconscious to conscious awareness:

> There probably were some facial expressions or body language that were that you know I might been could have consciously or unconsciously been noticing…just seemed like there had to be something else here….other than just that and … through the process of doing some some investigative counseling around that issue, that things just weren't adding up….it just wasn't explaining….why they were there….I think I was becoming conscious of it as I was asking the questions.

The Development of Conscious Associations

Andy continued to grow increasingly conscious of the couple's nonverbal behaviors. In this passage, he connected his observations:

> There's an opportunity to sit together on a couch…There's an opportunity to sit apart…one person on the couch, one person in a chair, they chose to sit apart from each other and I remember thinking that … not that that was odd, but that just said something…So there were some, there were some signs but but I I think if I really rolled back some some tapes in my mind, there there would be a lot of married clients that choose to sit in opposite chairs…That's not an indication that there's anything wrong…but for some reason it felt like this was saying something more…. As I recall in that session, there there, at least retrospectively, as I think back on it, there were some behavioral signals from them that might have been supporting this notion that something more was was going on here.

Andy's conscious identification with this couple became another point of association:

> It just seemed that the issues that…were being presented didn't…. account for…the level or the intensity or the … fabric of the emotion that … I was sensing was present. The fact that they … couldn't get [Rose] to behave didn't add up to to why they were they were there for that session … I'm sure there were parents who just be pulling their hair so much because they couldn't get their kids [to do their homework without a struggle] who might say, we just need to go see a counselor about this….but I think most people because [my wife] and I have that problem…with the our boys but we're certainly not about to go see a counselor about it.

The Manifestation and Nature of the Intuitive Knowledge

He initially experienced his intuition as a felt sense that quickly developed as the associations grew:

> I felt that that was … something bigger in the room than than I mean the stated problem was 'we can't get [Rose to do her homework] [she's] disobedient…. It

> was almost like … a heaviness in the room … I don't know that I (pause) really remember feeling it as a specific sensation in my body I don't, I don't recall that, I recall it more more being just like a heavy presence in the room that maybe something that would something that wasn't being said.

As the session went on, Andy continued to attend to nonverbal behaviors and connected those observations to other cues:

> When I started to talk with them about um well maybe one thing that they could um possibly do to ease maybe the tenseness of the whole family situation was just to maybe … spend more time together, do do more stuff together, and I really, when I was saying that at that point, I didn't … didn't have any idea, at least I didn't have a conscious idea that I was heading towards doing marriage counseling with them. I was just thinking, you know ya'll were so busy…you work here and she works there, maybe if you just you know could spend feel closer to each other that might help things too, you know its like an additional thing I threw in, and … the reception to that idea that I got from her and from him was like like the icy kind of silence … and it may have been at that point that I said there' something…I feel like there's something else going on here and that's when she said yeah…there wasn't a quick response … to the question or the comment um um (long pause) she teared up but not, I think it was it was after we, after she kind of said there's something bigger here that she teared up, she didn't tear up before that, but in fact she teared up pretty quickly when we went to that that I said would you ya'll like to come back and and talk about this and they both pretty much really jumped at it…which indicated to me too that it something that was very pregnant that was right there getting ready to bust out and they both knew it.

Andy's experience of clinical intuition demonstrated the development of associations that propelled his awareness into a conscious comprehension of the present situation. At some point during his work with Rose, he sensed that this referral was not a typical reason to contact a counselor. That suggested that Andy, prior to meeting with the parents, may have been forming connections about the nature of the issue.

Then, he attended to the nonverbal communication between the couple as they situated themselves in his office. He also registered the reaction he received to his suggestion that they spend more time together. Andy intuitively felt a sensation in the room that provided a degree of information about the clinical situation. That felt sense

alerted him to something relevant. This sensation grew with the associational observations that he continued to make. Finally, the nonverbal and verbal reaction from his clients confirmed his growing awareness that it was not Rose who needed counseling.