

**A
Portfolio of
Academic, Therapeutic Practice
and
Research Work**

**Including investigations of the experiences of
subfertile men and of people with psoriasis' experience of therapy**

By

Eldad Farhy

Submitted for the degree of Psych. D in
Psychotherapeutic and Counselling Psychology

University of Surrey

August 1999

ProQuest Number: 13803814

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 13803814

Published by ProQuest LLC (2018). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code
Microform Edition © ProQuest LLC.

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

Acknowledgments

I would like to thank the staff team, my supervisors and my fellow trainees for their support throughout the Psych. D course. In particular I am very grateful to DR Adrian Coyle for his invaluable guidance and encouragement and to Kay Hambleton for her patience and help. Many thanks to the participants who were willing to share their experiences with me and to the clients, I was privileged to work with. Finally, my special thanks to my parents and to my wife Hagar, without whom this degree would not have been possible.

Copyright statement

No part of this portfolio may be reproduced in any form without the written consent of the author unless authorized by the Librarian of the University of Surrey for legitimate academic purposes.

© Eldad Farhy, 1999

Contents

Introduction to the Portfolio.	1
Academic Dossier	
Introduction to Dossier.	3
Advanced Theory and Therapy Papers	
Psychoanalysis and Evidence Based Practice. Is Psychoanalysis Testable? Should It Be Tested? What Have Tests Found?	4
In Cognitive Therapy, Therapeutic Change is Not Dependent Upon The Therapeutic System of Delivery But on the Active Components That Directly Challenge the Client's Faulty appraisals.	19
Options Paper	
Transference and Counter Transference in Cognitive Analytic Therapy.	31
Issues in Counselling Psychology Reports	
Psychology, Psychotherapy and Paymasters.	41
Financial Aspirations and Their Effect on Therapeutic Outcomes.	54
Therapeutic Practice Dossier	
Introduction to Dossier.	68

Placements Reports	
Description of Placements.	69
Integration of theory and practice paper	
Integration in Therapy: Choice or responsibility?	73
Research Dossier	
Introduction to Dossier.	97
Literature Review	
The Psychological Sequelae of Male Sub-Fertility.	99
Appendices.	128
Empirical Research	
Still Shooting Blanks: A Qualitative Investigation of Sub-fertile Men's Self, Social and Therapy Experiences.	132
Appendices.	169
Psychological Therapy and Psoriasis: Understanding the therapy experiences of a group of people with psoriasis.	224
Appendices	271
Publications and Conference papers	
Psychology, Psychotherapy and Paymasters: a cautionary tale.	307

Introduction to the Portfolio

This portfolio represents a selection of the work carried out in fulfillment of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It represents the core areas of training: academic papers, therapeutic practice and research. Accordingly, it contains a range of topics from my work, emphasizing theory and practice links and the role of ethics in governing Counselling Psychology.

Due to the confidential nature of therapeutic work, practice related material has been edited. The full reports and notes are available in the confidential appendix, submitted separately and not publicly available. Throughout the portfolio, where personal material is cited or referred to, the names of the individuals concerned have been changed and any identifying information altered or omitted to protect their confidentiality.

**Academic
Dossier**

Academic Dossier

This dossier contains a selection of papers and reports submitted over the duration of the course. Two 'Advanced Theory and Therapy' papers which address issues relating to the integration of theory and practice, are included. These explore the role of the therapeutic alliance in cognitive therapy and the importance of evidence based practice in Psychodynamic therapy. A paper from the final year's Options course, discusses the understanding and use Cognitive Analytic Therapy makes of Transference and Counter-transference. Finally two reports on issues in "Counselling Psychology" are submitted. One examines the possible role of the quest for money and power in the development of psychology and the other the possible therapeutic hindrance caused by clients' financial expectations.

Psychoanalysis and evidence based practice

Is Psychoanalysis testable? Should it be

tested? What have tests found?

Abstract

The present work briefly examines existing literature to determine whether Psychoanalysis can be tested using the traditional quantitative methods common in the so called hard sciences. It then presents the case for subjecting it to such tests and examines both direct and circumstantial evidence. It concludes that results from empirical tests, which Psychoanalysis can and should be subjected to, are still equivocal.

The issue of testability has been a thorn in the side of many a social science, but perhaps no more so than for the field of psychology and the closely related practice of Psychoanalysis. Of the many reasons for this, 'physics envy', that only half-jocular term describing the desire of many psychologists and psychoanalysts to attain for their profession, through the implementation of the rigorous testing methodology employed in physics, a scientific status akin to that of the natural sciences, is perhaps foremost. The problem caused by their adherence to this method is, that according to the positivist/empiricist paradigm that had dominated scientific inquiry for so many years, testability is of paramount importance in defining a field of human knowledge as a science (Bacon, 1620). Empiricist dogma postulated that not only was objective testing possible but that it was imperative that claims should be testable (in theory at least) in order for them to be considered scientific and apparent failure in achieving this end has and remains a stumbling block for achieving this goal.

The role of tests

Whilst the rapid dissemination of Popper's (1963) view that true objectivity was impossible and that scientific theories became such by virtue of their falsifiability rather than their putative objectiveness may have contributed to testability's importance being on the wane nowadays. If Psychoanalysis wishes to flourish, or even survive, in the current, predominantly market driven, social system which embraces the maximisation of return on investment as its new morality, it better be able to offer to its value for money-minded consumers (be they individual clients or NHS purchasers), some so-called hard figures. This however, is easier said than done, as Popper himself said when he singled out Psychoanalysis as an example of a non falsifiable theory claiming that,

'I could not think of any human behaviour that could not be interpreted in terms of either (psychoanalytic and Marxist) theory. It was precisely this fact - that they always fitted, that they were always confirmed - which in the eyes of their admirers

constituted the strongest argument in favour of these theories. It began to dawn on me that this apparent strength was in fact their weakness.' (Popper 1963, p. 114)

This does not of course mean that Popper was correct. Valentine (1992) cited both evolution and geology as largely non-falsifiable theories, based as they are on post hoc interpretations where much relevant evidence is not accessible, that yet are accepted as scientifically correct. Lakatos (1970) too, rejected Popper's suggestion that falsification was a sufficient basis for determining scientificity, suggesting instead that in addition to it, an ability to provide empirical evidence is needed to arbitrate between competing theories. Moreover, sound as Popper's falsification theory's may have been as a criterion, practitioners of the so-called hard sciences were as unlikely to use falsification as a test of their theories (but were happy to use it on those of their rivals) and certainly did not use it more often than ministers of religion (Valentine, 1992) thus being no different from Psychoanalysis practitioners (Smith, 1996). In this light, Psychoanalysis' supporters can claim that it conforms to Laudan's (1977) proposal of research tradition, as a family or cluster of theories sharing a common ontology and methodology. To fit Laudan's proposal, Psychoanalysis needs but a set of malleable core traditions, which albeit modifiable by empirical testing, provide continuity and adherence to metaphysical principles that although providing for ontology had no need to be explicit and thus allow for the simultaneous co-existence of contradictory theories that nevertheless share the same fundamental commitments. A description that the present writer believes, closely describes Psychoanalysis' research's current state.

Given this situation, and considering the lamentable fact that early attempts to provide an empirical basis for Psychoanalysis had, in common with the rest of much psychological theorizing, been stymied by the simple fact that its subject matter, that is, mental events and life was neither directly measurable nor observable, it is not surprising that it has been proposed that Psychoanalysis should eschew all causal explanations, whether constructive or reductive, in favour of

other explanatory models. These ranged from: Dennet's rational intentionality based ones (1971), Allport's (1962) suggestion that psychology ought to abandon its attempt to be a general science and become an idiographic science of the individual to Grunbaum's (1952) early proposal that instinctive empathic understanding or 'Verstehen' was as important as scientific explanation and understanding if not more.

Notwithstanding these refutals of empiricist demands, a sizable part of the people using the services of psychology and Psychoanalysis still expect a scientific rationale to provide its practitioners with a justification for their actions and understandings. Similarly, not all psychoanalytic writers agree that Psychoanalysis should not attempt to use testable hypotheses in its construction (Edelson 1983) or does not allow scientific rigor. Smith (1992) goes as far as to claim that Psychoanalysis' communicative school at least, satisfies Nagel's verificationist critique, Poppers' falsificationist critique, Grunbaum's epidemiological-experimental test and criticisms based on Lakatos' concept of degenerating/evolving research traditions. For these writers it is important that a method of testing psychoanalytic tenets and concepts if not Psychoanalysis as a whole should be at least attempted if only for the sake of the intellectual honesty inherent in explicitly stating under what conditions one is willing to give up one's theories.

Testable tenets

Before discussing some of the tests that have arguably provided Psychoanalysis with empirical support, it may be of use to review some of its basic formulations. Whilst this review will perforce be both inadequate and contentious, it will nevertheless provide an example of the kind of statements and postulates that would require empirical support if Psychoanalysis is to wrap itself in a scientific mantle. Modern psychoanalytic thought shows the influence of various individuals,

Anna Freud, Klein, Sullivan, and Winnicott, to name just some of the better known. However its core tenets are indisputably based on Sigmund Freud's writings. According to Kovel (1977) the gist of these (at least in Psychoanalysis' classical form) is the human psyche's functional model whose three dynamic components (the Id, the Ego and the Superego) manifest themselves through different realms (the Conscious, the Unconscious and the Preconscious buffer zone). Psychoanalysis further stipulates that the psyche undergoes universal developmental stages (oral, anal, etc.), and that throughout its existence it is largely governed by innate drives and basic needs (primarily the sexual drive or Libido), constantly urging the individual towards their gratification. Whilst a successfully developing psyche succeeds in assuaging some of these drives in a manner acceptable to all its components (and society), many of these unconscious drives clash, either amongst themselves, with other social mores and reality, or with internalised representations of external objects, thus creating conflicts. Psychoanalysis further posits, that these conflicts and their resulting neuroses have their roots in human childhood. This was summarised by Guntrip (1971) who described childhood as a period of prolonged dependency, intense narcissism, unbounded yearning and special way of thinking, during which self aroused wishes are continuously frustrated by the lack of power inherent in childhood and which furthermore, whose achievement is too frightening to contemplate. Although many of the conflicts born during this period were solved or managed in ways not too expensive nor too deleterious, others were left unsolved or demanded more effort for their containment that could be given. These usually unconscious conflicts, were kept under check, nor allowed to make themselves known to the conscious self, nor to openly dictate behaviour (repression). Yet although normally confined to the unconscious these conflicts continued to smoulder (or rage) within it and the nervous energy thus generated seeped onto consciousness. This seepage could occur gradually but more often than not it followed a provoking event which insignificant in itself, nevertheless struck a psychic fault line, thus precipitating the conflict's emergence. However, this emergence or neurosis rarely revealed the conflict's true nature instead appearing in different, sometimes bizarre, guises.

These range from diffuse, persistent anxiety permeating one's life, to specific manifestations such as: obsessions, compulsions, phobias, hysterical attacks and so on. Similarly varied, was the neuroses' intensity and accompanying feelings. Early examples of neuroses ranged from; forgetting a proper name to phobias so severe that the patient had to spend his or her life in bed and the accompanying feelings were usually; pain, anger, guilt and anxiety, which albeit under disguise, also surfaced onto consciousness.

Vague concepts and empirical testing

Having established some of the psychoanalytical concepts that could be subject to testing another problem becomes salient in addition to the earlier mentioned one of testing the unobservable; that the psychological terms and concepts used and explained by Psychoanalysis do not necessarily mirror those used by other psychological theories or even other psychoanalytic ones. Different theorists both within and outside Psychoanalysis, use identical terms to describe different ideas and others use different terms to describe almost identical notions. For instance Kohut (1971) used 'Self' and Scharfetter (1996) used 'Ego' to describe the individual's inner being whilst Jung (1933) used 'Ego' to describe just a single component of that inner being. In a likewise manner, Psychoanalysis, (and other schools), uses specific conceptualisations that are not shared with others, making its tests difficult to evaluate by non partisan observers. Furthermore, psychoanalytic theory explains both phenomena that are postulated to occur generally and some that are particular to its therapeutic encounters and are therefore not re-enactable in tests. In other words, these semantic-conceptual mismatches make it difficult for theorists from other schools or even from differing branches of Psychoanalysis, to assess or accept attempts to empirically test psychoanalytic phenomena (Brewin, 1988). Despite this, some attempts have been made to empirically validate psychoanalytic theories with varying success. These were less than convincing, especially in comparison to the relative success of

cognitive-behavioural psychologists in supporting their theories. As previously mentioned, many were seen as proof only by those who enacted them and their supporters, but at least a few seem to have been able to demonstrate the existence of phenomena predicted by Psychoanalysis to a level that is commensurate with the one achieved by cognitive-behavioural theories. These attempts fall into two main categories. The first consists of experiments that albeit not primarily conducted to test a psychoanalytic tenet nevertheless have produced results that would have been predicted by Psychoanalysis theory. Those of the rarer second type, were expressly designed to test a Psychoanalysis concept and provide therefore even stronger support for Psychoanalysis theories.

Concerning the first type, it is to Psychoanalysis' advantage that these tests were rarely performed by its supporters and thus researcher bias was arguably minimal. Additionally it is advantageous to Psychoanalysis' cause in that many of them were obtained in experiments conducted by proponents of psychology who have often claimed that their school's relative success in amassing empirical support was a mark of its superiority over Psychoanalysis. While cognitive-behaviourism's advantage in this respect could be an artifact of the limited level at which it approaches the psyche, that is, cognitive-behavioural data advantage could be no different from the advantage a theory, explaining a car turning by empirically showing that all cars turn if their steering wheel is turned, would have over one trying to explain the motives that made the driver turn the wheel in the first place, it is an elegant solution to Psychoanalysis' testability credibility, to find that cognitively inspired empirical experiments point to the basic correctness of its theories. This seems to have been the case when despite their early focus on consciousness, cognitive researches studying the processes involved in attending emotional stimuli, the processing circuits and pathways leading to emotional responses and the schemata involved in them, have been inexorably drawn to studying the unconscious. Thus evidence had emerged that unconscious cognitive processes were not only low level (such as feature extraction) but that higher level ones could either be suppressed (automatisation) or occur altogether below

conscious awareness. For instance, Storms and Nisbett's (1970) study of cognitive dissonance found that patients in which significant effects were caused by placebos did not verbally report cognitive dissonance as leading to this effect, but gave a plethora of personal reasons for it. Likewise, the evidence gathered by Broadbent (1984, 1986) on attention tasks performance, the dozens of subliminal stimuli processing studies summarised by Marcel (1983) and the effect non detectable, olfactory, auditory and even visual stimuli had (Dixon, 1981), leave little doubt that unconscious psychological processing occurs and that it includes at the very least, structure and meaning analysis, associations' retrieval, conditioning and the evocation of emotional and Behavioural responses (Brewin, 1988). Furthermore, Williams (1988) concluded that 'the weight of the evidence indicates, that conscious awareness may actually restrict information processing.' Similarly, findings of innate unconscious schemata could be construed as, providing a cognitive-behavioural basis for Jung's notion of the Collective Unconscious Archetypes (Minton, 1995). In a similar way, Williams' et al. (1988) empirically based claim that, 'in emotional disorders, attention is biased, memory is biased and judgments are biased,' mirrors Guntrip's (1971) belief that patients' frequent inability to do something they claim to want, disguises neurotic emergence. Guntrip stated that under scrutiny, this inability was usually found to be unwillingness. An unwillingness disguised as helplessness or inability because of the patients' genuine conscious desire to do what appeared impossible was accompanied by an unconscious dread that doing it will cause great pain, thus resulting in an object of desire that was also an object of pain and whose duality caused further conflicts.

Of course these results are not absolute proof. Nisbett's results for instance, may have had more to do with difficulties in verbalizing a conscious process rather than with the existence of an unconscious one, nor were the unconscious processes of cognitive-behavioural theories mirror images of the psychoanalytic unconscious concept, yet nevertheless, their evidence does support its existence.

Puddings and evidence

The second kind of tests, although as mentioned above far rarer, is by no means unheard of. However, many tests set to prove the existence of psychoanalytically derived concept or that Psychoanalysis had an empirical basis were criticised strongly for failing to meet both validity and reliability standards (Eysenck, 1966). One test that seems to have done so in a manner that seems to answer those criticisms, was performed by Fried, Crits-Christoph and Luborsky (1992). In this test they attempted to find whether support could be found for the existence of transference within psychotherapy as is postulated in Psychoanalysis. Working on and with Transference has been considered by a number of writers to constitute the analyst's key activity in psychoanalytic therapy (Freud, 1912, 1915). Using content analysis methodology, Fried and his colleagues took multiple measures to form a profile of what they called the Core Conflictual Relationship Themes of the narratives thirty-five adult subjects used in therapy to describe their relations with significant figures in their lives. They then applied the same measures to transcripts of the participants' narratives about their interactions with their therapists. In virtually all cases, relationship styles with others were significantly correlated to relationship style with the analysts. Furthermore, a number of independent judges who were unfamiliar with the subjects, were asked to match subjects' narratives of their relations with significant others to eight therapy sessions transcripts, only one of which was from the narrating subject. Not only was the judges' ability to match narrative and therapy transcripts significant, but inter-judge reliability coefficient was 0.69, demonstrating that matches were not idiosyncratic. Of course knowing

that consistent relationship styles occur, does not prove that transference exists, but findings that people behave in a way psychoanalytic theory predicts, confers on it considerable scientific kudos.

Another possible approach would be to adopt a pragmatist stance and rather than ask whether Psychoanalysis was scientifically sound? Ask instead, does it work? Why should therapy be exempt from the rigorous test applied to the proverbial pudding? Doesn't its proof too, lie in the eating? Eysenck (1966) who was quite openly biased against Psychoanalysis, did have a point (then) in criticizing its supporters' habit of citing their (putative) successes in curing/alleviating psychological pain by use of theory derived understanding as a proof of their theories' validity as deeply flawed. Alas, today's opinions are still as sharply divided as ever. Practically every therapy school has no lack of both champions and detractors. For example, comparing Psychoanalysis to Personal Construct Therapy, Grawe et al. (1990) and Epstein and Vole (1981) found that Personal Construct Therapy achieved higher recovery rates than Psychoanalysis, but Gerde, Manz and Ori (1994) found that the opposite was true. At the same time, while Fish (1980) claimed both were helpful, Armstrong, Yasuna and Hartley (1980) and Blomeyer (1985) claimed that although both helped solve immediate psychological problems, only Psychoanalysis helped solve long term ones and Cross et al. (1982) found that the quality of the therapeutic relationship rather than the technique used determined success. Further complicating the matter, were Hand's (1991) findings that most studies comparing the effectiveness of different therapy techniques had serious methodological flaws and Gallo's (1978) claim that comparing the success rate of Psychoanalysis to Cognitive-Behavioural Therapy or any other non analytic approach was meaningless, since Psychoanalysis's approach, goals, techniques and ways of measuring success differed radically from the others. A view that was echoed by Kovel (1976), who said that since each therapy school was primarily concerned with different aspects of the mind, each suited different purposes, and their success levels were difficult to gauge as each defined success differently.

Conclusion

Returning to the three questions posed at the beginning of this article, is Psychoanalysis testable? Should it be tested? And what have tests found? It seems that the answers to these are: probably yes, yes, and depends who you ask. Psychoanalysis, or at least some of its constructs, seem to be testable both by positivist standards and certainly by post-positivist ones. Psychoanalysis should be tested, for pragmatic reasons if not for more altruistic ones such as intellectual honesty and inquiry. Lastly, finding whether tests have shown it to be a scientifically sound endeavour, still seems to depend more on who do you ask than on the tests' results.

References

- Allport, G. W. (1962). The general and the unique in psychological science. *Journal of Personality*, 30, 405-422.
- Armstrong, S., Yasuna, A. and Hartley, D. (1980). Treatment; Specific Vs. nonspecific outcomes in psychotherapy. *Research Communication in Psychology Psychiatry and Behaviour*, 5, 313-322.
- Bacon, F. (1620). *Novum Organum*. T. Fowler (ed.), 1979. Darby, PA: Arden Library.
- Blomeyer, R. (1985). Psychische Krankheit: Sinn und Analyse. *Analytische Psychologie*, 16, 2, 104-113.
- Brewin, C. R. (1988). *Cognitive Foundations of Clinical Psychology*. Hove: Erlbaum Associates.
- Broadbent, D. E. (1984). The Maltese Cross: A new simplistic model for memory. *Behavioural Brain Science*, 7, 55-94.
- Broadbent, D. E. (1986). Implicit and explicit systems in the control of complex behaviours. *British Journal of Clinical Psychology*, 77, 33-50
- Cross, D. et al. (1982). Short and long term follow up of clients receiving insight based and behaviour therapy. *Journal of Consulting and Clinical Psychology*, 50, 1, 103-112.
- Dennett, D. C. (1971). Intentional systems. *Journal of Philosophy*, 68, 87-106.

- Dixon, N. F. (1981). *Preconscious Processing*. London: John Wiley and sons.
- Epstein, N. B. (1981). Research on the results of psychotherapy: A summary of evidence. *American Journal of Psychiatry*, 138, 8, 1027-1035.
- Eysenck, H. J. (1966). *The Effect of Psychotherapy*. New York: International Science Press.
- Fish, J. M. (1980). Direct versus indirect approaches to imagery in psychotherapy: the status of the transference explanation. *Journal of Mental Imagery*; 4, 1, 161-163.
- Freud, S. (1912). *The Dynamics of Transference*. Standard edition, 12. London: Hogarth Press.
- Freud, S. (1915). *Observations on Transference Love*. Standard edition, 12. London: Hogarth Press.
- Fried D., Crits-Christoph, P. and Luborsky, K. (1992). The first empirical demonstration of transference in psychotherapy. *The Journal of Nervous and Mental Disease*, 180, 326 - 331.
- Gallo, P. S. (1978). Meta-Analysis, a mixed meta-phor? *American Psychologist*, 33, 5, 515-517.
- Gerd, R., Manz, R. and Ori, C. (1994). Outcome of psychoanalytic treatments. *Seitschrift fur Psychosomaticshe Medizin und Psyuchoanalyse*, 40, 1, 25-40.

- Grawe, K. et al. (1990). Differential psychotherapy research: A comparison of four types of psychotherapy. *Zeitschrift für Klinische Psychologie. Forschung und Praxis*, 19, 4, 362-376.
- Grunbaum, A. (1952). Causality and the science of behaviour. *American Scientist*, 40, 665-676.
- Guntrip, H. (1971). *Psychoanalytic Theory Therapy and the Self*. New York: Basic Books.
- Hand, I. (1991). Comparative treatments studies: A critical appraisal of design treatment contents and outcome interpretations. *Zeitschrift für Klinische Psychologie. Forschung und Praxis*, 20, 3, 280-285.
- Jung, C. G. (1933). *Modern Man In Search of a Soul*. London: Routledge and Kegan Paul.
- Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.
- Kovel, J. (1976). *A Complete Guide to Therapy. From Psychoanalysis to Behaviour Modification*. Hassocks UK: Harvester Press.
- Lakatos, I. (1970). Falsification and the methodology of scientific research programmes. In I. Lakatos and A. Musgrave (eds), *Criticism and the Growth of Knowledge*. Cambridge: Cambridge University Press.
- Laudan, L. (1977). *Progress and its Problems*. Berkeley: University of California Press.

- Marcel, A. J. (1983). Conscious and unconscious perception: An approach to the relation between phenomenal experience and perceptual process. *Cognitive Psychology*, 15, 238-300.
- Minton, H. (1995). Psychology lecture at Royal Holloway College, University of London, 5Th Dec.
- Popper, K. R. (1963). *Conjectures and Refutations*. London: Routledge and Keagan Paul.
- Scharfetter, C. (1996). *The Self Experience of Schizophrenics. Empirical Studies of the Ego/Self in Schizophrenia, Borderline Disorders and Depression*. Zurich: Private Publication.
- Smith, D. L. (1992). Where do we go from here? *International Journal of Communicative Psychoanalysis and Psychotherapy*, 7, 1, 17-26.
- Smith, D. L. (1996). Should psychoanalysts believe what they say? *British Journal of Psychotherapy*, 13, 1, 64-74.
- Storms, M. D., Nisbett, R. E. (1970). Insomnia and the attribution process. *Journal of Personal and Social Psychology*, 2, 319-328.
- Valentine, E. R. (1992). *Conceptual Issues in Psychology*. London: Routledge.
- Williams, J. M. G., et al. (1988). *Cognitive Psychology and Emotional Disorders*. London: Wiley.

In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components that directly challenge the client's faulty appraisals.

Abstract

This article examines the notion that Cognitive and other therapies tap or contain distinct active elements to whose action therapeutic advance may be largely attributed. Evidence from existing therapy process research is presented and its implications concerning this notion and the role of theory and of the therapeutic alliance in therapeutic outcomes are discussed.

Introduction

The title statement of the present article postulates that Cognitive Therapy (CT) comprises both distinct active elements and a system of delivery. It implies that the latter is inert and non active and that it subsumes the former. At face value it also seems to claim that CT works by helping its recipients correct their faulty appraisals. Leaving aside the last claim, various interpretations of the statement's other parts are possible and two such interpretations will be presently examined. The first interpretation considered will be that the term, 'System of Delivery', referred to the theoretical foundation of the therapeutic intervention. Its examination will focus therefore on the evidence for the notion that if the active elements used in CT are implemented, therapeutic change will occur whether or not they are embedded in a theoretical and methodological matrix and regardless of its precise nature. The second interpretation is that this term referred to the relationship between therapist and patient and thus evidence for the claim that these active elements' putative therapeutic effectiveness is independent of the therapy's interpersonal aspects, will be considered.

CT and active elements

According to Trower, Casey and Dryden (1988) CT is a therapeutic school whose conception is commonly attributed to Aaron T. Beck. Although older schools such as Rational Emotive Therapy (RET) are now also considered cognitive, it was he who formally proposed much of CT's theory and techniques in the 1970's. According to Beck (1976) CT was not merely a talking therapy. It combined the best of Psychodynamic (PT) and Behavioural (BT) Therapies in that it required clients to act as well as talk. In common with Psychodynamic Therapists, its practitioners were interested in gaining access to their clients' beliefs and thoughts and like Behaviour Therapists they employed behavioural tasks. However, unlike

either, their goal was not insight or behaviour changes per se, but finding and altering the dysfunctional cognitions that underlay the clients' emotions and deeds. For example, both CT and BT therapists will ask agoraphobic clients to practice leaving home, but while BT practitioners will do so to extinguish the clients' fear responses, CT ones will do so to help them find that their mal-adaptive beliefs about going out, were wrong. Although Beck (1976) believed that PT and BT's effectiveness was largely a function of their ability to tap into and change cognitions, albeit indirectly, he clearly acknowledged CT's debt to both. When proposing CT as a viable therapy (1976) he readily admitted that he developed it by integrating the best elements from the two approaches and claimed that CT was superior to these schools because it employed these techniques and accessed cognitions in a more cogent and better directed manner. A number of studies have supported the view that CT contained or tapped particularly active elements. For instance, Oei and Free (1995) surveyed forty-four and subjected twenty-one studies examining the relationship between changes in cognitions and improvement in depressive scores of subjects who received CT to meta-analysis. They found a significant positive correlation between the two although such a link also occurred in the other therapy types studied.* Of course none of the above constitutes proof of the title statement's first claim; that there are distinct elements within CT, but it seems to be an axiom of the studies quoted and of much present therapy research, that distinct elements not only exist but that some at least may be measured empirically. Furthermore, as will be seen later, there are claims that these elements apply across therapeutic schools and some writers such as Okun (1990) have attempted to show that because of their universality, competent therapists, may, perhaps ought to, apply the techniques that best engage these elements, regardless of their theoretical stance and the techniques' origin.

* Although its title refers to CT this article will also include data from studies of Cognitive Behavioural Therapy (CBT) since not only is it CT's most common variant but according to Beck (1976) BT itself is but a subset of CT.

Elements and theory

Since this article examines under what conditions CT's active elements are therapeutically most efficacious, identifying first those elements within CT that could be considered active, would be useful. According to Trower, Casey and Dryden (1988) CBT's active factors were; the tasks carried out by the clients, joint activities and active, even directive, interventions by therapists. They suggested that in the main the first consisted of: monitoring activating events and emotional upsets, identifying mal-adaptive thinking and beliefs, testing out these by examining evidence for and against them, engaging in their cognitive challenge and behaving in manner contrary to that dictated by them. Joint activities were concerned with goal and agenda setting. The third type, they claimed, consisted mainly of the help given by therapists to clients in recognizing and formulating their problem cognitions, Socratic discussion, formulating therapeutic goals, drafting the necessary strategies for achieving these and devising the required tasks. In addition, helping clients adopt the logical chaining methods of CT and activities such as explanation and life-skills training, role plays and interpretation, could also be actively used in CT.

As far as the first interpretation considered, that CT's active elements are effective even outside a theoretical matrix, there seems to be a qualified consensus amongst researchers that while indeed effective by themselves, these elements lose much of their potency if not utilised as part of a coherent, theoretically guided strategy. Both Beck (1976) and later Freeman, Pretzer, Fleming and Simon (1990), seemed to think their effectiveness was lower under such circumstances, since being unable to accurately decide when and how to use or juxtapose them, therapists had to use them haphazardly. One of Beck's (1976) main criticisms of BT was precisely that. He claimed that although its practitioners used effective elements, they based their work on simple descriptive formulations whose theoretic content was unable to provide them with a detailed causal understanding of their clients' psychopathology

and hence guide their interventions satisfactorily. Hawton, Salkovskis, Kirk and Clarck (1989) remarked that in addition to this, the lack of a theoretically comprehensive meta-structure, hampered therapeutic effectiveness because it meant that rather than being able to explain their interventions to clients and thus to enlist them as collaborators, practitioners had to rely instead on their blind faith. A faith that although was often sufficient (as is the case with gurus), was nevertheless less desirable or effective than informed cooperation. Also espousing Beck's view about the importance of theoretically coherent framework but explicitly criticizing CBT (and implicitly CT) were Holt and Lee (1989). In their view CBT lacked such a framework and consisted from an amalgamation of select treatment strategies, suggesting that the empirical challenges to its efficiency claims were attributable to its paradigmatic uncertainty.

Lamentably there is little research material comparing theory based (or driven) to purely phenomenological therapy. This is not surprising considering that even if interventions without a theoretical foundation (threadbare as it may be) would be feasible, they would nevertheless be ethically unacceptable in practically all therapy schools and particularly impossible to include in any publishable experimental study. However, when pondering existing work showing the qualitative advantage of experienced therapists in comparison to novitiates (Fiedler, 1950A, 1950B, Cross, 1982) the possible role of theoretical competence as a factor cannot be discounted.

Elements or relationship

The second question further muddles up the issue. Therapy is usually also a relationship between two or more persons. So can the active elements be successfully applied outside a therapeutic relationship? Two diametrically opposed positions can be discerned. On one hand is the, medical type, view of the active elements as akin to medication, supposed to work even if recipients do not believe

in their efficacy. On the other hand are those researchers who believe that change is purely due to the influence of therapists on their clients and that techniques are of little consequence (Pentony, 1981). Supporters of the first view may point out to the plethora of self help books, broadly based on CT and CBT principles that are available to the public. Their authors contend that by following their instructions, clients can therapy themselves. Since, despite the dearth of evidence, some people seem to benefit from them, active elements can be considered as having therapeutic merit per se inasmuch as these books engage them. Supporters of the second view may ask, can one get people to take psychologically painful steps and persevere without establishing a trusting relationship? They may point out that CT tasks are often onerous and frequently ask for trust on the clients' side. They then may ask, why would clients carry out these tasks and offer their trust unless that trust was built and nurtured by therapists? Brown and Pedder (1991) also pointed out that unless the active elements are embedded in a positive relationship, clients may find it difficult to integrate their benefits in an enduring form.

Modern views of CT and CBT do recognise the important role played by the therapeutic relationship and decry claims that, in CT it has no importance (Trower, Casey and Dryden, 1988). Beck readily admitted this and the important role of the therapist when he wrote, 'The most effective application of techniques depends not only on the clear conceptualisation of the case and the formation of a friendly working relationship, but also on the artistry of the therapist.' (Beck and Freeman, 1990, p. 79). At the same time he also criticised BT for losing effectiveness by not paying sufficient attention to the relationship and not tailoring its interventions to the client's needs. Espousing to some degree both positions was Dryden (1986) who emphasised the importance of emphatic, unconditional, philosophical and affective acceptance of the clients by their therapists and the effect (positive when part of psychotherapy) active, indeed directive, attitudes and involvement by the therapists had on their clients' cognitions. A third aspect of this divide concerns the, 'System of Delivery.' Even if active elements are embedded into a sound

relationship, the location, timing, balance of work between home and sessions and the rest of the variables that are dependent on the specific practices of the various therapeutic approaches, can be said to play an important role in therapy. Perhaps akin to that of catalysts in chemistry, not active per-se, but strengthening or stifling the overall reaction. Thus, whether working together as co-investigators or as physician and patient and the type of activities pursued in the session may influence outcomes even if their goals share the similarities identified by Nelson - Jones (1988).

Empirical evidence is once more equivocal. Fiedler (1950A, 1950B) and Cross (1982) found that the client and therapist relationships of experienced therapists of various schools (prevalent at their time) had more in common with each other than with those of inexperienced therapists of the same school and interpreted this as supporting the psychoanalytic belief, that disturbed relations were often at the core of the clients' problems and that the therapeutic relationship per se was a powerful tool for insight and change. After Rogers (1957) formulated his six necessary and sufficient conditions for therapeutic change, a number of studies found that the third, fourth and fifth ones, dubbed authenticity, unconditional acceptance and empathic understanding, were prominent in successful therapeutic relationships of the most diverse kinds and have suggested therefore that they form the basis for a therapeutic alliance between therapist and client regardless of the therapy's theoretical mien (Nelson-Jones, 1988). With the growing number of studies finding that therapeutic alliance strength was a major predictor of therapeutic outcome (Saffran and Wallner, 1991) and with the growth of the transpersonal school of psychotherapy (Okun, 1990) a (perhaps not surprising) change could be discerned in the arguments used by supporters of CBT and CT. Instead of minimizing the role of the therapeutic alliance they now claimed it existed in both. In their comparison of CBT and Interpersonal Psychodynamic Therapy, Raue, Castinguay and Goldfried, (1993) and Raue, Goldfried and Barkham (1997) found that therapeutic alliance strength was significantly higher in CBT. On the other hand, Salvio, Beutler, Wood and Engle (1992), claimed that in comparisons of CT,

Focused Expressive Therapy and Supportive Self Directed Therapy, the therapeutic alliance's strength did not differ between schools, only between therapeutic dyads. Although not incontestable proof, these findings make it difficult to deny that unless practiced within a viable therapeutic relationship any active therapeutic elements will be less and perhaps un-effective.

Conclusion

Although it was seen that there is some support for both the claim that Cognitive Therapy's active elements function both within and without a theoretical matrix or a therapeutic relationship, there is still disagreement about the validity of the evidence supporting either notion. For instance, Frank (1973) commented that any effect attributed to RET and BT could be due to a placebo effect. He illustrated this point using a medical maxim that when compared to an analgesic under double blind, a placebo has a 0.56 percent efficacy on average and that this effect can be increased if the patients are given the placebo by someone, they perceive to be a highly skilled rather than a junior physician, or if either patient or practitioner believe the placebo to be a strong rather than weak drug. Following his reasoning, active participation may thus be considered a condition enhancing placebo effect and it is interesting to note that just as placebo effects become weaker with repeat courses, clients with previous therapy experience are in psychological prattle, often claimed to be more difficult to help than new ones.

Another type of criticism was expressed by Fonagy (1989) who pointed out that the enhanced efficacy often attributed to CBT and CT in comparison to Psychodynamic treatments may have been no more than an artifact of the greater overlap between treatment modality and mode of outcome measurement. Similarly, Heckrath and Dohmen (1997) pointed out the difficulty in constructing truly equivalent conditions across therapies and therapists, while Hand (1991) claimed that although theoretically possible, such comparisons lacked meaning and

Gallo (1978) stated that their theoretical basis could not be logically justified. Typical of the complications surrounding this issue were the results from a study of the processes involved in CT by Hayes, Castonguay and Goldfried (1996). While they claimed that it was interventions that addressed interpersonal and developmental domains that were associated with improvement rather than those addressing the cognitive domain, a subsequent critique of their study by Stiles (1996) claimed that they missed their findings' point by analyzing only their rare positive correlations rather than examining the meaning of their failure to find correlations between most of their variables. It is thus that this article ends with what is not an uncommon concluding remark in psychological research. That there is evidence showing that Cognitive (and other) Therapy contains active elements and that these may be of use by themselves. However, a considerably larger body of evidence shows that these elements have a better therapeutic value when embedded within a theoretically and interpersonally sound therapeutic alliance.

References

- Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: New American Library.
- Beck, A. T. and Freeman, A. (1990). *Cognitive Therapy of Personality Disorders*. New York: Guilford Press.
- Brown, D. and Pedder, J. (1991). *Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice*. London: Routledge.
- Cross, D. (1982). Short and long term follow up of clients receiving insight based and behaviour therapy. *Journal of Consulting and Clinical Psychology*, 50, 1, 103-112.
- Dryden, W. and Golden, W. (1986). *Cognitive Behavioural Approaches to Psychotherapy*. London: Harper and Row.
- Fiedler, F. E. (1950). The Concept of an ideal therapeutic relationship. *Journal of Consulting Psychology*, 14, 239-245.
- Fiedler, F. E. (1950). A comparison of therapeutic relationships in Psychoanalytic Non-directive and Adlerian therapy. *Journal of Consulting Psychology*, 14, 436-445.
- Fonagy, P. (1989). On the integration of cognitive behaviour theory with psychoanalysis. *British Journal of Psychotherapy*, 5, 4, 557-563.
- Frank, J. D. (1973). *Persuasion and Healing: A Comparative Study of Psychotherapy*. Baltimore: John Hopkins Press.

- Freeman, A. M., Pretzer, J. L., Fleming, B., Simon, K. M. (1990). *Clinical Applications of Cognitive Therapy*. New York: Plenum Press.
- Gallo, P. S. (1978). Meta-Analysis, a mixed meta-phor? *American Psychologist*, 33, 5, 515-517.
- Hand, I. (1991). Comparative treatments studies: A critical appraisal of design treatment, contents and outcome interpretations. *Zeitschrift für Klinische Psychologie. Forschung und Praxis*, 20, 3, 280-285.
- Hayes, A. M., Castinguay, L. G. and Goldfried, M. R. (1996). Effectiveness of targeting the vulnerability factors of depression in cognitive therapy. *Journal of Consulting and Clinical Psychology*, 64, 3, 623-627.
- Heckrath, C. and Dohmen, P. (1997). On the empirical foundation of the highly significant superiority of the cognitive - behavioural compared with the psycho-analytic therapies. *Zeitschrift für Psychosomatische Medizin und Psychoanalyse*, 43, 2, 179-201.
- Holt, J. and Lee, C. (1989). Cognitive behaviour therapy re examined: problems and implications. *Australian Psychologist*, 24, 2, 157-169.
- Nelson-Jones, R. (1988). *The Theory and Practice of Counseling Psychology*. London: Alden Press.
- Pentony, P. (1981). *Models of Influence in Psychotherapy*. New York: Free Press.
- Oei, T. P. S. and Free, M. L. (1995). Do Cognitive Behaviour Therapies validate cognitive models of mood disorders? A review of the empirical evidence. *International Journal of Psychology*, 30, 2, 145-180.

- Okun, B. F. (1990). *Seeking Connections in Psychotherapy*. San Francisco: Jossey Bass Publishers.
- Raue, P. J., Castonguay, L. G. and Goldfried, M. R. (1993). The working alliance: a comparison of two therapies. *Psychotherapy Research*, 3, 3, 197-207.
- Raue, P. J., Goldfried, M. R. and Barkham, M. (1997). The therapeutic alliance in Psychodynamic-interpersonal and cognitive behavioural therapy. *Journal of Consulting and Clinical Psychology*, 65, 4, 582-587.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-104.
- Safran, J. D. and Wallner, L. K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Psychological Assessment*, B, 2, 188-195.
- Salvio, M. A., Beutler, L. E., Wood, J. M. and Engle, D. (1992). The strength of the therapeutic alliance in three treatments for depression. *Psychotherapy Research*, 2, 1, 31-36.
- Stiles, W. G. (1996). When more of a good thing is better: a reply to Hayes et al. *Journal of Consulting and Clinical Psychology*, 64, 5, 915-918.
- Trower, C., Casey, P., Dryden, W. (1988). *Cognitive Behavioural Counseling in Action*. London: Sage.

Transference and Counter Transference in Cognitive Analytic Therapy

Abstract

While many writers have considered that Transference (T) and Counter Transference (CT) are perhaps the two most important elements used in psychoanalytic therapy and devoted accordingly much effort to their study (Sandler et al., 1992), their role in other therapeutic schools, particularly those purporting to belong to the cognitive or cognitive influenced streams, has not been examined to the same degree. This article briefly examines that role in one such school, Cognitive Analytic Therapy (CAT).

Transference and Counter Transference

Before addressing this issue, a definition of Transference and Counter Transference (T and CT) may be of use. In the psychoanalytic circles, where these terms originated, there is little agreement on their meaning. Ego Analysts tend to see them as expressions of instinctual wishes, Kleinians see them as representation of unconscious phantasy and Interpersonal Analysts see them as a type of two person interactions (Bateman and Holmes, 1995). If such is the case among those who purportedly believe that *'The hallmark of psychoanalysis is the use of Transference and Counter Transference as a guide to understanding the inner world'* (Bateman and Holmes, 1995), then it is not surprising that scholars from other schools show even less agreement.

First mentioned and developed by Freud (1905, 1927) T came to the fore of psychoanalytic thought in the work of Strachey (1934), who proposed that analysts were at their most effective when addressing patients' T of primitive introjected imagoes from their superego onto the analysts. Another major influence was Klein (1932), whose work with children led her to believe that most behaviours were repetitions of patterns established in the individuals first year of life, and who tended to regard much of the analytic encounter as an arena for their re-enactment through the T based projective identification. CT has also similarly evolved over time. Originally mentioned by Freud in a letter apologizing to Ferenczi for his CT interfering in the later's analysis (Jones, 1955), CT had by 1915 become in Freud's understanding *'a sort of resistance in the analyst to the task of analysis.'* Freud's disciples were quick again to expand the meaning of the term, with Balint (1933) and Balint and Balint (1939) claiming that in the analytic relationship CT encompassed all elements that pertained to the analyst's relation to the analysand. Heimann (1950) though, was perhaps the first to suggest, that CT represented the analysts unconscious understanding of the patient and that rather than seeing it as hindrance, the analyst must use its counter-transferential emotional changes, as a

key to understanding their patients' unconscious communications. Although a Kleinian, Heimann did not link CT to projective identification. It was Racker (1953), who first proposed that CT was the analyst's response to the analysand's projections.

This situation has brought Sandler et al. (1992) to state that T and CT have become terms whose meaning is as varied as those who used them. On the one hand, T and CT are said to encompass the whole of the analytic situation (and according to some, go beyond it), while on the other, some restricted them to the transfer within the situation of one's representations of past objects onto present ones. In this, they echoed Kernberg's (1965) critique, *'that the terms T and CT have been broadened to such an extent that they lost any specific meaning.'*

In addition to the argument over T and CT's nature, the lack of valid and reliable empirical evidence for their very existence has been raised (Eysenck 1966). However, Fried, Crits-Christoph and Luborsky (1992) offered an elegant demonstration of T in therapy. Using content analysis methodology, they combined multiple measures into a construct called Core Conflictual Relationship Themes (CCRT). This started with the narratives that thirty-five adult clients used to describe their relations with important figures in their lives. They then applied the same measures to transcripts of the clients' narratives about their interactions with their therapists. In virtually all cases relationship styles with these figures were significantly correlated to their relationship style with the analysts. Finally, a number of independent judges who were unfamiliar with the clients were asked to match each client's narrative of its relations with significant others, to eight therapy sessions transcripts, only one of which was from the narrating client. Inter-judge reliability coefficient was 0.69 and significant, demonstrating that matches were not idiosyncratic.

CAT

CAT was developed over the last twenty years by Anthony Ryle (1979, 1991, 1995). In his works Ryle described the development of CAT as a bottom down process. That is, it grew in response to his clinical observations during the course of therapy rather than in response to theoretical work. Put simply, CAT aspires to amalgamate cognitive and analytic principles into a single approach. Believing that analytic type self knowledge is an important and often pre-required tool for change, CAT utilises a number of cognitive techniques (diaries, questionnaires, scales) together with analytic interpretations for simplifying its attainment by clients. Once such understanding is reached, it is believed to facilitate a triumph over the difficulties encountered when practicing various behavioural and cognitive tasks (goal setting, Socratic questioning, gradual exposure, etc.), which CAT therapists assigned to their clients so as to achieve change in their circumstances (Ryle 1991). In practice, this means that material from specialist questionnaires and the clients' self disclosures, is formulated by the therapists into a Reformulation Letter that they present to clients at about their fifth session. In this letter, that they both subsequently refine, the main events leading to the formation of the clients' Target Problems Procedures or TPPs, their present day effects and their ensuing Reciprocal Role Procedures (RRP's) are described. In CAT parlance TPPs are a summary of the main obstacles preventing the clients from reaching their life goals and their correction is the therapy's major goal. CAT also postulates that the main mechanism maintaining TPPs are RRP's. These are unconscious repetitive behavioural patterns which clients employ to manipulate their environment into providing them with the inputs needed for confirming and maintaining their TPPs.

The uses of T and CT in CAT

According to Ryle (1991), T and CT events are said to play an important role In CAT. Ponyton (1991) similarly recommends a focus on T and CT interpretations when working with clients whose personalities are poorly integrated. However, CAT approaches T and CT in a different manner from that used in psychoanalytic therapies. The therapist's observations of T events and their own CT are a major influence on their contribution to the definition of the clients' TPPs. CAT theory assumes that these will encapsulate the clients' repetitive difficulties in relationships and thus anticipate the T themes that will emerge in the therapeutic encounter. Hence, when T and CT become significant, therapists are believed to be able to quickly identify them and by linking the in-therapy behaviours of clients to specific RRP, make evident the later's role in maintaining the clients' TPPs. While Ryle (1991) acknowledged that the T aroused by an active, involved, jointly working, task giving therapist will be different from that evoked by the traditional, reflective or inert, therapist, he claims this will not invalidate working with the T. In fact, he claimed quite the opposite. He believed that this therapeutic style made T issues more conspicuous and thus easier for the therapists to interpret and for the clients to incorporate into their insights. Furthermore, Ryle (1991) stated that once the basic initial CAT steps were taken, a positive transference will have formed and assured and that any further appearance of T issues in a later stage of the therapy will indicate either setbacks or the manifestation of TPPs. He also suggested that if these were to reappear, then they would almost certainly do so at termination and in cases where past losses have been incompletely mourned. In this, his stance was not too dissimilar from that of Camnieszki (1991), who advocated incorporating behavioural modification techniques into psychodynamic therapy and claimed that interpreting the effects these have on the therapy's T and CT was a major contributor to therapeutic advance. Ryle's later work (1998) further emphasised the importance of T and CT to CAT, as he stressed the importance of matching the introduction and timing of cognitive tasks in CAT, so that they neither over-structured nor blocked clients' self initiated exploration.

In CAT, T and to a lesser extent CT, are not only tools for therapeutic use, they are also considered as possible obstacles to therapeutic advance, especially when they take an overtly sexualised or delusional form. That is, when they are resistant to insight. This negative aspect of T and CT was suggested by Ryle and Marlowe (1995) to be effectively removed by incorporating them into Sequential Diagrammatic Reformulations (SDR). These are graphic models illustrating the clients' TTPs and RRP's which in CAT thinking are believed to help clients visualise and grasp their effect role in their lives. In later work, Ryle (1996, 1998) recommend that other therapy schools adopt CAT's approach to T and CT. He postulated that, since in CAT those self states leading to T and indirectly to CT were clearly described in the fifth session Reformulation Letter, any further occurrence of these issues could be easily explained to them, thus reinforcing their insight by connecting present life experiences to past patterns.

Conclusion

Very little has been written in the emerging CAT literature about the practice experiences of CAT therapists with T and CT. Thus, evaluating whether Ryle's assumptions concerning both their usefulness and low problematicity in CAT is presently well nigh impossible. Nevertheless, it seems that in theory, CAT's understanding of T is close to what Bateman and Holmes (1995), called the modern pole. In their view, both T and CT could be described as constructs positioned along two bipolar scales. Each with a classical and a modern pole. Classical views of T saw it as a displacement, by infantile based aggressive/libidinal drives of a past reality onto the analysts. This distorts an (objective) present. The therapists' task was seen as facilitating this process by being a neutral objective blank screen and enabling a decrease in the distortions and their originating infantile wishes by means of interpretation. Modern pole adherents though, viewed T as a tendency to organise one's present experiences according to internal models

drawing from past ones. They considered present reality to be subjective and saw T as a part of normal adaptive processes. Modernists also saw the therapist as a subjective participant who interacted with the client and whose main intervention was reflecting the patient's construction to help their rigid schemata become more flexible and varied. This conclusion is reinforced by Ryle writing, 'only if, by 'analytic,' is implied an unyielding transference-centered interpretative mode, is the cognitive component intrusive' (1991 p. 27).

Concerning CT, Holmes and Bateman (1995) offered a considerably less outright dichotomy than for T. Here their classic pole was broadly similar to Freud's view of CT as being the analyst's transference to the patient and albeit emanating from the analyst, a resistance to the analytic process. The views they clustered at their modern pole, seemed to consider CT to be the therapist's response to the client's T, to its projective identification, and an aspect of the therapist's empathy and of the interpersonal field created in therapy.

CAT's position vis a vis CT was similarly less well defined than its position concerning T, but both could occasionally veer towards the classical point of view. Ryle (1991, p. 43) wrote, 'transference feelings can be difficult.... when they are aimed too unerringly at the therapist's counter transference vulnerabilities.' By emphasizing the client's responsibility for CT, Ryle failed to pay due attention to what Gilch - Geberzahn (1998) decried as the effect therapists' self states had on their perception of their clients and their interpretation of the later's T. The extent of this bias was demonstrated by McClure and Hodge (1987), whose study found that when compared to personality tests' results, therapists consistently over-estimated the similarity between their personalities and that of clients they liked, while underestimating the similarity with clients they disliked.

Evaluating the above evidence it is undeniable that CAT theory has paid some attention to the role of T and CT in the therapy. It also seems to have been quite confident that its use of explicit RRP's will enable therapist to defuse or side step

their effect in a rapid and forthright manner. This contrasts to the central role and painstaking attention paid to them in psychodynamic therapy. Also, the swift manner in which formulating the RRP's is supposed to defuse T, is reminiscent of Fenichel's (1941) warning that a factually correct but contextually hasty interpretation, 'augments the anxiety and with it the ego's defenses, instead of diminishing it'. While a decision which of these two approaches is correct is a topic that goes beyond the scope of this article and could beget many more research papers. For the moment though, the present article considers that this brings up the question whether CAT is truly analytic in practice or merely utilises psychodynamic formulations in what is basically another variety of cognitive behavioural therapy?

References:

- Balint, M. (1933). *Primary Love and Psychoanalytic Technique*. London: Tavistock.
- Balint, M. and Balint, A. (1939). *Primary Love and Psychoanalytic Technique*. London: Tavistock.
- Bateman, A. and Holmes, J. (1995). *Introduction to Psychotherapy*. London, Routledge.
- Fenichel, O. (1941). *Problems of Psychoanalytic Technique*. New York: PsychoAnalytic Quarterly Inc.
- Freud, S. (1905). *Three Essays on the Theory of Sexuality*. Standard edition, 7. London: Hogarth Press.
- Freud, S. (1927). *The Question of Lay Analysis*. Standard edition, 20. London: Hogarth Press.
- Freud, S. (1937). *Constructions in Analysis*. Standard edition, 23. London: Hogarth Press.
- Fried, D., et al. (1992). The first empirical demonstration of transference in psychotherapy. *The Journal of Nervous and Mental Disease*, 180, 326 - 331.
- Heimann, P. (1950). On counter transference. *International Journal of Psychoanalysis*, 31, 81- 84.

- Jones, E. (1955). *Sigmund Freud: Life and Work*, vol. 2: New York, Basic books.
- Kernberg, O. (1965). Notes on counter-transference. *Journal of the American Psychoanalytical Association*, 13, 38 - 56.
- Klein, M. (1932). *The Psychoanalysis of Children*. London: Hogarth Press.
- Ponyton, A. (1991). Basic Treatment Procedures. In A. Ryle (ed.), *Cognitive Analytic Therapy*. London: John Wiley and Sons.
- Racker, H. (1953). A contribution to the problem of counter transference. *International Journal of Psychoanalysis*, 32, 313 - 324.
- Ryle, A. (1991). *Cognitive Analytic Therapy: Active Participation in Change*. London: John Wiley and Sons.
- Ryle, A. (1995). History and recent Developments. In A. Ryle (ed.), *Cognitive Analytic Therapy: Developments in Theory and Practice*. London: John Wiley and Sons.
- Sandler, J. (1973). Counter transference and role responsiveness. *International Review of Psychoanalysis*, 6, 35 - 45.
- Sandler, J. et al. (1992). *The Patient and the Analyst*. London: Karnac Books.
- Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *International Journal of Psychoanalysis*, 15, 127 - 159.
- Spinelli, E. (1995). *Demystifying Therapy*. London: Constable.

Psychology, Psychotherapy and Paymasters

Abstract

This essay suggests that it is possible to see the development of counselling psychology and psychotherapy as driven by practitioners' desire for influence, status, power and money. That technical and so called ethical changes in these disciplines, arguably owe more to, what could be conceptualised as changes in product targeting and consumer tastes, rather than to clinical or theoretical breakthroughs. The article also contends that while support for its allegation is at best coincidental, the possibilities raised in it warrant a re-examination by counselling psychologists of the motivation driving them when constructing their craft and therapeutic encounters.

Introduction

When considering the evolution and development of a professional discipline, it is possible to do so from what might be seen as an internal perspective, one that focuses on the changes and processes that occurred within that discipline. However, while this method can give an account of a discipline's past history and perhaps even extrapolate its future direction, by neglecting external events that influenced it, it risks being a logical and detailed analysis that nevertheless misses its point. One example of this is the advance of modern physics. Whilst 20th century physics can be said to be dominated by an internal event, the formulation of the specific theory of relativity by Einstein, any account of its development that disregards the opportunities and direction given to it by political and economic forces, will be deeply flawed. As Leahey (1992) remarked, if USA federal funding of physics research, would not have increased from \$18 million per annum in 1942 to \$500 million in 1945, physics would not stand today where it does. In fact, modern physicists might still be attempting to split the atom. Was it a coincidence that nuclear and electromagnetic research, flourished when radar and the A-bomb were the military buzz words, or that optical research was spurred, when lasers were envisaged as the weapons of the future?

While we are not physicists, the development of our profession is often described as being due to our heroic striving for improved knowledge of the mind, our rigorous attempts to study human phenomena in an objective manner with resultant theoretical breakthroughs. However, was it just that? Were there not perhaps events and powers which, although not part of psychology, nevertheless significantly affected its development? Spinelli (1995) quotes Foucault (1962) and Howard (1992) who have examined the development of science and medicine and concluded that the development of these disciplines was at least influenced if not wholly determined by their psycho-social context. It is therefore the intention of this report to examine the development of psychology, psychotherapy and their

interlaced offshoots from this position and try to find out if various stages in their history, lend themselves to such interpretation.

However, this attempt should not be seen as supporting the wholesale criticism of psychology and psychotherapy as was done by Szasz (1978). Szasz's contention that psychotherapists' avowed aim of helping others, is a pretense to be kinder or wiser than others, does not invalidate our right to improve our condition and the status of our craft, just as other professionals do. Rather than phrasing this issue, as Szasz did, black or white, honest versus dishonest, this is an attempt to understand the co-construction of therapeutic reality and the need to be aware of how the forces that are often overlooked have shaped it.

The Past

Psychoanalysis

There is evidence from as far back as the 19th century that highlights what many of us take for granted, i.e., that external forces impact on the direction and content of psychological research. Mason (1984) described, in his expose of psychoanalysis, how Sigmund Freud battled in Vienna to establish psychoanalysis as a respectable and acceptable method of curing mental illness. Although many scorned his efforts, he tirelessly advocated it as a tool worthy of serious attention. His idea that the sexual seduction of children by adults caused hysteria, was received with furore and extreme animosity. Mason suggested that, at this point Freud changed his theory to one that was more palatable and less obnoxious to his public. The abhorrence caused by Freud's (1896) Child Seduction Theory was well documented in the scientific literature of its time (Mason, 1984), as were his retraction of this idea and the formulation of the Phantasy Theory a year later. Mason has shown that Freud's zeal in establishing psychoanalysis could have brought him to relinquish his earlier views for the sake of expediency.

Behaviourism

It is undeniable that behaviourism dominated psychology in the first half of our century. So strong was its influence, that Watson's (1913) claim that psychology was the science of behaviour, was for many years, the layperson's definition of psychology. It is interesting to consider why this turn of events may have occurred. Were behaviourist ideas so eminently correct that they swept all the old ideas before them, or was there something else at work? Were behaviourists only looking for a better understanding of humans? Did they truly believe that humans were just a cluster of mechanistic responses acquired as a foil to environmental pressures, or were they engaged in a self serving exercise. An exercise that enabled them to promise the authorities of the time, that given enough funds, better methods of controlling the masses, would become available. The behaviourist school made no secret of its aim to provide a way for socially adjusting humanity. One of its most outspoken proponents, B. F. Skinner, clearly believed that psychology's goal, ought to be the manipulation of individuals and of human society, to maximise adjustment within and between them. In his utopia *Walden Two* (1948), and his work *Science and Human Behaviour* (1953), Skinner did not regard such control as evil, but as necessary and ultimately good. Thus, although in *Beyond Freedom and Dignity* (1971) he admitted, that accomplishing what he called, 'a technology of behaviour', was still far away, he nevertheless believed in and supported its eventual attainment. These and similar occurrences were used by Ehrenreich and English (1979) to support their claim that the belief in the possibility of controlling human behaviour and the promise to bring forth techniques for human engineering, were in tune with the traditional goals of political and economic elites. They claimed that this was the real reason why government funds (Rockefeller Foundation grants in 1920 and Office of Naval Research funding in 1950, to give just two examples) and public acceptance, became available to behavioural psychologists.

Similarly, should we not ask ourselves how the contexts within which we work as contemporary counselling psychologists in an increasingly resource starved National Health Service, or in Employee Assistance Programmes with very limited time available for therapeutic engagement, may influence our clinical judgments and therapeutic practices. As well as with the demand for 'evidence based practice'. Ehrenreich and English (1979) further described how this rapport between psychology and the political elites, eventually culminated in the enormous thrust psychology received, by involving itself in the military effort of WW II. Alas, despite the great advances made by psychology in this period and the valuable insights it gained and notwithstanding popular ideas about brainwashing, the goal of a technology of behaviour was as distant after the war as before.

At the same time, we can see that when psychology has failed to be included in the National Science Foundation's list of approved disciplines, the result was that federal funding in the USA, by then psychology's main arena, suddenly dried up. Was it a coincidence that the revolutionary forces that eventually gave birth to new brands of psychology in the nineteen fifties, started stirring at this time?

Humanist

The third force in psychology, as Maslow (1968) called Humanist Psychology, seemed to model itself on the exiting advances occurring at that period in computer science and on the espousal by large segments of society, of the individual's rights, with their rejection of the state's right to regulate its citizens. However, were the humanistic revolutionaries just participating in theoretical upheavals, or were they attempting once more to secure funds and real world influence for psychology and psychotherapy? Despite claims by the new psychology to have forsaken the 'king's shilling', might it not be seen as offering the same old promises, adjustment and control, in new and sometimes less than new terms, to a new patron, the individual consumer?

However, looking at the promises couched in papers of the times: Human Deviance, Social Problems, and Social Control, (Lemert, 1967), Recent Advances in Brain Control, (Delgado, 1968), Existential Psychology (Strickland, 1968) and LSD-type Drugs and Psychedelic Therapy (Unger, 1968), it is possible to see that despite the adoption of socially and culturally fashionable words, psychology's promises seem to have changed little. This is perhaps best revealed in a paper, by the then president of the American Psychological Association, titled Psychology as a Means of Promoting Human Welfare, (Miller, 1969). Miller (of 7 + or - 2 fame) did not speak of control and human engineering anymore. Instead he spoke of, 'Psychology's revolutionary potential... concern with human beings... a new scientifically based conception of Man as an individual' and denied that control of behaviour ever was psychology's goal. Yet Miller promised his readers, that were they to trust psychology and allow it to evolve, a wonderful way of attaining happiness and self fulfillment will become available to all. This trend was also reflected in the new therapies, promises of things such as: Humanism (Rogers, 1964) and Self Actualisation (Maslow, 1967) that appeared at the time, continue today apace as is elucidated below. Although Miller (1969) conceded that they gave the public what the public seemed to want, Leahey (1992) claimed they were 'pseudo psychology', using psychological jargon, to lend their promises of happiness to all, a scientific respectability.

The present

Today, despite concerns such as those that Goldberg (1996) voices, e.g., that psychotherapy still lacks a unifying theory, and that psychotherapy has been reluctant to tackle the most important social issues facing society, it would seem that psychology and psychotherapy are a success story. Psychotherapy is more popular now (at least in number of practitioners and users) than ever before. It seems that psychologists may have attained the acceptance they wanted and that if not from the establishment, funding from the individual client is assured. Popular

psychology guides, such as 'I'm OK, You're OK' (Harris, 1970), 'Feel The Fear and Do It Anyway: How To Turn Your Fear and Indecision Into Confidence and Action' (Jeffers, 1987), promise instant psychological help and they became best sellers. The number of psychologists in the USA grew fifteen fold since 1945 (Leahey 1992) and Spinelli (1995) quotes Persaud's statement that in the UK '30,000 earn their living from counselling and a further 270,000 in the voluntary sector. Over 2,500,000 use counselling as a major component of their jobs.' The increase being both numerical as well as the increased visibility of psychological concerns in contemporary social discourse. However, popularisation, proliferation of therapies and the ever increasing promises of happiness do not necessarily correspond to a growth in care or knowledge, but may rather reflect a continuation of the old twin desires for money and influence. These desires are perhaps best seen by the ever increasing use, psychologists and psychotherapists, individual practitioners and institutions, are making of commercial advertising in both popular and professional journals.

Szasz (1978) summarised his view of psychotherapy as base and demagogic rhetoric, when he stated that 'in the past, they (psychotherapists) promoted such overt values as chastity, obedience, thrift. Today they advocate such covert values as the common good, mental health, welfare - blanks that may be filled with any meaning the speaker or listener desires.' Szasz (1978), Pilgrim (1996), Parker, et al. (1995), Foucault (1961) and Smail (1995) have all voiced concerns about the role of the state in issues of the emotional life and professional psychological practice, as well as voicing concerns regarding state funded psychotherapy since state controlled therapy can be seen as another method of state repression. For instance, Holowinsky's (1990) report, that with the wane of Communist dogma in the USSR, soviet psychology removed political deviance from its list of mental aberrations amply illustrates this point. Espousing a mirror stance Pilgrim (1993), criticised instead the growing tendency of psychotherapists to work privately. He claimed that by seeking to further their financial needs, therapists engaged in an 'ipso facto discriminatory activity'. In opting to work privately, he believed,

therapists were ministering to the strong rather than the needy, helping those who wield power in our society at the expense of those oppressed by it.

This scrambling after status, respectability and fortune was seen by Spinelli (1995) as a major reason for the squabbling between psychiatrists, psychologists, psychotherapists and counsellors, over who does what, who is qualified to do it, who should be permitted to do it. Questions that perhaps could be summarised as, who should be paid for it?

So, with a history such as this, we need to ask whether psychology and psychotherapy's aims are not, power, money, influence and status? There is little doubt that as society's demands change, the terms used in their promises, will also change. That as they discarded human engineering and telephone exchange for self-fulfillment, reprogramming and computers, they will likely discard these in turn for models drawn from new technologies. However, that old tendency to pander to whomsoever holds the purse strings, seems as strong today as ever. That view was also taken by Pilgrim (1991) who claimed that 'while from the mid sixties to the mid seventies psychotherapy sided with informed progressive even radical social movements... the current reductionist, socially blinkered, understanding of therapy, can be traced back to sectional interest of professionalism'. This view was also held by Jacoby (1975) who claimed that the humanistic psychology does nothing more than reconcile individuals to unacceptable conditions rather than empower them to reject the social basis for such situations and ultimately change them.

Conclusion

The previous sections of this paper, espoused one possible interpretation of changes within psychology and psychotherapy. Hopefully, they also demonstrated that historical trends could be validly interpreted as supporting the argument. However, it has to be reasserted, that although the facts cited may be true historically, they were not, indeed could not have been more than some of the many elements affecting the development of psychology and psychotherapy. Even a dire critic of psychotherapy such as Mason (1993) admitted that, 'as yet no entirely suitable substitute for therapy has been found'.

There is no cabal of psychologists that decides how to advance the cause of our discipline. There are individual psychologists and therapists who over time and through exposure and experimentation, amongst other factors, adopt or discard approaches, (usually with great discord - see the acrimony that resulted in the splitting of the British Confederation of Psychotherapists from the United Kingdom Council for Psychotherapy). It is thus important that individual practitioners consider their approach and change it if needed. It is also individuals who should consider and effect changes in their practices, in the practices of their work settings and their professional bodies, hopefully leading to useful developments across the discipline.

For counselling psychologists who wish to practice ethically, it is useful to consider, not only their own actions, beliefs and values, but also the four principles originally proposed by Kohut (1979) and later expanded by Meara et al. (1993) and Patton and Meara (1996). These principles define the ethical counselling psychologist, as operating with Integrity, Respectfulness, Benevolence and Prudence. Integrity in this context, implies the possession of reasonably stable, justifiable, moral values together with an active fidelity to these values in judgment and in action. Respectfulness, is granting autonomy to clients and also respecting them on their own terms. Benevolence, is the intent of engaging in therapy for the

welfare or the goals of the clients, and prudence, refers to the care and humility counselling psychologists (or any other therapists) need to adopt when engaging with (often less robust) others. These terms seem straightforward on first reading, but they are complex concepts affecting us differently in different settings and with different social roles. The place of values is an important issue for counselling psychologists, so much so that our discipline has a clear statement regarding the central role of values in the therapeutic endeavour (DCoP, 1995) .

Thus, if individual practitioners consider and incorporate these principles in professional practice, it may assist in developing our awareness of the myriad forces shaping the co-construction of counselling psychology, thereby helping ensure that the above version of the advance of psychology and therapy will remain a cautionary tale rather than become an actual truth.

References

- Delgado, J. M. R. (1968). Recent Advances in Brain Control. In P. Powers and W. Baskin (eds), *New Outlooks in Psychology*. New York: Philosophical Library.
- Division of Counselling Psychology, (1995). *Guidelines for the Professional Practice of Counselling Psychology*. British Psychological Society, Leicester.
- Ehrenreich, B. and English, D. (1979). *For Her Own Good: A Century of the Experts' Advice to Mothers*. N.Y.C: Pluto Press.
- Foucault, M. (1961). *Madness and Civilisation: History of Insanity in the Age of Reason*. London: Routledge.
- Goldberg, C. (1996). Critical Issues confronting the profession of psychotherapy: now and into the new millenium. *International Journal of Psychotherapy*, 1 (1).
- Harris, T. A. (1970). *I'm OK, Your'e OK*. London: Pan Books.
- Holowinsky, I. Z. (1990). Restructuring Soviet Psychology in the Context of Gorbachev's 'Glasnost'. *School Psychology International*, 11, 3, 303-308.
- Jacoby, R. (1975). *Social Amnesia: A Critique of Conformist Psychology From Adler to Laing*. Hassocks: Harvester Press.
- Jeffers, S. (1987). *Feel the Fear and Do It Anyway: How to Turn Your Fear and Indecision Into Confidence and Action*. London: Random House.

- Kohut, H. (1979). Four basic concepts in self psychology. In P. Orenstein (ed.), *The Search for Self: Selected Writings of Heinz Kohut 1950-1978*. Vol. 2. Madison Ct: International Universities Press.
- Leahey, T. H. (1992). *A History of Psychology: Main Currents in Psychological Thought*. Englewood Cliffs, NJ: Prentice Hall.
- Lemert, E. M. (1967). *Human Deviance, Social Problems and Social Control*. Englewood Cliffs, NJ: Prentice-Hall.
- Maslow, A. (1968). Self actualisation and beyond. In J. F. T. Bugental, (ed.), *Challenges of Humanistic Psychology*. New York: McGraw-Hill.
- Masson, J. M. (1984). *The Assault on Truth: Freud's Suppression of the Seduction Theory*. New York: Farrar, Strauss and Giroux.
- Meara, N. M. et al. (1993). Principles and virtues: a foundation for ethical decisions, policies and character. *The Counselling Psychologist*, 24, 4-77.
- Miller, G. A. (1969). Psychology as a Means of Promoting human Welfare. In R. D. Gross (ed.), *Key Studies in Psychology*. London: Hodder and Stoughton.
- Patton, M. J., Meara, N. M. (1996). Kohut and Counselling. *Psychodynamic Counselling*, 2, 3, 244-261.
- Pilgrim, D. (1993). Objections to private practice. In W. Dryden (ed.), *Questions and Answers on Counselling in Action*. London: Sage.

- Rogers, C. R. (1964). Toward a science of the person. In T. W. Wann (ed.), *Behaviourism and Phenomenology: Contrasting Bases for Modern Psychology*. Chicago: University of Chicago Press.
- Skinner, B. F. (1948). *Walden Two*. New York: McMillan.
- Skinner, B. F. (1953). *Science and Human Behaviour*. New York: McMillan.
- Skinner, B. F. (1971). *Beyond Freedom and Dignity*. New York: Alfred A. Knopf.
- Spinelli, E. (1995). *Demystifying Therapy*. London: Constable.
- Smail, D. (1995). Clinical psychology: Liberatory practice or discourse of power? *Clinical Psychology Forum*, 80, 3-6.
- Szasz, T. (1978). *The Myth of Psychotherapy*. Syracuse, NJ: Syracuse University Press.
- Strickland, B. (1968). Existential Psychology. In P. Powers and W. Baskin (eds), *New Outlooks in Psychology*. New York: Philosophical library.
- Unger, S. (1968). LSD-type Drugs and Psychedelic Therapy. In P. Powers and W. Baskin (eds), *New Outlooks in Psychology*. New York: Philosophical Library.

Financial aspirations and their effect on therapeutic outcomes

Abstract

This article briefly examines existing literature on the role of financial expectations in therapy outcomes. Limited data was found and this seemed to be sharply divided between those who thought that financial loss, particularly termination of benefits, hindered therapeutic advance on one hand and those who thought they played no role except in the therapists' and society's prejudice against the poor and the sick on the other. Since extant research provides insufficient data, rather than reach a definite conclusion about these roles, the article ends with a number of suggestions for working with clients whose therapeutic advance, therapists believe, may be hindered by financial expectations.

Introduction

One assumption commonly encountered among psychologists and other psychological professionals, is that patients attend therapy because they wish to improve their psychological state (Brown and Pedder, 1991). However, this is not always the case. Some clients may attend because they were ordered by the courts to do so, while others were pressurised into attendance by relatives and friends. Others may attend because of curiosity and others still, because it's a way and a place to make contact with another person and some seem to attend therapy because they want their beliefs reaffirmed by a professional. With these clients, as with others, resistance is an always present issue that can become a major obstacle. Those pressurised to attend may refuse to take part in the process, merely attending the sessions. The lonely may limit their improvement to a level that will ensure a continuation of the therapy, but may avoid improving to a degree at which it will be deemed no longer necessary, while those looking for professional approval will often fiercely resist any change in their situation. In fact, the psychoanalyst Sandler (1992) classified no less than ten forms of resistance, most of which fell into the category of internal psychological processes.

One form of resistance in whose aetiology external circumstances, or at least beliefs about external repercussions were largely involved, was labeled by Freud (1926), Secondary Gain. Paolino (1978, p. 188) defined Secondary Gain as, 'A favored environmental or intrapsychic situation that is a consequence of the symptoms or the treatment... It can be so profoundly favored as to significantly contribute to un-treatability and may be associated with a great number of symptoms even those that cause great psychic suffering.' So for example, a client obsessed with cleanliness not only assuages his or her anxieties by constant cleaning, but also gains power over his or her social network when its members, often out of concern, capitulate to their needs and demands. While gaining and maintaining power over one's relatives and friends is a type of secondary gain that

has been quite widely explored before, another type of gain, the financial one has hardly been studied before. This does not refer to the well evidenced finding that lack of money prevents people from attending and receiving therapy (Pilgrim, 1983), but to the little researched effect of financial expectations on therapeutic processes and outcome.

The hope for gain

As mentioned above, there is an assumption that clients attend therapy to improve their psychological condition. Another assumption that seems inherent in our models of therapy and the human condition, is that it is in our clients' economic interest to improve as quickly as possible so as to begin generating more income. However, this is far from being a universal case. A judicial case, reported in the news in early 1998, concerned a junior doctor who won hundreds of thousands of pounds in compensation from the NHS. Barely one year after graduation, this doctor pricked her finger on a discarded needle. Although she was not infected, she became averse to needles and other sharp objects and was diagnosed as having a very severe phobia to needles and other surgical instruments. Since her lawyers convinced the court that her condition prevented her from ever resuming her intended career, she was awarded by it the best part of a million pounds in compensation for lost earnings. In a similar case reported by Kennedy (1977), an American air controller, who was diagnosed as extremely anxious, was retired at age thirty-four on full pay since he was too unwell to work. In both these cases the notion that these individual hoping to financially benefit from their psychological condition were averse to its improvement, cannot be disregarded. Particularly if like the air controller, resuming his duties in today's job market would entail an income cut, or if like the doctor's surgical phobia, the condition only affected a part of their life.

Such resistance may not be limited to cases where large amounts of money are involved. A substantial proportion of NHS mental health referrals seems to be for treating Agoraphobia. Clients with this condition find it very hard to leave a secure place (usually their home) and venture elsewhere. Although, they may be able to move away from that safe place for a limited distance or accompanied by a trusted person, the agoraphobic client is usually unable to self care in various ways: shopping, attending social events, visits to professionals, etc., which may constitute onerous tasks. These often become burdens carried by their carers (Eysenck, 1994). One activity which people with agoraphobia often find difficult is attending a place of work. So, unless they are able to work from home they rely for their sustenance on private income, relatives, or in our society, state benefits. This article does not claim that agoraphobia is not a genuinely distressing condition and recognises people suffering from it are quite genuine in their wish for improvement. Still, do those patients relying on disability benefits face a major financial incentive hampering therapeutic advance? In particularly those highly disadvantaged clients whose economic prospects without the agoraphobic label may be bleaker than with it?

Concerning state benefits, one could claim that there is no need for the psychologically disturbed individual to prolong his or her state in order to continue receiving them. It is entirely feasible and occurs quite often that individuals today live their entire lives with no declared income except for Job Seeker's Allowance and Hardship Benefits. However, obtaining these requires some effort on their part. One has to attend the Employment Centre every two weeks. Jobs might be offered and if rejected benefit may be withdrawn, training schemes may be compulsory in the long term and special needs are not so easily accounted for. With Disability Benefit though, far less constraints are placed on the recipient. Once found incapacitated, there is very little they need do, except for periodically undergoing a medical examination to ascertain that they are still incapacitated.

The role of fear

So far this article has discussed the role of financial incentive in hindering recovery from a psychological condition, as no different from its role in hindering recovery from physio-medical conditions. However, there is an aspect where these roles differ markedly. In physio-medical conditions improvement can and is expected, to take place largely irrespective of motivational factors. However, in psychosomatic and psychological conditions, motivation is often regarded as playing a large part in determining outcome (Ginsburg, 1995). Moreover, it may not be just the clients' conscious motivation that is affected by financial incentives, but a genuine wish on their part to improve may be beset by largely unconscious fears concerning the consequences of improvement.

To date, few works have directly examined how financial expectations influence therapeutic success, but those who had, have come up with three rather different views. On one hand, researchers such as Goodwinn (1974) found that middle class persons (and that covers most psychologists) significantly de-emphasised the work ethic and motivation of welfare recipients.' Thus, indicating that 'freeloading' and other beliefs about the propensity of the poor to abuse the benefits systems, were more of a middle class myth than a widespread phenomenon.

Others such as Antebi (1970) and Rivinus (1977) found that the availability of benefits sharply reduced improvement rates in psychological therapy. Antebi even proposed that a syndrome akin to compensatory neurosis affected individuals who wanted to receive benefits, while Rivinus believed the need for benefits was a powerful influence hindering clients recovery both directly and through their families. In a like manner, Simon (1965) reported that lower socio-economic status was positively correlated to a lowered wish to be discharged from mental hospitals.

The third view, is that emerging from work that although not specifically researching therapeutic outcomes (Furnham 1982, 1986, Furnham and Rose, 1987) nevertheless suggested that individuals possessed differing ethical belief systems concerning life-goals, money, work and benefits and that the effect of these was consistent through various domains and under varying circumstances. If these findings are reliable and there is no evidence at the moment disputing them, we can consider that while clients with high work or wealth ethics, that is those for whom work per se or the independence from others wealth often allows, were important, may have been more motivated to improve in therapy even if this led to greater demands for them to support themselves. On the other hand, clients with high leisure and welfare ethics, that is those who espoused recreation as the main means to personal fulfillment or believed that exploitation of state benefits as a primary income source was desirable, may have been less enthusiastic about improvement if this curtailed these goals.

While Furnham's findings tied in with Ludwig's (1981) theory of the Disabled Society, a society where a growing proportion of people finds it morally acceptable and economically advantageous to become recipients of Disability Benefits and to postpone or forego return to work, they as well as the other studies quoted clearly fail to deliver sufficient evidence to decide whether financial motivation is more than an occasional factor in therapeutic process. Moreover, these issues are not only important therapeutically. As Schutz (1982) found, if by helping our clients or if by disclosing our opinion that financial motives may hinder their recovery we cause them a financial loss, we may be open to the unlikely, but not impossible, lawsuit for unintentional tort.

Therapeutic process and financial expectations

Assuming that financial expectation may intrude in therapy from time to time, what are therapeutic practitioners to do when encountering such a situation? When despite our best efforts little therapeutic advance is made and we come to believe that it is the client who for economic reasons wishes not to advance further, then understanding how these expectations affect the process of therapy and being able to deal with such clients becomes necessary.

The effect of financial gains on clinical improvement can be conceptualised as mediated through a number of pathways. Applying Ludwig's arguments (1981) to agoraphobia as an example, then improvement in the case of agoraphobic clients on disability benefits may be impeded by their reasoning thus. If I show improvement I will cease to receive disability benefits, I will then be expected to start working/attend the benefits centre and may even be making less than I am at present.

A more circumspect pathway may be as follows: if I show improvement, I will cease to receive disability benefits. I will then be expected to start working/attend the Benefits Centre. To do this I will have to leave my safe place and venture out, only to attend a stressful place. The stresses of venturing out, plus the stress at the destination will make me feel worse. Hence, to feel better will make me feel worse. Two more possibilities emerge from Furnham's work (1982, 1986). Some clients may lack a work ethos and prefer instead to live off the state. After all, why should an individual, male or not, work for her or his income when one can be received without having to. Others who share the work ethic may feel uneasy living at tax payers expense for no particular reason, but will find receiving benefits for medical reasons, a morally more acceptable choice.

Financial hindrance: or therapists and society

Before making any conclusions regarding clients being affected by financial motivation, psychologists must remember that membership of a less favored socio-economic group has been positively correlated with lowered therapeutic success rate all over the world (Arieli and Reznick, 1979, Pilgrim and Treacher, 1992). Many reasons were given for this phenomenon. Some, such as Freud's (1905), were indigenous and regarded the poor as inherently less able to benefit from therapy. Others thought that intervening factors such as social reinforcement and lack of appropriate role models may have prevented the poor (including welfare recipients) from making full use of therapy (Goldstein, 1973). Similarly therapists' behaviour and beliefs may have magnified or wholly created the problem. For instance, Pilgrim (1983) described psychiatry and to a large extent clinical psychology, as having undertaken the social functions of controlling deviancy and providing jobs for psychiatric workers. He also described both, as disciplines that because of the individualistic, conservative, world view of their practitioners, enforced social conformity, a conformity that may well include keeping benefit recipients at their dis-empowered position. On a more personal level, Brown (1980) described therapists as psychically usurious for demanding exorbitant rates of return on the loan of their self for therapeutic purposes. If his view holds true, then clients would hardly feel encouraged to relinquish benefits for the sake of therapeutic advance. These worries about the role of therapists in lower success rate of poorer clients was reinforced by Schnitzer (1996) finding that beliefs similar to Freud's opinions, about the poor being poor therapeutic prospects, were still held by the majority of her psychology professionals sample. Moreover, her finding that impoverished people were routinely described during psychology training in terms such as: have different morals, impaired cognitive competence, or lowered sense of responsibility, may fall into what Abberly (1995) called disabling ideology, both disabling our clients and perpetuating their self view as disabled. Some researchers believed that therapists colluded with clients who remained unwell for financial motives. Either because they saw them as entitled to this

collusion (Rivinus, 1977), or because the therapists found fiscal issues a difficult topic in therapy, perhaps because they knew they stood to gain financially from it (Weissberg, 1991).

Conclusion

Despite the above reservations there is a distinct possibility that some clients may consciously or unconsciously exhibit a resistance to improvement due in part to financial expectations. What are practitioners to do when faced with a client whose therapeutic advance, they believe, is impeded by fears on his or her part, that if therapeutic improvement takes place they'll be financially worse off.

First, as Paolino (1977) recommended practitioners should not be too quick to dismiss this client as unsuitable for treatment. They should examine very carefully whether these are real hindrances or, perhaps because of some counter-transference, just perceived as such. Even an external gain or loss involved should be found it should be examined to determine whether it is so central so as to impede therapeutic advance. Then the example of professionals who regularly work with reluctant clients should be taken. Probation, forensic and even educational psychologists, all work regularly with reluctant clients who often doubt improvement will serve their interests (Weakland and Jordan, 1992) and perhaps taking into account their needs and fears, re-formulate with them the therapy's goals. Similarly, therapy for clients for whom success may be financially punitive could also focus on improved fiscal responsibility so that even if receiving less financial help, they would be better able to use their remaining benefits (McAlevey, 1997). Most useful perhaps is that practitioners become aware of Kennedy's (1977) recommendation that in order for them to help reluctant clients and at the same time save themselves from a loss of confidence in their efficacy, they are to accept their clients as reluctant or uninterested in therapy. In other words, treat reluctance as they would treat any other emotion expressed in therapy. They must

accept that sometimes nothing effective can be done to change situations or change others and need to accept that in such cases they can only change themselves. Kennedy also recommended that after examining if there is something in the practitioner's response that hindered advance, he or she should proceed with the client to examine their reluctance. Not as an attempt to win them over, which may prove a thankless task and a coercive experience for the clients, but as an honest exploration that was possible within the confines of such situation. Reluctant people he said and I concur, must be recognised for what they are, people who may not want to be in the therapist's office and who need to be accepted and understood as such before any real progress can be made.

References

- Abberley, P. (1995). Disabling ideology in health and welfare: The case of occupational therapy. *Disability and Society*, 10, 2,221-232.
- Antebi, R. N. (1970). State benefits as a cause of unwillingness to work. *British Journal of Psychiatry*, 117, 205-206.
- Arieli, A. and Reznick, R. (1979). A community psychiatric service in Maalot. *Israel Annals of Psychiatry and Related Disciplines*, 17, 4, 278-290.
- Brown, E. C. (1980). Usuriousness and psychotherapy. *Psychotherapy; Theory Research and Practice*, 17, 4, 420-424.
- Brown, D. and Pedder, J. (1991). *Introduction to Psychotherapy*. London: Tavistock-Routledge.
- Eysenck, M. W. (1994). *Individual Differences: Normal and Abnormal*. London: Lawrence Erlbaum Associates.
- Freud, S. (1905). *Three Essays on the Theory of Sexuality*. Standard edition, 7. London: Hogarth Press.
- Freud, S. (1926). *Inhibitions Symptoms and Anxiety*. Standard edition, 20. London: Hogarth Press.
- Furnham, A. (1982). The Protestant work ethic and attitudes towards unemployment. *Journal of Occupational Psychology*, 55, 4, 277-285.
- Furnham, A. (1986). The determinant of attitudes towards social security recipients. *British Journal of Social Psychology*, 24, 1, 19-27.

- Furnham, A. and Rose, M. (1987). Alternative ethics: the relationship between the wealth welfare work and leisure ethic. *Human Relations*, 40, 9, 561-573.
- Ginsburg, I. H. (1995). Psychological and psycho-physiological aspects of psoriasis. *Dermatology Clinician*, 13, 4, 793-804.
- Goldstein, A. P. (1973). *Structured Learning Therapy: Toward a Psychotherapy for the Poor*. New York, NY: Academic Press.
- Goodwin, L. (1974). Middle class mis-representations of the high life aspirations and strong work ethic held by the welfare poor. *American Journal of Orthopsychiatry*, 43, 4, 554-564.
- Kennedy, E. (1977). *On Becoming a Counselor: A Basic Guide for Non Professional Counselors*. New York, NY: Gill and Macmillan.
- Ludwig, A. M. (1981). The disabled society? *American Journal of Psychotherapy*, 35, 1, 5-15.
- McAlevey, M. E. (1997). Art therapy and the IV-E Grant in New Jersey. *Art Therapy*, 14, 1, 44-49.
- Paolino, T. J. (1978). *Psychoanalytic Psychotherapy: Theory, Technique, Therapeutic Relationship and Treatability*. New York, NY: Brunner Mazel Publishers.
- Pilgrim, D. (1983). Politics Psychology and Psychiatry. In D. Pilgrim (ed.), *The Psychotherapy Reader*. London: Routledge.

- Pilgrim, D. and Treacher, A. (1992). *Clinical Psychology Observed*. London: Routledge
- Rivinus, T. M. (1977). The abuse of Social Security income. *Psychiatric-Annals*, 7, 2, 85-89.
- Sandler, J., Dare, C. and Holder, A. (1992). *The Patient and the Analyst*. London: Karnac Books.
- Schnitzer, P. K. (1996). They don't come in: stories told, lessons taught about poor families in therapy. *American Journal of Orthopsychiatry*, 66, 4, 572-582.
- Schutz, B. M. (1982). *Legal Liability in Psychotherapy*. London: Jossey Bass Publishers.
- Simon, W. B. (1965). On reluctance to leave the public mental hospital. *Psychiatry*, 28, 2, 145-156.
- Weakland, J., and Jordan, L. (1992). Working briefly with reluctant clients: Child protective services as an example. *Journal of Family Therapy*, 14, 3, 231-254.
- Weissberg, J. (1991). The fiscal blindspot in therapy. In S. Klebanow and E. L. Lowenkopf (eds), *Money and Mind*. New York, NY: Plenum Press.

Therapeutic Practice
Dossier

Therapeutic Practice Dossier

The contents of this dossier address those issues concerning practicing counselling psychology that arose during the three year long placements. The nature and experiences of training in diverse National Health Service settings are discussed. An essay on the integration of theory, practice and research concludes this dossier.

Placements reports

This section comprises a description of the three PsychD placements and of the therapeutic administrative and educational roles undertaken as part of them.

First Year Placement: An NHS Community Mental Health Team.

January 1997 -- August 1997

During this placement, I was based in a Community Mental Health Team (CMHT) in one of London's most deprived areas. Although I saw clients from diverse backgrounds, they were predominantly, economically very deprived, members of a single cultural group. Presenting problems included: depression, anxiety, phobias, bereavement, relationship issues, sexual abuse, personality disorders and drug and alcohol abuse. I also had the opportunity to participate with a senior psychologist in therapeutic work with inpatients.

My supervisor at this placement was a clinical psychologist from the CMHT. The placements' theoretical orientation was largely cognitive-behavioural although supervision was influenced by the supervisor's phenomenological mien. Interventions were also varied with person centered and problem solving perspectives being offered in addition to CBT. Further opportunities for involvement with the psychology team included: team meetings (where I had the opportunity to present clients) an awayday concerning HIV and AIDS and a three day training workshop on "Phenomenological Therapy for Psychosis".

Second Year Placement: An NHS Psychoanalytic Psychotherapy Department.

September 1997 -- August 1998

Based in a London teaching hospital, this placement was an opportunity to work within a Psychodynamic frame. Clients were either seen for six or twelve months courses of treatment, providing me the opportunity to experience working in a relatively long-term therapy. Their presenting problems included: depression, anxiety, sexual dysfunction, complex loss and bereavement issues, sexual abuse and multiple diagnosis issues, e.g., borderline personality disorder and sexual masochism. An additional opportunity for further involvement in the team was the weekly clinical meeting, where client issues were discussed. At this placement I also was involved in a clinical outcomes evaluation programme.

Supervision for this placement was provided by a psychoanalytic psychotherapist. This consisted of joint supervision with another trainee, in which, using a largely Kleinian framework, process notes from one client were discussed each week. Additional psychodynamic group supervision was provided by a psychiatrist who was also a psychoanalyst.

Third Year Placement: A Adult Mental Health Service.

September 1998 -- August 1999

This placement took place in the Adult Clinical Psychology Service of the Coordinated Psychological Services directorate of a inner London NHS trust. Because of its geographical area and nature (weekday NHS service) its clientele comprised mainly individuals belonging to lower socio economic strata with a large proportion belonging to ethnic minorities, being unemployed or asylum seekers (with their concomitant problems). Its tertiary service nature also meant that a large proportion of the clientele, suffered from severe or chronic mental health and personality problems and so were repeat users of the service. Their presenting problems included: post traumatic stress disorder, panic and general anxiety disorders, agoraphobia, obsessive compulsive disorders, coping with delusions and intrusive thoughts, childhood sexual abuse and complex issues such as the effects of torture and persecution being compounded by having to abandon family members to danger. I also had the opportunity to perform a number of supervised cognitive assessments. In addition to individual client work, I set up and co-led with a clinical psychologist a CBT group on anxiety management.

The service's modal approach was time limited CBT (12 to 16 sessions) although Cognitive Analytical therapy (originally developed at the trust) was also on offer. Individual supervision in this placement was provided by a clinical psychologist specializing in neuro-psychology. Group supervision and CAT training were provided by two other clinical psychologists. Hence, although the predominant mode of formulating and working with clients was cognitive-behavioural, this was refined by an enhanced awareness of underlying issues.

Integration in Therapy: choice or responsibility?

Abstract

This paper examines the integration of theory, ethics and research into therapeutic practice. The notion of integration in existing literature is presented and some of its benefits and drawbacks explored. Examples from the present author's training as a Counselling and Psychotherapeutic Psychologist, are utilised to elucidate its use in therapy.

Introduction

Because we are far from being able to match clients and therapies and no single school has proven invariably able to treat all problems, there is a growing movement towards creating an integrated multi-modal psychotherapeutic approach (Fonagy, 1989). A process that began over fifty years ago, (Dryden and Norcross, 1990) integration is often divided into three main levels: technical eclecticism, theoretical integration and common factors (Norcross and Grencavage, 1990). More recently, attempts at integration at two or all levels led to the creation of formalised therapeutic approaches, integrating technical elements from disparate schools into theoretical composites such as, Cognitive Analytic Therapy (CAT, Ryle, 1991) and Dialectical Behaviour Therapy (Linehan, 1993). A few writers such as Wachtel (1984) have even attempted the unification of extant methods into new theoretical structures. In addition to the integration of theories from different therapeutic schools, it has been suggested that theory and research, often divorced from real life experience, should also be integrated clinical practice (Woolfe, 1996).

This work presents the pivotal role integration plays in the shaping of my working approach as a Counselling and Psychotherapeutic Psychologist. It is not intended as a justification of the therapeutic encounters it portrays, but rather as an insight into the influences (ethics, placement contexts, client encounters, theories and research) that shaped my practice. It starts by briefly examining current understandings of the term integration, looks into the benefits of practicing integratively, followed by examining some of the risks this entails and ends by describing my personal position vis a vis integration. It also uses case material to illustrate the points it will be making but in particular to illustrate how that integration refers not only to therapeutic models but also to basing clinical practice on research and theory.

Why integrate

Notwithstanding the bickering concerning the meaning of integration and how it differs from eclecticism and common concepts theories, there is little doubt it is a growing force in psychotherapy. About half of American psychotherapy professionals, describe themselves as integrative or eclectic (Norcross and Grencavage, 1990). What strange attractors has integration, to have caused this situation? Furthermore, integration is particularly important to newly fledged psychologists and therapists, especially those whose training did not follow the dictums of a single model but included various influences and points of view. How otherwise, are new practitioners to form the basis for what will become their future modus operandi and to create a viable integrated entity, wisely sift among the myriad techniques, approaches and research they were exposed to during their training? This need arises as soon as supervised practice commences. For instance: during my first year as trainee, I saw a thirty-three year old married mother of two who had requested therapy to overcome her anxieties and food abuse. When she was two years old, her father abandoned the family. At twelve she was sexually abused by two maternal uncles and raped by an older boy. She was not able to confide in her mother from whom she always felt distant. The abuse stopped after she disclosed it to her stepfather, but he died when she turned seventeen. At eighteen, she sought her biological father, but he was not interested in her and soon after, her compulsive eating began. Working cognitively, her concerns were formulated as schematic adaptation to male betrayal, by predisposing her to mistrusting all men and through her weight problem she literally built up a barrier against them. When she found it difficult to engage with the task oriented CBT approach, despite being trained in working in a Cognitive Behavioural Therapy (CBT) informed mode, I negotiated with my supervisor to try a modified approach. Because of research evidence regarding the difficulty abuse victims have in forming relations (Haugaard and Reppucci, 1988) the client's mistrust was re-understood as indicating that she had transferred her feelings of betrayal from her

mother/uncles/father/stepfather to me. So rather than working directly on her schemata, her transference was interpreted accordingly. This resulted in a tearful session where she said that all men in her life had betrayed and called all females, including herself, bitches. She then began a period of inner exploration that seemed to bring about a lowering in her reported anxiety and joined a weight control group. Had I not been able to (formulate her problems psychodynamically and change my technique), she may have found it more difficult to achieve any of the concrete changes originally set as the therapy's goals.

In the integration Vs single model debate, both sides can muster support. More often than not, their contentions seem to revolve round clinical effectivity. While supporters of single therapy models such as Andrews, Moran and Hall (1983) and Shapiro and Shapiro (1983) have concluded that their chosen model was superior to all others, supporters of integration, perhaps because in their effort to promote it as a way of helping each patient with the most powerful technique available, tended to point at research demonstrating the rather similar success rates of extant therapies, as supporting their view that none of these approaches had an ultimate advantage over the others. They concurred with Fiedler (1950A, 1950B) and Cross' (1982) findings that the client and therapist relationships of experienced therapists of various schools (prevalent at their time), had more in common with each other, than with those of inexperienced therapists from their schools, as well as with Stiles, Shapiro and Elliot (1986) who concluded that despite technical diversity, there was no differential effectiveness between psychotherapeutic schools. While Frank (1982) posited that all psychotherapeutic methods were versions of a basic psychological healing process, Rogers' (1957) formulation of the six necessary and sufficient conditions for therapeutic change, codified our understanding of the central role of the therapeutic relationship in achieving this. His third, fourth and fifth ones in particular, dubbed authenticity, unconditional acceptance and empathic understanding, seemed to offer a basis for a therapeutic alliance between therapist and client, regardless of the therapy's theoretical mien (Nelson-Jones, 1988). The reason why focusing on the quality of the therapist's

presence may be particularly useful in integrative practice, is that integrative practice may be the place where that presence is best able to mediate between what Edwards (1990) defined as the two poles of therapy: opening up the clients' world and allowing them to express it more fully, on the one hand, and identifying their cognitive inconsistency, selectivity, distortions and avoidance and developing strategies for change, on the other.

Integration may work at different levels: technical eclecticism, composite theory or common factors. An example of technical eclecticism may be a therapeutic intervention I carried out with Mrs. S. during my first year of training. A woman of sixty, Mrs. S. was referred to the service because of panic and anxiety attacks that occurred whenever her husband or adult son were away from home. However, in assessment it was found that her history of anxiety preceded these attacks. It seemed that Mrs. S. developed an acute fear of hospitals at an early age and that three years before referral she was diagnosed with a brain tumour. For her, this meant that not only was she faced with an 'objective,' anxiety causing life event, but an event to which she was particularly susceptible because of her particular phobias and life experiences. As a result, her anxiety had intensified to the extent that catastrophic and hopeless ideation constantly intruded on her mind, negatively coloring her affective state. The most compelling of these ideas, that her condition was either terminal or disabling prompted Mrs. S. to use avoidance as her main defense mechanism. Once more, despite working primarily in a CBT mode, psychodynamic theory provided a particularly clear metaphor for conceptualizing this problem. Since her condition was hard to deny, her fears were transformed by an atypical displacement mechanism. While turning on the self is common in displacement (Brown and Pedder, 1991), it seemed that Mrs. S. had turned away from self, displacing her fears from her safety and health to that of her husband and son. Nevertheless, despite using a psychodynamic conceptualisation, it was clear that Mrs. S. was too distressed to make much use of such insight so that we continued working in a Cognitive-Behavioural mode. This compromise drew from Trower's (1988) suggestion, that clients with mixed presenting

concerns, were better helped by treating first those problems that had specific aetiologies and treatments, as well as from Sandler's et al. (1992) recommendation to avoid interventions in areas that clients were unprepared for. Early on, our focus was thus on CBT work that was meant to help her realise the unrealistic nature of her fears for her son and husband. Later it shifted to exploration of the emotions linked to her earlier life experiences and only after this aim was achieved, we attempted alleviating her fears, using Eye Movement De-sensitisation and Re-processing derived techniques.

Why not

Integration is not problem free. Some (Lazarus, 1990, Messer, 1983) have said that present attempts to achieve it, have come at a far too early a stage in our understanding of therapeutic principles. Moreover, even the issue of proficiency may contraindicate integrative practice. The possible contribution of theoretical competence to Fiedler (1950A, 1950B) and Cross' (1982) findings about the qualitative advantage of experienced therapists in comparison to novices, cannot be ignored and thus another conclusion from these would be that practitioners well versed in particular methods, as single model ones are assumedly, would be better able to assist their clients than those who like the integrative, use them intermittently. Confusion is another problem that may beset integrative therapists and their clients (Douglas, 1989). Should one give homework tasks in a primarily psychodynamically oriented therapy? Should one change from a focus on controlling emotion and changing behaviour to expressing emotions and exploring meanings at random? Halfway through the session? After an X number of sessions? And so on. Similarly, does the integration of medication and psychotherapy fall within that term's meaning (Norcross and Grencavage, 1990)? Part of the integrative therapists' bafflement may be attributable to abrupt changes in the technique they are using. Another may be due to the change in perspective needed when an approach changes focus from inner to objective realities and vice-

versa (Messer and Winokur, 1980). After all, 'how can one be, simultaneously, neutral in the service of transference, real and genuine in the service of authenticity and didactic in the service of guiding the client when each role interferes to some extent with the other?' (Messer, 1990, p. 76). As a result, it is not impossible that therapists that favour CBT derived methods and outcome measures, may abandon collaboration and try to get clients to do things when they encounter passive or dependent clients or that those who are psychodynamically inclined, will favour interpretive work over goals setting and behavioural planning? This confusion also extends further into the theoretical realm. Could the different world views held by different therapy schools be simultaneously maintained? If one should be discarded, should not its epistemological underpinnings be also discarded (Messer, 1990)? On a more specific level could not one ask, how should integration proceed, (Lazarus, 1990)? Should a therapy be selected or devised for each client? Should clients be treated first by shorter term methods and then transferred to long term psychodynamic work? Perhaps one should employ a psychodynamic method shored up with behavioural and cognitive techniques (Fonagy, 1989, Ryle 1991) or encourage inner exploration and insight in a CBT based treatment mode (Raue, Castinguay and Goldfried, 1993).

As Mrs. S. case showed, eclectic interventions can include techniques such as that use of EMDR, where fashion or extraneous influences, rather than a theoretical basis, determined their inclusion. In retrospect, perhaps rather than attempting to use an unfamiliar technique, a CBT technique I was more familiar and confident with, should have been utilised with Mrs. S., minimizing our uncertainty and increasing our efficiency.

Many integration attempts have been widely criticised. Fonagy (1989) did so claiming that, they often go no farther than formulating the client's problems in a variety of theoretical terms without modifying their therapeutic interventions. On the one hand, Beitman (1990) criticised them for lacking a formal *raison d'etre*, a compelling theoretical basis for their particular methodologies and on the other,

Lazarus (1990) lambasted those trying to meld disparate theoretical stances when the simpler use of techniques from various origins would suffice. Integrationists have also been strongly criticised by some because while attempting to create a common language of therapy (Norcross, 1987), they fell into the trap of creating a language and concepts not shared by the rest of the psychology world (Ryle, 1987) and consisting of little more than semantic baggage and ill defined labels (Lazarus, 1990). While some of these critiques may be overzealous, it has to be noted that as Ryle admitted concerning the development of CAT, the particular choice and form these integrations followed, often seemed to owe more to the vagaries of their creators' professional biography, than to a pre-conceived and meticulously planned evolutionary plan. Thus some attempts at integrative therapy demand what Douglas (1989) called, 'a disjointed form of practicing'.

Critics of integration have also questioned its methodology and scope. Not only does much of integration research rely on what practitioners say they do in their sessions, rather on what they are seen to do, or what their clients experience them to do (Goldfried and Safran, 1986), but it also seems to have focused almost exclusively on the possibility of integrating elements of CBT and psychodynamic therapies. Notwithstanding some notable exceptions such as Fodor (1987) or Kirschner and Kirschner (1986), relatively little has been written about the possibility of integrating these with additional elements from schools such as gestalt or phenomenology. For instance, few researchers examined the possibility or impossibility of combining phenomenology's emphasis on individually generated meanings with CBT's focus on objective reality (Edwards, 1990). Integration has also fallen into the trap of external similarity. 'In many instances what appears at first glance as commonality, becomes on closer inspection, so basic a difference that we wonder on what grounds, therapists of different theoretical persuasions can meet.' (Messer and Winokur, 1981, p. 1547).

An example of the ways in which integrative practice, even if ultimately helpful, may prolong therapy unnecessarily or subject the client to baffling shifts in focus

may be discerned from the case of Mr. G. He was a fifty-seven year old man, who due to disease, lost his hearing, his job and his house and was referred because of a moderate depressive episode. Mr. G., whose stated therapy goal was improving his mood and feelings, engaged well with CBT. However, despite his earnest task completion, his depression did not seem to abate. Reviewing his case notes, it became noticeable that although he claimed to have come to grip with his losses, he kept blaming the government for wasting money on foreign refugees, yet failing to help him at his time of need. When this was interpreted as a transference phenomenon, that perhaps he was angry with me (a foreigner) and that perhaps he expected me to fail him now as the government failed him then, he accepted this and acknowledged that he still had not come to term with his losses. Still, despite his new found insight, his depression did not show a concomitant improvement. Thinking of our therapeutic relation in communicative terms (Smith, 1996) it was realised, that although the anger I felt at him for his anger at foreigners had been acknowledged, I was still angry during our sessions. Analyzing this anger, it was found to be self directed. This realisation resonated with comments made by Mr. G. that before his illness, he never asked for state help and how even today, he would not accept his (well off) family's financial help. It therefore seemed likely that I was experiencing projective identification of Mr. G.'s self directed anger at his perceived failure. When this issue was discussed in our sessions, we were able to continue in our CBT tasks and the client reported some decrease in sleep disturbance and irritability as well as an uplift in his mood. Looking back at the length of time Mr. G.'s therapy took and the various changes in its focus, even when the client is not put off by these sudden changes and the therapist does not find them baffling, one wonders how can the integrative practitioner know if a particular technique or focus is proving successful? Which of their elements facilitated a positive change? Does one rate insight as success, or must behavioural change take place before improvement is acknowledged? In this way, integration is also due a share of Holt and Lee's (1989) criticism of CBT for consisting of an amalgamation of select treatment strategies whose claims to empirical efficacy were attributable to its paradigmatic uncertainty rather than its sound theoretical

foundation. Nevertheless, Beutler's (1986) warning that eighty percent of psychotherapy literature is devoted to the specific procedures that account for only ten or twelve percent of therapeutic change, must be remembered and perhaps integrative research requires much more work before these criticisms could be accepted unconditionally.

Why do I practice integratively

While experiences with clients, as a client in (Humanistic) therapy and observations of other therapists, are to me (anecdotal) proof that Rogers' conditions are indeed necessary, they have not shown them to be sufficient. Work such as Pentony's (1981), claiming that therapeutic change was mainly due to the influence of therapists on their clients and that techniques were of little consequence, is difficult to reconcile with these experiences. They seem to agree far more with arguments such as Hawton, Salkovskis, Kirk and Clarck's (1989) claim that the lack of a theoretically comprehensive meta-structure hampered therapeutic effectiveness. If only because it meant that rather than being able to explain their interventions to clients and thus to enlist them as collaborators, practitioners have to rely instead on their clients' blind faith. Similarly, a purely pragmatic approach - when one matches interventions to the clients' difficulties - does not indicate at which level these should be addressed, or which method should be tried first, (Douglas, 1989). However, since ideally psychotherapists should operate by a limited number of flexible principles (Kelly, 1955), perhaps rather than argue on technical grounds each approach's relative merits, it is ethical considerations that compel one to favour integration. Arguments such as Kitzinger and Perkins' (1993, p. 37) that all therapy did was '*patching up women*' and that it was '*a way of looking at the world*' which fostered heteropatriarchic views and advocated change as '*individual internal phenomena instead of social and political transformation*' (p. 38) and Szasz's (1978) depiction of psychotherapy as a 'base rhetoric,' make it abundantly clear how easy it is to practice in a manner that is either abusive, or politically

rather than therapeutically, motivated. Similarly, theoretical and therapeutic changes can all too often be self serving rather than client oriented (Farhy and Milton, 1998). Thus, basing therapeutic practice on technical grounds without the support of a solid theoretical framework, although often effective, is problematic because of two further reasons. First It allows practitioners to follow a recipe book approach to their clients' problems, absolving them from the need to offer each the best possible treatment. Second, rather than rely on a generally accepted methodology, it leaves all decisions to the individual practitioner's ethical integrity (or lack thereof). A responsibility that clients can rarely share in, due to therapy's inherent power imbalance.

In addition to this, practitioners who eschew working in a single procedural mode, run the risk of becoming haphazard psychologists, ones who practice chaotically rather than coherently (Douglas, 1989, Fonagy, 1989). Even the use of previous research as guideline to integration is fraught with difficulties, since research pointing that certain problems are best treated by certain methods (Smith, Glass and Miller, 1980) may be later refuted by another work showing this correlation to be spurious (Shapiro and Shapiro, 1982). Here too, the use of ethical criteria can provide a self referent mechanism, lessening experimentation at the clients' expense. Meara et al. (1993) and Patton and Meara (1996) expanded the ethical principles of Integrity, Respectfulness, Benevolence and Prudence, originally proposed by Kohut (1979) and suggested that integration had to be ethically grounded for its practitioners to avoid haphazardness and become truly integrative. Integrity in this context, implied the possession of reasonably stable, justifiable, moral values together with an active fidelity to them in judgment and in action. Respectfulness, was granting autonomy to clients and respecting them in their own terms. Benevolence, was the intent of engaging in therapy for the welfare or the goals of clients, and Prudence, referred to the care and humility needed when engaging with (often less robust) others. Abeyance to these principles and a developing awareness of the myriad forces shaping the co-construction of therapeutic encounters, are in my view, how the core of psychotherapeutic craft,

namely those elements within psychotherapeutic encounters that are far more likely to determine their outcome than any external or theoretical factors, (Spinelli, 1995), will remain intact. Practicing in this manner also meets Beck's caution that; 'The most effective application of techniques depends not only on the clear conceptualisation of the case and the formation of a friendly working relationship, but also on the artistry of the therapist' (Beck and Freeman, 1990, p. 79)

Integration in my practice

When practicing I have tried to amalgamate the various influences I have encountered (and still encounter) into a sustainable, integrated, ethically governed, approach. However, as with Rogerian conditions, ethical soundness is necessary but not sufficient for effective therapy. Since it is well known which proverbial road is paved with good intentions, additional mechanisms must be implemented if an integrative practice is to remain judicious. First, further therapeutic techniques can be learnt so as to increase the therapist's skills gamut. Second, the experience of others in integrating can be harnessed to enhance the individual's abilities. While in my practice I try assiduously to follow these steps as well as ethical guidelines, it is however, sometimes hard to decide which path to follow with a particular client, or to paraphrase Fonagy (1989), what mixture of therapeutic techniques is best suited to a specific client. To increase the accuracy of these decisions, two complementary steps are useful. First, using for this purpose, principles similar to Lazarus' BASIC ID (1990) or those described by Douglas (1989) enables a more systematic clinical decision making process. Lazarus' eclectic choice of technique was based on his evaluation of the client's Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, Drugs/biological factors. Douglas' advice, stipulated that prior to choosing an appropriate therapeutic mode, therapists ought to first take note of the kind of problems described by the client and its history. Then, the problems' relative intensity and associated distress should be gauged. Thirdly, she said, the way in

which the client relates to its problems and the therapist must be considered, as are the client's stated therapy goals. And lastly, an evaluation must be made concerning what approach is the most likely to be a beneficial course of action for that particular client at that precise stage in its life. Only after all these steps were followed, clinically valid decisions become systematically feasible. As Mrs. S. and Mr. G.'s case notes hopefully showed, these four steps - particularly the third, process awareness - brought a change in their therapies' direction.

Because 'one cannot integrate what one does not know' (Norcross and Grencavage, 1990), I chose during my third year to pursue specialised training in CAT in addition to CBT. Although borrowing heavily from Cognitive research findings, CAT was developed by Ryle (1979, 1991, 1995) in response to his clinical observations during the course of therapy, rather than in response to theoretical concerns. Put simply, CAT aspired to combine cognitive and analytic principles into a single approach that at the same time amalgamate CBT's research backing with what Ryle perceived as the psychodynamic process of the therapeutic encounter. Believing as it does, that analytic type self-knowledge is an important and often pre-requisite tool for change. CAT accompanies a number of cognitive techniques (diaries, questionnaires, scales) with analytic interpretations. This, CAT therapists believe, facilitates a triumph over the difficulties encountered when clients practice various behavioural and cognitive tasks (goal setting, Socratic questioning, gradual exposure, etc.) to achieve the therapy's goals (Ryle, 1991). In practice this means that material from specialist questionnaires and the clients' self disclosures is formulated by the therapists into a re-formulation letter that they present to clients at about their fifth session. In this letter, subsequently jointly refined, the main events leading to the formation of the clients' Target Problems Procedure or TPPs, their present day effects and their ensuing Reciprocal Role Procedures (RRPs) are described. In CAT discourse, TPPs are the processes maintaining Target Problems (TPs), the main obstacles preventing the clients from reaching their life goals and their correction is the therapy's major goal. CAT also postulates that the main mechanism maintaining TPPs are the RRP. These are

unconscious repetitive behavioural patterns which clients employ to manipulate their environment into providing them with the inputs needed for confirming and maintaining their TPPs.

While CAT falls short of Douglas' category (1989) of fully integrated theory, it has transcended its origins as the technical integration of psychodynamic overview and CBT exercises. In Ryle's later writings (1991, 1995) as well as in that of others e.g., Ponyton (1991), CAT has been researched and refined as an independent school. Ryle (1991) stated that when developing CAT it had tried to avoid what Laing (1967) described as behaviourism's error of turning people into things and psychodynamic therapy's simplification of mental processes into the play of forces in the mind. Of course, CAT can be criticised both for failing to pay due attention to what Gilch - Geberzahn (1998) decried as the effect therapists' self states had on their perception of their clients and their interpretation of the latter's transference and for its over reliance on school-specific measuring instruments. A phenomenon Ryle himself warned against in his earlier work (Ryle, 1987). However, CAT's sixteen or so sessions, enable its practitioners to deliver to their clients a more or less rounded therapy, no mean feature in today's, quick results NHS culture. Furthermore, it does so without its directive mien becoming coercive and it includes in its clientele many who are considered too difficult by other schools (i.e., clients diagnosed with Borderline Personality Disorder), while keeping the flexibility Beitman (1990) believes is essential for successful integrative practice.

Perhaps a concrete example of how CAT is used in therapy can be gleaned from my work with Ms. J. She is a twenty-six year old woman referred because of recurrent anxiety attacks requiring the use of medication. A previous attempt to help her through a CBT based anxiety management group, proved unsuccessful. An only child, she was born in Surrey to middle class parents. Her childhood was described as not particularly eventful although she remembered being a 'rather upset sort of girl.' Upon finishing the local comprehensive, she attended a sixth

form college and then read English literature at university. After completing her studies, Ms. J. became a marketing executive for an advertising company. During her university days, Ms. J began a relationship with what she said she knew was an unsuitable man, depressed, dependent and manipulative. But she said, she found that same unsuitableness attractive. For three years they remained in what she described as a relation centered round her giving and his taking. Although she eventually terminated their relationship, she had twice more begun relations with needy men and finding herself drawn to them, preferred to cut those relationships short. At the time of therapy Ms. J. was living in shared flat and socializing quite extensively.

In accordance with CAT methodology, we first used specialised questionnaires, events, cognition reports and narratives to find Ms. J.'s main TPs. The first was anxiety attacks at work, when prior to meetings she would panic and resort to beta blockers to alleviate this. The second occurred when she related with men socially. Initially rejecting, she would find herself falling under their spell and then terminate the relation in a panic feeling that they were manipulative and exploitative. In our fifth session Ms. J. was given a letter summarizing my understanding of those TPs and the TPPs and RRP's maintaining them. This letter was jointly revised to achieve a consensual understanding of her problems. We agreed that Ms. J. grew up in a rather cold and troubled household. Her father was kind but weak and deferred to her mother who outwardly a strong woman, a pillar of local society and a charity director, was an alcoholic whose competence was a mask protecting her brittle inner self. Whenever Ms. J. felt angry or in doubt her mother refused to listen to her telling her instead that if she only did what she needed do, she would not feel bad or in doubt. In response to these and later experiences, Ms. J. developed three TPPs. She saw herself as if either good and bottling up her feelings or as bad, furious and out of control. As if either she was independent, responsible but needy and isolated, or dependent, irresponsible and guilty. And as if pleasing others and being taken for granted or as aggressive, rejected and unloved. As we discussed these issues further over our next few meetings, we decided on

the appropriate solutions to these TPPs and their maintaining Reciprocal Role Procedures. To accept that both the 'bad' and 'good' girls could coexist. To recognise that neediness and independence were both possible without loss of self, and to learn to assert her needs appropriately. We devised behavioural tasks and strategies that enabled her to practice and implement those exits and over the following sessions Ms. J. practiced them at home and discussed her results at the sessions. Again using report forms and questionnaires. During the same time we also discussed our relationship, as her TPPs included both difficulties with authority figures and men, using its development and change to illustrate those TPPs. Thus, after sixteen sessions Ms. J. felt that she had a better understanding of the problems she felt beset by for years, as well as the rudiments of new ways of being. She did not though, feel wholly ready to stop therapy at that stage, but was reassured by the prospect of a follow up session three months later to help her check and monitor her progress.

Conclusion

CAT is not a perfect therapeutic school, nor do I feel adept at it yet. However, it gave Ms. J. a strong therapeutic experience that combined both understanding and external life changes. It gave me the possibility to combine psychodynamic understandings acquired in other settings and by reading, together with the opportunity to use, research based, CBT derived operationalisations, goal setting and change measuring instruments, to better gauge Ms. J.'s condition and advance. It did so without obliging me to use specific techniques, but offered me a theoretical skeleton to which I could attach those techniques, I believed, were appropriate and that I could use reasonably well. It therefore is one of the main ways in which, at this stage in my professional development, I bring into active practice my integrationist stance.

References

- Andrews, G., Moran, C. and Hall, W. (1983). Agoraphobia: A meta-analysis of treatment outcome studies. Unpublished manuscript. University of New South Wales Medical School.
- Beck, A. T. and Freeman, A. (1990). *Cognitive Therapy of Personality Disorders*. New York: Guilford Press.
- Beitman, B. B. (1990). Why I am an Integrationist (Not an Eclectic). In W. Dryden and J. C. Norcross (eds), *Eclecticism and Integration in Counselling and Psychotherapy*. Loughton: Gale Centre Publications.
- Beutler, L. E. (1986). Systematic eclectic psychotherapy. In J.C. Norcross (ed.), *Handbook of Eclectic Psychotherapy*. New York: Bruner Mazel.
- Brown, D. and Pedder, J. (1991). *Introduction to Psychotherapy*. London: Tavistock-Routledge.
- Cross, D. (1982). Short and long term follow up of clients receiving insight based and behaviour therapy. *Journal of Consulting and Clinical Psychology*, 50, 1, 103-112.
- Douglas, A. R. (1989). The limits of Cognitive Behaviour Therapy: Can it be integrated with Psychodynamic therapy? *British Journal of Psychotherapy*, 5, 3, 390-401.
- Dryden, W. and Norcross, J. C. (1990). *Eclecticism and Integration in Counselling and Psychotherapy*. Loughton:Gale Centre Publications.

- Edwards, D. J. A. (1990). Cognitive -Behavioural and Existential Phenomenological approaches to therapy: complementary or conflicting paradigms? *Journal of Cognitive Psychotherapy*, 4, 2, 105-120.
- Farhy, E. and Milton, M. (1998). Psychology, psychotherapy and paymasters: A cautionary tale. *Counselling Psychology Review*, 13, 35-38.
- Fiedler, F. E. (1950). The Concept of an ideal therapeutic relationship. *Journal of Consulting Psychology*, 14, 239-245.
- Fiedler, F. E. (1950). A comparison of therapeutic relationships in Psychoanalytic Non-directive and Adlerian therapy. *Journal of Consulting Psychology*, 14, 436-445.
- Fodor, I. G. (1987). Moving beyond Cognitive - Behaviour Therapy: Integrating Gestalt Therapy to facilitate personal and inter-personal awareness. In N. S. Jacobson (ed.), *Psychotherapists in Clinical Practice*. New York: Guilford
- Fonagy, P. (1989). On the integration of Cognitive - Behaviour theory with Psychoanalysis. *British Journal of Psychotherapy*, 5, 4, 557-563.
- Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey and M. M. Parks (eds), *Psychotherapy Research and Behaviour Change*. 1981 Master Lecture Series. Washington D.C.: American Psychological Association.
- Freud, S. (1915). *Observations on Transference Love*. Standard edition, 12. London: Hogarth Press.

- Gilch - Geberzahn, G. (1998). From perceiving to interpreting: The inner work of the analyst. *Forum Der Psychoanalyse: Zeitschrift Fuer Klinische Theorie and Praxis*, 14, 1, 34-51.
- Goldfried, M. R. and Safran, J. D. (1986). Future directions in psychotherapy integration. In J.C. Norcross (ed.), *Handbook of Eclectic Psychotherapy*. New York: Bruner Mazel.
- Haugaard, J. J. and Reppucci, N. D. (1988) *The Sexual Abuse of Children*. San Francisco, CA: Jossey-Bass
- Hawton, K., Salkovskis, P. M., Kirk, J. and Clarck, D. M. (1989). *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*. Oxford: Oxford University Press.
- Holt, J., Lee, C. (1989). Cognitive Behaviour Therapy re examined: problems and implications. *Australian Psychologist*, 24, 2, 157-169.
- Jacobson, E. (1938). *Progressive Relaxation*. Chicago: University of Chicago Press.
- Kelly, G. A. (1955). *The Psychology of Personal Constructs*. New York: W. W. Norton.
- Kirschner, D. A. and Kirschner, S. (1986). *Comprehensive Family Therapy: An Integration of Systemic and Psychodynamic Treatment Models*. New York: Bruner Mazel.
- Kitzinger, C. And Perkins, R. (1993). *Changing Our Minds: Lesbian Feminism and Psychology*. London: Onlywomen press.

- Kohut, H. (1979). Four basic concepts in self psychology. In P. Orenstein (ed.), *The Search for Self: Selected Writings of Heinz Kohut 1950-1978*. Vol. 2. Madison, Ct: International Universities Press.
- Laing, R. D. (1967). *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin.
- Lazarus, A. A. (1990). Why I am an Eclectic (Not an Integrationist). In W. Dryden and J. C. Norcross (eds), *Eclecticism and Integration in Counselling and Psychotherapy*. Loughton:Gale Centre Publications.
- Linehan, M. M. (1993). *Cognitive Behavioural Treatment of Borderline Personality Disorders*. London: The Guildford Press.
- Meara, N. M. Et al. (1993). Principles and virtues:a foundation for for ethical decisions, policies and character. *The Counselling Psychologist*, 24, 4-77.
- Messer, S. B. (1983). Integrating Psychoanalytic and Behaviour Therapy: Limitations, Possibilities and Trade-offs. *British Journal of Clinical Psychology*, 22, 131-132.
- Messer, S. B. (1990). Eclecticism and Integration in Counselling and Psychotherapy: Cautionary notes. In W. Dryden and J. C. Norcross (eds), *Eclecticism and Integration in Counselling and Psychotherapy*. Loughton: Gale Centre Publications.
- Messer, S. B. and Winokur, M. (1980). Some limits to the Integration of Psychoanalytic and Behaviour Therapy. *American Psychologist*, 35, 818-827.

- Messer, S. B. and Winokur, M. (1981). Therapeutic change principles: Are commonalities more apparent than real? *American Psychologist*, 36, 1547-1548.
- Nelson-Jones, R. (1988). *The Theory and Practice of Counseling Psychology*. London: Alden Press..
- Norcross, J. C. (ed.), Special section: Toward a Common Language for Psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 4, 165-205.
- Norcross, J. C. and Grencavage, L. M. (1990). Eclecticism and integration in counselling and psychotherapy: Major themes and obstacles. In W. Dryden and J. C. Norcross (eds), *Eclecticism and Integration in Counselling and Psychotherapy*. Loughton:Gale Centre Publications.
- Patton, M. J. and Meara, N. M. (1996). Kohut and counselling: applications of self psychology. *Psycho-dynamic Counselling*, 2, 3, 1353-1376.
- Pentony, P. (1981). *Models of Influence in Psychotherapy*. New York: Free Press.
- Ponyton, A. (1991). Basic Treatment Procedures. In A. Ryle (ed.), *Cognitive Analytic Therapy*. London: John Wiley and Sons.
- Raue, P. J., Goldfried, M. R., Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive behavioural therapy. *Journal of Consulting and Clinical Psychology*, 65, 4, 582-587.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-104.

- Ryle, A. (1979). The focus in brief interpretative psychology: Dilemmas, traps and snags as target problems. *British Journal of Psychiatry*, 134, 46-64.
- Ryle, A. (1987). Cognitive Therapy as a common language for psychotherapy: *Journal of Integrative and Eclectic Psychotherapy*, 6, 168-172.
- Ryle, A. (1991). *Cognitive Analytic Therapy: Active participation in change*. London: John Wiley and Sons.
- Ryle, A. (1995). History and recent developments. In A. Ryle (ed.), *Cognitive Analytic Therapy: Developments in Theory and practice*. London: John Wiley and Sons.
- Sandler, J., et al. (1992). *The Patient and the Analyst*. London: Karnac Books.
- Shapiro, D. A. and Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin*, 92, 581-604.
- Shapiro, D. A. and Shapiro, D. (1983). Comparative therapy outcome research: Methodological implications of meta-analysis. *Journal of Consulting and Clinical Psychology*, 51, 42-53.
- Smith, D. L. (1996). Should psychoanalysts believe what they say? *British Journal of Psychotherapy*, 13 (1), 64-74.
- Smith, M. L., Glass, G. V. and Miller, T. J. (1980). *The Benefits of Psychotherapy*. Baltimore: John Hopkins University press.

- Stiles, W. B., Shapiro, S. A. and Elliot, R. (1986). Are all psychotherapies equivalent? *American Psychologist*, 41, 165-180.
- Spinelli, E. (1995). *Demystifying Therapy*. London: Constable.
- Szasz, T. (1978). *The Myth of Psychotherapy*. Syracuse, NJ: Syracuse University Press.
- Trower, C., Casey, P., Dryden, W. (1988). *Cognitive Behavioural Counseling in Action*. London: Sage.
- Wachtel, P. L. (1984). On theory, Practice and the nature of integration. In H. Arkowitz and S. B. Messer (eds), *Psychoanalytic Therapy and Behaviour Therapy: Is Integration Possible?* New York. Plenum Press.
- Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe and W. Dryden (eds), *Handbook of Counselling Psychology*. London: Sage Publications.

**Research
Dossier**

Research Dossier

Three research reports are included in this dossier, one from each year. Together they constitute a single research programme that albeit somewhat loosely, investigated how psychological interventions could help people diagnosed with chronic health conditions. The initial paper, reviewed existing literature concerning male experiences of subfertility. This theme was taken up by the second year paper which through interviews, empirically explored the experiences of some of these men. By interviewing people with psoriasis, the final year's paper examined the role of therapy in their managing their illness as a specific example of the possibility that psychological assistance can help in the management and amelioration of a chronic physiological condition.

The Psychological Sequelae of Male Sub-Fertility: A Review of the Literature

Abstract

Objective. The provision of counselling by fertility clinics is now mandatory for certain interventions in human infertility. However, little is known about the particular problems of sub-fertile men and the psychological interventions best suited to their needs. The aim of this article was to present an overview of present understandings.

Design. A literature search of professional journals, books and electronic data bases published after 1980.

Results. The most common problems found were anger, feelings of inadequacy, lowered self esteem and increased likelihood of marital discord and depression.

Conclusion. The influence of social stereotypes and expectations and the importance of fertility for constructing and maintaining a positively-evaluated male identity are suggested as the putative psychological factors leading to the effects found. Tentative recommendations are offered for actions and approaches that the authors believe will enable more effective psychological interventions.

Keywords. Sub-Fertility, reproduction, masculinity, identity

First and foremost man is a fertiliser of women. His need to inject his genes into a female is so strong that it dominates his life from puberty to death. This need is even stronger than the urge to kill, it is a drive that was built into him long before he became a human. (Greenstein, 1993)

Introduction

This work focuses on the psychological experiences of males who experience sub-fertility (SF). It examines the burdens they are subjected to and, while reserving moral judgment about the above quotation, it lays responsibility for many of these burdens on such beliefs. Whether that be because sub-fertile men adopt them and thus are destined to continuous failure, or because others adopt these beliefs and deride sub-fertile men for failing to procreate.

SF is commonly defined as a failure to achieve a successful pregnancy after twelve months of regular sexual intercourse without the use of contraception. The lifetime incidence of SF has been estimated to be around seventeen per cent, or one in every six couples. For example in the USA, at least five million couples are estimated to be sub-fertile. Male factors are estimated to be present in nearly fifty per cent of these cases and to be the sole cause of circa thirty-five per cent (Whitworth, 1996). Thus, using a conservative estimate of only half of the adult population of the UK being in a dyadic relationship, of one in ten couples experiencing SF and of these only one in three being male factor, nearly a quarter

of a million men in the UK, are sub-fertile. However, although male factor SF problems are as common as female ones, the most cursory glance through library catalogues and databases will show that studies focusing on female factor SF are far more numerous than those studying male factor. Although this lack may be partially attributed to medicine's relative dearth of possible interventions in cases of male factor SF, this does not explain the particularly noticeable imbalance in researching the psychological effects of male factor SF on men as compared to the effect of female factor SF on women (Whitworth, 1996).

The psychological effects of SF and its treatments.

Most SF treatment advances in recent years have concerned female factor SF. Indeed, the perfection of a viable In Vitro Fertilisation (IVF) technique in 1978 by Steptoe and Edwards has, nearly halved the percentage of female factor SF cases where pregnancy was not achieved (Whitworth, 1996). While some male factor cases benefited from those advances (e.g., the use of washed sperm in IVF was a boon to men whose sperm was hitherto rendered inactive by agglutination), the development of male treatments lagged behind that of female factor treatments. Even today, cold water scrotal baths and donor insemination (DI) are recommended by many fertility specialists as suitable treatments, despite the lack of supportive evidence for the former and the problems inherent in the side-stepping, rather than resolving, nature of the latter. Only in 1993 when Intra Cytoplasmic

Sperm Injection (ICSI) was developed, was a significant advance made. This technique by which a single sperm cell was injected directly into the ovum opened a window of opportunity for sub-fertile males who, although sperm producers, had semen of a quality unsuitable for standard IVF, much less unassisted conception.

It may be argued that SF does not invariably cause distress. However, since trouble free functioning of all human body systems is almost universally desired (Klein, 1989), SF constitutes an unwanted defect and as such, besides its physiological repercussions, it leads to a plethora of intertwined psychological and social effects. Of course, becoming a parent also causes psychological distress (Abbey, Andres and Halman, 1994) but a number of studies (Edelmann and Connolly, 1987) and books (Klein, 1989, Lee, 1997, Pfeffer, 1993) have posited that diagnosis as sub-fertile is often followed by such distress.

A few studies addressed directly the range of emotions felt by sub-fertile men. Mason (1993) identified, in an interview based study, a number of recurring themes. Many of these were akin to those felt by men (and women) with other medical conditions. Mason found that after initial disbelief, anger and hopelessness, a perceived loss of one's control over one's destiny and increased somatisation were common. He also found evidence that feelings of guilt and jealousy towards those perceived as free of the ailment were prevalent. Lowered self esteem and the more circumscribed feelings of emasculation and feeling that life has no point and that one is worthless, were also quite common. Similar

findings of lowered self esteem, guilt and feelings of inadequacy were reported by Edelman, Connolly and Bartlett (1994) as the effects sub-fertile men reported following diagnosis. Similarly, the appearance of more negative body perceptions among sub-fertile persons, irrespective of gender, was documented by Pruzinsky (1990). Unfortunately, these findings were based on relatively small samples so their generalisability can be questioned. Moreover, these effects may have been no different from those following other difficult life events, especially chronic medical conditions (Anderson and Bury, 1988).

One possible reason for the relative dearth of research on this subject may be that it goes against the received wisdom, that men's distress at childlessness is markedly less than that of women. This representation is reinforced by studies such as that of Abbey, Andrews, Halman and Jill (1991) who found that women in infertile marriages found infertility more stressful and felt greater personal responsibility for it than their husbands. Similar findings were also reported by Draye, Woods and Mitchell (1988), who reported that in infertile couples, thirty-five per cent of the women reported distress due to the condition compared to one per cent of the men. However, such findings, have been criticised on a number of grounds. Berg, Wilson and Weingartner (1991) contended that while level of strain was similar for men and women, this was experienced differently. That is, men were prone to self blame, women to hopelessness; men to sexual dissatisfaction, women to marital dissatisfaction. This view was partially reflected by Abbey's et al. (1991) report of increased home stress and lowered home life performance of husbands in infertile

marriages and in Edelman and Connolly's (1987) report that male partners in sub-fertile dyads were frustrated, self blaming and lacked confidence, while the females experienced isolation rather than frustration as their main distress. Hence, studies measuring emotional responses may have been marred by gender bias or may have led to unwarranted inferences. Others such as Abbey et al. (1991, 1994) claimed that gender related differences in response to SF mirrored general gender differentiated responses to stressors rather than a sub-fertile specific pattern. Additionally, sub-fertile couples may have perceived their plight as a female factor type, in which case feelings of guilt by the women and their lack in the men, would have favored a preponderance of females reporting distress. This last suggestion was arguably supported by Connolly, Edelman and Cooke (1987) who found increased distress in both men and women when their infertility was due to a male factor.

Carmelli and Birenbaum-Carmelli (1994) who examined the difference between distressed and non distressed sub-fertile males, found that sub-fertile males were far more distressed and scored lower in a masculinity questionnaire than matched controls whose partner was sub-fertile. In like manner, Glover, Gannon, Sherr and Abel (1996) found in a self rating study of men who were recently diagnosed as sub-fertile, that they were significantly more anxious and self blaming as well as less satisfied with their lives, than fertile controls. Moreover, this difference showed little abatement over time and the difference in scores in repeated measurements, eighteen months after they were first tested, was still statistically

significant. Along with the above, a number of additional effects were also found among sub-fertile men and their families. The Edelmann and Connolly study (1987) mentioned earlier, also found an increased likelihood of marital problems following a diagnosis of SF, while Burns (1987) found that the sexual bond between sub-fertile men and their partners often deteriorated after such diagnosis. According to Burns, it was as if the sexual relationship lost its long term potential and thus a major part of its meaning. Moreover, he also found that this altered perception was transmitted to the couple's adopted/DI children whose attitude to sex was significantly more disinterested and who were less careful in their sexual practice compared to matched controls from fertile families. The deleterious effect on marital relationships could also be inferred from the large proportion of sub-fertile men in Berger's (1980) study who experienced impotence after diagnosis (thirteen out of sixteen).

Another under-researched aspect of sub-fertile males' distress that may have contributed to the frustration described by Mason (1993) as his participants' main grievance, is that of superfluity. Most of the work and attention in SF treatments are female centered. This may have been due to the male originated focus on females as the crux of sub-fertility, but this has now resulted in a situation where males are made to feel marginalised in SF interventions. Even when the problem is male factor, male involvement may involve nothing more than masturbating into a glass jar. This 'anomie', coupled with the availability of sperm donation, has resulted in male feelings of dispensability and alienation from the process and their

partners (Carmelli and Birenbaum-Carmelli, 1994). Of course, emotional reactions were not restricted to male partners. Their female partners felt similar levels of distress, sadness and grief as sub-fertile women (Pfeffer, 1993). Moreover, sadness at their perceived entrapment and anger towards the male were reported by fourteen out of the sixteen women in Berger's (1980) study.

Besides the direct psychological consequences of sub-fertile diagnosis, it has been suggested that psychological distress in men diagnosed as sub-fertile actually lowers their seminal quality in comparison to its pre diagnosis values (Kedem, Mikulincer, Nathanson and Bartoov, 1990). The notion of a link between stress and the immune system is not new, but no replication of Kedem's et al. data has been reported to date. A physiological link rather than a psychological one has also been suggested as accounting for at least part if not all the psychological differences between fertile and sub-fertile men. Hellhammer, Hubert, Freischem and Nieschlag (1985) believed that certain SF aetiologies where gonadotropin and sex steroid levels differed from the norm, may have been causally linked to the low score in parameters such as sociability and extroversion and affect scores of critique, anxiety and demand. However, lack of further evidence renders this data specious and unless it is established that low psychological scores precede diagnosis as sub-fertile, it must be viewed with caution.

Perhaps studying the experiences of sub-fertile women can shed light on their male counterparts. Both sub-fertile groups have a condition that is often unknown until

voluntarily investigated. Both can keep quiet about it or pretend they chose not to have children and both can function with no or few daily reminders of their condition. However, as the previous sections have shown, these groups only share some experience characteristics. Although they both feel less self worthy and more guilty and angry and although both experience relationship problems, other emotions and the extent to which these are felt, vary considerably between the two groups. Also the social construction of and the reactions to male and female infertility are different and so the experience of sub fertile men and women will differ in important respects. Pengelly et al. (1995) also noted that roles within sub-fertile relationships differed across genders. Males were supportive and took charge of organizing the couples' actions concerning SF while females expressed distress and longing. It is therefore quite possible that the possibility of extrapolating from female to male experiences is limited. Further complicating these issues was the studies' great diversity of sample sizes, methodologies and control of confounding variables. For instance, Berger's (1980) study had only sixteen participating couples, Carmelli and Birenbaum Carmelli (1994) twenty-three females and nine men representing twenty-five couples, while Edelman and Connolly (1987) sent questionnaires to eight hundred and forty-three couples. Some did not focus on male factor SF but on the couples (Edelman and Connolly, 1987) while others studied only male SF (Kedem, Mikulincer, Nathanson and Bartoov 1990). Methodologies too were nearly as varied as the studies themselves. For instance, Edelman and Connolly's (1987) study was based on a postal questionnaire sent to couples who were treated by a fertility clinic up to ten

years previously, while in their 1996 study they administered questionnaires to couples who were attending their first appointment at such a clinic and Berger's study was interview based. Similarly, Kedem, Mikulincer, Nathanson and Bartoov (1990) were unusual in that they compared their participants' responses to those a group of matched controls while most other studies followed a more exploratory approach eschewing the use of controls. Hence, clearly any conclusions drawn from them should be considered tentative.

Coping mechanisms

Mason (1993) reported that sub-fertile men employed a number of strategies to cope with the psychological difficulties of their situation. Some men found or developed new interests, while others immersed themselves in work. The most prevalent strategies involved drawing on the partner for support and engaging in problem solving behaviours and cognitive reassessment followed by acceptance. Coping mechanisms, though, were not without their risks. For instance, most treatments for male factor SF assign a large, even central, role to the woman, particularly as a producer of ova for IVF and ICSI. This meant that men who chose these problem solving procedures as their coping mechanism were more likely to feel guilty because of the health risks that hormonal treatments carry for female partners (Solomon, 1989). Opting for such solutions was also a risk factor for increased female resentment because of the risk and stress they were subjected

to in order to solve what was perceived as the male's problem (Solomon, 1989). Moreover, the women's central role may have been conducive in some men to an increased sense of the sort of marginalisation discussed earlier (Carmelli and Birenbaum-Carmelli, 1994). Morrow, Thoreson and Penney (1995) reported that male distress was linked to self blame and to opting for avoidance as a coping strategy and Edelmann et al. (1994b) found that coping styles were an important risk factor, action-taking being positively correlated to adjustment. Those men who chose DI as their problem solving method felt this even more keenly, since DI effectively bypassed the man altogether. A number of studies showed that these men were liable to feel less close to the resulting children and to their partners than men who chose adoption or had succeeded in their quest for genetic offspring (Lebovici and Bouaziz, 1997).

Somewhat surprisingly, DI did not always seem to be a threat to sub-fertile men. Blaser, Maloigne-Katz and Gigon (1988) found that sub-fertile husbands whose wives conceived following DI but had not yet given birth, were not threatened by the event, while fertile controls found the notion of becoming the father of a DI child a threat. One interesting finding was that of Ulbrich, Coyle and Tremaglio-Liabre (1990) who found that men whose wives have good jobs were less distressed. These researchers suggested that perhaps these men may have perceived their wives as having lost less and thus felt less guilty, or that perhaps the wives did lose less and so were less antagonistic toward their husbands.

Psychological and social factors in the evaluation and emotional experience of Sub-Fertility

The studies by Edelmann and Connolly (1987), Edelmann, Connolly and Bartlett (1994) and Pengelly et al. (1995) also seemed to indicate that not all men faced with SF were subject to emotional distress or at least did not report it. Additionally, some who may have experienced it may have been able to cope with it without relying on supportive agencies. Still, two main findings seem to have emerged from studies of those who sought support. First, men who were involved in relationships where SF was solely male factor were significantly more distressed than men in relationships where SF was solely female factor or both male and female factor (Connolly, Edelmann, Cooke and Robson, 1992). Second, as discussed below, males whose sex role scores were low seemed to suffer distress more often than men whose identity was strongly masculine. Guilt and a sense of failure seem to have been the factors most directly involved in determining the incidence of distress in cases of male factor SF.

Why though, do these feelings arise following difficulties in fathering a child? The answer seems to lie in the way that societies throughout the world see fathering a child as an important attribute of manhood and regard men who cannot father as lacking a substantial part of the requirements for full male status (Gilmore, 1990). Many societies will not consider a man fully masculine unless his fertility has been established. The importance of fertility as central to male identity can hardly be

doubted. In studies from South Africa (Zichl, 1994), India (Hussain, 1992), Israel (Linn, 1995) and the USA (Whiteford and Gonzalez, 1995) sub-fertile men were found to experience stigmatisation and social retaliation for their condition. In societies that value the ability to father children, particularly strongly paternalistic ones, the sub-fertile male may encounter derision and even be excluded from traditional male positions or activities. Rarely are the elders of a social group childless men (Gilmore, 1990). It is as if a failure to impregnate entails an inability to lead or “father” the group.

The role played by social representations of procreative masculinity in the distress of sub-fertile men was also indicated by findings that they usually had low masculinity scores in sex role questionnaires. Adler and Boxley (1985) who correlated distress and sex role scores, found no difference between sub-fertile persons and controls. However, in both groups, those who scored highly in masculinity or both femininity and masculinity were significantly less distressed than those who were highly feminine or had low scores. This result may have indicated that the distress caused by SF, was related to the male evaluation of their impaired fertility as evidence that their virility and/or masculinity were somehow impaired. This notion found theoretical support in theories of identity construction and of disorders following setbacks in this process. For instance, an important aspect of self identity is social identity which by definition incorporates a strong input from one’s milieu (Bandura, 1986). Men whose self assessment is weak or whose identity is not secure may be in greater need of positive social

reinforcements. Since fathering is often seen as an essential part of maleness, men who are unsure about their sex role or who need it socially reaffirmed may be particularly at risk of psychological setbacks.

In addition to considering SF men somehow inadequate, more hostile reactions also seem quite common. In Miall's (1985) study of the social beliefs and experiences of childless individuals, participants reported that fertile people often considered infertility to be caused by a psychosomatic or psycho-sexual malfunctioning on the part of the woman. The sub-fertile participants also believed that fertile people saw SF as a master condition, i.e., as a characteristic that overrode other characteristics. They also believed that fertile persons also saw it as stigmatizing, as a cause for blame and pity particularly when male factor was the cause. In another study, Miall (1996) found that in European communities, fatherhood was perceived as learned and motherhood as biologically inherited. Hence childlessness was seen as far more distressing for women than men. This was reflected in the amount of social support given to the male and female partners. She also found, that while distress seemed prevalent in societies where the construction of a socially afferent masculine identity was strongly associated with virility and fertility, these societies offered better support and understanding of the sub-fertile persons' plight than the, less fertility-exalting, Northern European societies. In a third study focusing on the social construction of SF, Miall (1994), found that the fertile tended to classify it as either due to male sexual dysfunction or to female psychological factors. Consequently, males were stigmatised for

failing while women received sympathy. Miall's findings were supported by others. For instance, Laurance (1982) found that society has a preconceived time when procreation is expected. Missing it caused increasing amounts of social pressure, eventually leading to typecasting as selfish and cold and to retaliation. According to him this was reflected in the Western socio-economic system, which put economic pressures on and set standards that were punitive to sub-fertile individuals.

In conclusion the possibility that the largely negative social reactions towards SF and the sub-fertile play an important causal role in the distress clearly warrants further investigation. Participants in Miall's three studies (1985, 1994, 1996) reported as much and the similarity between their distress reports and those of participants in other studies may be indicative that such an aetiology is quite common. However, much more research needs to be done on this aspect before the present muddled picture becomes clearer.

Psychological interventions in male sub-fertility

The picture emerging from the above reviewed studies raises a number of questions. If SF constitutes a psychological problem for men, would they benefit from some form of counselling intervention? Do they want psychological help at all? Although these questions have not been investigated directly, research findings

imply positive answers to both. According to Edelman and Connolly (1987) in one fertility centre, twenty-nine per cent of sub-fertile men accepted an offer of counselling, following a SF diagnosis and others may have sought it elsewhere, e.g., from church, support groups, GPs or privately from counsellors or therapists. Also not all those seeking help presented as a couple. At another fertility centre, Pengelly, Inglis and Cudmore (1995) found that of the clients who took advantage of the counselling service it offered, forty-two per cent came as a couple; in forty-one per cent of cases the women came alone and in seventeen per cent the men did. As will be seen, many societies either treat SF as a non event and spare little thought for its victims (Meyers, Winshel, Scharf, Kezur et al., 1995), or see it as a negative event and ostracise its victims, while purporting to pity them (Miall, 1994). So, while social change is often the best response to human originated or human magnified distress, counselling and psychotherapeutic interventions can, in the meantime, concentrate on developing both better understanding and better interventions for the specific stresses caused by SF.

Although a clear picture of what psychological counselling may offer sub-fertile men is still unavailable, some possibilities suggest themselves. Firstly, an increased rate of success in fertility treatments may be possible. Be it because lowering stress improves the quality of seminal fluid (Van Hall, 1983), or because sub-fertility is sometimes aggravated by sexual problems, (e.g., non consummated relations or low intercourse frequency) whose elimination through couple or sex therapy can help (Burns, 1995). However, the most important contribution that

psychology can make to the understanding and treatment of sub-fertile individuals in general and males in particular, may lie in the realm of identity theory. Kikkendal (1994) suggested that fertility counselling should focus on the discrepancy between the ideal self (parent) and actual self (childless), on the lowered self esteem and perhaps most of all, on the feeling that one's life will have no continuation and thus no meaning. To do so effectively, psychologists working in contexts where fertility issues may be encountered should be suitably familiar with the problems of SF, psychologically ready to deal with them and conceptually equipped with possible avenues of intervention.

Concerning knowledge, psychologists should be aware that SF is a male loss as well as a female one and that in male factor SF, male distress may be greater than that of the female partner (Miall, 1994). Psychologists should also remember that the inequality of modern male SF treatments opens the door to male cajoling, bargaining and pressurizing and female resentment (Humphrey and Humphrey, 1987). The importance of this point was reinforced by Leiblum (1993) and Benazon, Wright and Sabourin (1992) whose findings linked SF to lower scores in dyadic adjustment and sexual satisfaction scales that decreased further, the longer treatments lasted. Awareness of this issue may therefore help understand unhealthy dyadic tensions and a focus on relationship and communication skills may help defuse them. Another point that psychologists should bear in mind is Greil, Porter, Leitko, and Riscilli's (1989) finding that, while treatment offers hope to sub-fertile persons, it also makes the experience open ended rather than time

limited. According to these researchers, while yesteryear's medical diagnosis "you are sub-fertile and there is nothing that can be done about it" was brutal, it constructed sub-fertility as irremediable and may have thus enabled sub-fertile persons to eventually accept their condition. Today's repetition of time consuming, low success interventions and the slow development of new techniques, although offering hope, effectively mean an open ended treatment. This prolongs suffering because not reaching a definite "no more hope" point quite possibly makes coming to terms with one's condition doubly difficult. Generic problems may also affect the treatment of sub-fertile clients. For instance, as Schover (1981) reported, both male and female psychologists are often ill at ease with client sexual material, although males are more prone to this. It may therefore be expected that some psychologists will find the sexually tinged SF issues difficult to handle. Similarly, Meyers et al. (1995) found a major discrepancy between the SF perceptions of sub-fertile persons and those of American family psychologists. Therefore, in the same way that effective cross cultural therapy requires familiarity with the clients' experiences, psychologists treating sub-fertile persons need to ensure that they have an appropriate knowledge of the subject.

As identity issues represented an important feature of the psychological implications of sub-fertility, it may be useful to employ a model of identity to explain the identity challenges faced by sub-fertile men and to inform therapeutic practice. Although there are many models of identity, Breakwell's (1986, 1996) identity process theory may be most appropriate because it does not specific

identity content but focuses instead on identity processes (i.e., assimilation-accommodation and evaluation), thus giving it much flexibility and explanatory potential. As this model was developed to account for situations of identity threat, it may be particularly applicable to the identity challenges faced by sub-fertile men who may find their identity as men and as husbands/partners threatened by sub-fertility. Due to the negative social evaluations attached to sub-fertility, this element cannot be easily assimilated into the existing identity structure without threatening at least some of what Breakwell sees as desired identity end-states, i.e., self-esteem, continuity, positive distinctiveness and self-efficacy.

She held that identity threats could be dealt with through intra-psychic, interpersonal and inter-group coping strategies. For example, at an intra-psychic level, sub-optimal strategies might involve deflecting the identity threat through denial or taking refuge in fantasy whereas more effective strategies might involve incorporating the threatening element into one's identity but minimizing the damage it may cause to desired identity end-states, for example, by re-evaluating it (which may also involve an interpersonal or inter-group strategy if the re-evaluation is to be maintained). Applying such a model to sub-fertile men could potentially lead to psychologically rich formulations of their difficulties that could then provide a clear map for interventions in counselling and therapeutic contexts. For example, psychologists may attempt to help clients to assimilate sub-fertility into their identity by exploring ways in which clients could interpret their situation

in order to ease assimilation or by exploring what changes might need to be made to existing identity structures to accommodate the sub-fertile element.

Conclusion

In recent years, sub-fertility and the experiences of sub-fertile men have begun to attract increasing research attention. The recurrent themes of this research suggest that sub-fertile men constitute a population that may experience high levels of psychological distress and that may benefit from psychological support. Certain points such as inter-relational skills, particularly intra-marital ones, the construction of maleness and masculine identity and the exploration of perceived discrepancies between experienced and aspired subjectivities, seemed to be particularly relevant in understanding this population. The connection between self blame, coping strategies and the level of distress among sub-fertile persons also seemed to warrant similar attention. However, as yet sufficient data do not exist to permit the development of confident conclusions about the specific nature and processes of psychological distress among this group and about effective therapeutic interventions. Thus, while future studies of male SF need to continue to address these tasks, it is necessary in the meantime to use the existing research outlined in this paper and combine it with appropriate theoretical models and existing therapeutic approaches to help us understand and remedy the difficulties that sub-fertile men may face.

References

- Abbey, A., Andrews, F. M., and Halman, L. J. (1994). Psycho-social predictor of life quality: How are they affected by infertility. *Journal of Family Issues*, 15, 253-271.
- Abbey, A., Andrews, F. M., Halman, L. J. and Jill, L. (1991). Gender's role in response to infertility. *Psychology of Women Quarterly*, 15, 295-316.
- Adler, J. D. and Boxley, R. L. (1985). The psychological reactions to infertility: Sex roles and coping styles. *Sex Roles*, 12, 271-279.
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Benazon, N., Wright, J. and Sabourin, S. (1992). Stress, sexual satisfaction and marital adjustment in infertile couples. *Journal of Sex and Marital Therapy*, 18, 273-284.
- Berg, B. J., Wilson, J. F. and Weingartner, P. J. (1991). Psychological sequelae of infertility treatments: The role of gender and sex role identification. *Social Science and Medicine*, 33, 1071-1080.

- Berger, D. M. (1980). Couples' reactions to male infertility and donor insemination. *American Journal of Psychiatry*, 137, 1047-1049.
- Blaser, A., Maloigne-Katz, B. and Gigon, U. (1988). Effect of artificial insemination with donor semen on the psyche of the husband. *Psychotherapy and Psycho-Somatics*, 49, 17-21.
- Breakwell, G. M. (1986). *Coping with Threatened Identities*. London: Methuen.
- Breakwell, G. M. (1996). Identity processes and social changes. In G. M. Breakwell and E. Lyons (eds), *Changing European identities: Social Psychological Analyses of Social Change*. Oxford: Butterworth Heinemann.
- Burns, L. H. (1987). Infertility and the sexual health of the family. *Journal of Sex Education and Therapy*, 13, 30, 34.
- Burns, L. H. (1995). An overview of sexual dysfunction in the infertile couple. *Journal of Family Psychotherapy*, 6, 25-46.
- Carmelli, Y. S. and Carmelli-Birnbaum, D. (1994). The predicament of masculinity: Toward understanding the males experience of infertility treatment. *Sex Roles*, 30, 633-677.

Connolly, K. J., Edelmann, R. J. and Cooke, I. D. (1987). Distress and marital problems associated with infertility. *Journal of Reproductive and Infant Psychology*, 5, 49-57.

Connolly, K. J., Edelmann, R. J., Cooke, I. D. and Robson, J. (1992). The impact of infertility on psychological functioning. *Journal of Psychosomatic Research*, 36, 459-468.

Coolican, H. (1990). *Research Methods and Statistics in Psychology*. Sevenoaks: Hodder and Stoughton.

Draye, M. A., Woods, N. F., Mitchell, E. (1988). Coping with infertility in couples: gender differences. *Health Care for Women International*, 9, 163-175.

Edelmann, R. J. (1990). Emotional aspects of IVF procedures: Review. *Journal of Reproductive and Infant Psychology*, 8, 161-173.

Edelmann, R. J. and Connolly, K. J. (1987). The counselling needs of infertile couples. *Journal of Reproductive and Infant Psychology*, 5, 63-70.

- Edelmann, R. J., Connolly, K. J. and Bartlett, H. (1994a). Coping strategies and psychological adjustment of couples presenting for IVF. *Journal of Psychosomatic Research*, 38, 355-364.
- Edelmann, R. J., Humphrey, M. and Owens, D. J. (1994b). The meanings of parenthood and couples reaction to male infertility. *British Journal of Medical Psychology*, 67, 291-299
- Grieger (ed.), *Handbook of Rational Emotive Therapy*, 14-20. New York: Springer Publishing Co.
- Gilmore, D. G. (1990). *Manhood in the Making: Cultural Concepts of Masculinity*. New Haven: Yale University Press.
- Glover, L., Gannon, K., Sherr, L. and Abel, P. D. (1996). Distress in subfertile men: a longitudinal study. *Journal of Reproductive and Infant Psychology*, 14, 23-36.
- Graumann, C. F. (1983). Theorie und Gschichte. In G. Luer (ed.), *Bericht Uber den 33 Kongress der Deutschen Gesellschaft fur Psychologie* (Vol.1). Gottingen: Hogrefe.
- Greenstein, B. (1993). *The Fragile Male*. London: Boxtree.

- Greil, A. L., Porter, K. L., Leitko, T. A. and Riscilli, C. (1989). Why me? Theodicies of infertile women and men. *Sociology of Health and Illness*, 11, 213-229.
- Hellhammer, D. H., Hubert, W., Freischem, C. W. and Nieschlag, E. (1985). Male infertility: Relationships among gonadotropins, sex steroids, seminal parameters and personality attitudes. *Psychosomatic Medicine*, 47, 58-66.
- Humphrey, M. and Humphrey, H. (1987). Marital relationships in couples seeking donor insemination. *Journal of Biosocial Science*, 19, 209-219.
- Hussain, S. H. (1992). Trichotillomania: Two case reports from a similar cultural background. *Psychopathology*, 25, 289-293.
- Jacobs, L. I. (1980). The ambivalent copulator: Ejaculatory incompetence and identity diffusion. *International Journal of Social Psychiatry*, 26, 179-183.
- Kedem, P., Mikulincer, M., Nathanson, Y. E. and Bartoov, B. (1990). Psychological aspects of male infertility. *British Journal of Medical Psychology*, 63, 73-80.

- Kikkendal, K. A. (1994). Self discrepancy as an important factor in addressing one's emotional reactions to infertility. *Professional Psychology Research and Practice*, 25, 214-220.
- Kimmel, M. S. (1987). *Changing Men: New Research on Men and In Masculinity*. Beverley Hills: Sage Publications.
- Klein, R. D. (1989). Resistance: From the exploration of infertility to an exploration of in-fertility. In R. D. Klein (ed.), *Infertility: Women Speak Out*. London: Pandora Press.
- Laurance, J. (1982). The moral pressure to have children. *New Society*, 61, 216-218.
- Lebovici, S. and Bouaziz, D. (1994). Some difficulties in the process of "fatherhood" in cases of medically assisted procreation. *Psychiatrie de L'enfant*, 37, 631-658.
- Leiblum, S. R. (1993). The impact of infertility on sexual and marital satisfaction. *Annual Review of Sex Research*, 4, 99-120.

Linn, R. (1995). Thirty nothing: what do counsellors know about mature single women who wish for a child and a family. *International Journal for the Advancement of Counselling*, 18, 69-84.

Mason, M. C. (1993). *Male Infertility: Men Talking*. London: Routledge.

Meyers, M., Winshel, M., Scharf, C., Kezur, D., et al. (1995). An infertility primer for family therapists. Medical social and psychological dimensions. Special section, Infertility. *Family Process*, 34, 21-240.

Miall, C. E. (1985). Perceptions of informal sanctioning and the stigma of involuntary childlessness. *Deviant Behaviour*, 6, 383-403.

Miall, C. E. (1986). The stigma of involuntary childlessness. *Social Problems*, 33, 268-282.

Miall, C. E. (1994). Community constructs of involuntary childlessness: Sympathy, stigma, and social support. *Canadian Review of Sociology and Anthropology*, 31, 392-421.

Miles, P. R. (1991). *The Rites of Man: Love, Sex and Death in The Making of The Male*. New York: Grafton.

- Moore, R. and Gillette, D. (1991). *King, Warrior, Magician, Lover: Rediscovering the Archetypes of the Mature Masculine*. San Francisco: Harpers.
- Morrow, K. A., Thoreson, R. W. and Penney, L. L. (1995). Predictors of psychological distress among infertility clinic patients. *Journal of Consulting and Clinical Psychology*, 63, 163-167.
- Pengelly, P., Inglis, M. and Cudmore, L. (1995). Couples experience of counselling in treatment centres. *Psycho-Dynamic Counselling*, 1, 507-524.
- Pfeffer, N. (1993). *The Stork and the Syringe: A Political History of Reproductive Medicine*. Cambridge: Polity Press.
- Pruzinsky, T. (1990). Psycho-pathology of body experience: expanded perspectives. In T. F. Cash and T. Pruzinsky (eds), *Body Images. Development, Deviance and Change*. New York: Guilford Press.
- Schover, L. A. (1981). Male and female therapies response to male and female clients sexual material: An analogue study. *Archives of Sexual Behaviour*, 10, 477-492.

- Solomon, A. (1989). Infertility as a crisis: coping surviving and thriving. In R. D. Klein (ed.), *Infertility: Women Speak Out*. London: Pandora Press.
- Tiefer, L. (1986). In pursuit of the perfect penis: The medicalisation of male sexuality. *American Behavioural Scientist*, 29, 579-599.
- Ulbrich, P. M., Coyle, A. and Tremaglio-liabre, M. M. (1990). Involuntary childlessness and marital adjustment: his and hers. *Journal of Sex and Marital Therapy*, 16, 147-158.
- Van-Hall, E. V. (1983). Psychosocial and emotional aspects of infertility. *Journal of Psychosomatic Obstetrics and Gynaecology*, 2, 251-255.
- Wasser, S. K. (1994). Psycho-sexual stress and infertility: Cause or effect? *Human Nature*, 5, 293-306.
- Whiteford, L. M., Gonzalez, L. (1995). Stigma: The hidden burden of infertility. *Social Science and Medicine*, 40, 27-36.
- Whitworth, B. (1996). *Infertility*. Shaftesbury: Element Books.
- Zichl, S. C. (1994). Experiencing infertility. *Maatskaplike-Werk/ Social Work*, 30, 137-148.

Appendices

1. Search Strategy
2. Notes for contributors to *Journal of Health Psychology*

Appendix 1. Search strategy

The search strategy was based on some of the guidelines indicated by the UK Cochrane Centre National Health Service Research and Development Programme and by the York University National Health Centre for Reviews and Dissemination. These guidelines suggest collecting clinical trials reaching certain standards of research design. The number of such studies in the field under review was negligible and meta analytic work was therefore impossible. However, the guidelines were followed insofar as search terms and search strategies were defined. These were as follows:

The central problem has been defined as the psychological effects of SF on men. Electronic data bases of published articles: Psychlit, Medline, Sociofile, BIDS (social sciences, sciences and humanities).

Electronic data bases of published books: Psychlit, BIDS (check) Libertas. Also searched were all the M25 consortium library catalogues.

Electronic data bases of unpublished material: ASLIB: (British M. Phil. And Ph.D. Theses 1980-1992)

Fourteen groups of search terms were used:

Barren and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Childlessness and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Fertility and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Impotence and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Infertile and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Infertility and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Masculine and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Masculinity and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples// identity/ men/ women/

Self-concept and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Sex-role and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Sterile and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Sterility and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Sub-fertile: and counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

Sub-fertility and: counselling/ therapy/ psychotherapy/ distress/ psychological/ mental/ masculinity /identity/ femininity/ dysfunction/ male/ female/ relationships/ couples/ masculinity/ identity/ men/ women/

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Still Shooting Blanks

A qualitative investigation of sub-fertile men's self, social and therapy experiences.

Abstract

Objective. The provision of counselling by fertility clinics is now mandatory for certain interventions in human infertility. However, little is known about the particular problems of sub-fertile men and the psychological interventions best suited to their needs. The aim of this article was to present some sub-fertile men's perception of their situation.

Design. A qualitative analysis of interviews with five such men.

Results. These indicated that the men's self concept was adversely affected by feelings of inadequacy and lowered self esteem, while anger at social institutions and responses to their situation seems to have been a common reaction. marital and social relations were similarly adversely affected.

Conclusion. The influence of social stereotypes and expectations and the importance of fertility for constructing and maintaining a positive male identity are suggested as the putative psychological factors leading to the effects found. Tentative recommendations for actions and approaches that the authors believe will enable more pertinent psychological interventions, are made.

Keywords. Men, sub-fertility, self-concept, therapy, IPA.

Introduction

A relative newcomer among the many aspects of human experience that psychologists work with, is the experience of sub-fertile (SF) men. Not that their plight is new, but little seems to have been written about them in psychological literature (Farhy, 1997). Since family research indicates that SF men are involved in up to two thirds of impaired fertility cases (Whitworth, 1996) a likely reason for this scarcity is that they have been reluctant to request help. This is not surprising as there is good evidence that being identified as a sub-fertile male often leads to stigmatisation and social victimisation (Miall, 1994, 1996). Also Lee (1996) reported that diagnosis as sub-fertile constituted such a blow to common male belief systems that 'many men go into total denial to survive' (p. 94). Still, times change. Edelman and Connolly (1987) found that in one fertility centre, twenty-nine per cent of men did accept an offer of counselling following diagnosis as SF and others may have sought it elsewhere, i.e., from church, support groups, GPs or private therapists. Pengelly, Inglis, and Cudmore (1995) found at another fertility centre, that of the clients who took advantage of the counselling service it offered, forty-two per-cent came as a couple, in forty-one per-cent of cases the women came alone and in seventeen per-cent the men did. A literature search by Farhy (1997), found that two of the most common social responses to male sub-fertility were refusal to acknowledge their problem and stigmatisation. This is why despite the claim that social change is often the best response to human originated or human magnified distress (Persaud, 1993), psychological interventions can in the

meantime concentrate on developing both a better understanding of and better support for SF men.

Mason (1993) and Edelman, Connolly and Bartlett (1994) identified a number of recurring themes in the experiences of SF men. These were: initial disbelief, anger, hopelessness, somatisation, a perceived loss of one's control over one's destiny, increased feelings of guilt, jealousy of the fertile, lowered self esteem and feelings of emasculation. Feelings that life has no point and that one is worthless, were also quite common. Similarly, Glover, Gannon, Sherr and Abel (1996) found in a self rating study of men who were recently diagnosed as sub-fertile, that they were significantly more anxious and self blaming as well as less satisfied with their lives, than fertile controls. Feelings of superfluity, dispensability and alienation from the process and their partners were reported by Mason (1993) and Carmelli and Birenbaum-Carmelli (1994) as common among their participants. Some of these authors' data indicated that the incidence of distress in cases of male factor sub-fertility was linked to a sense of guilt and of failing. This was apparently due to the way that societies throughout the world see fathering a child as an important attribute of manhood and regard men who cannot father as lacking a substantial part of the requirements for full male status (Gilmore, 1990). This may indicate that the distress caused by sub-fertility relates to male evaluation of this diagnosis as evidence that their virility and/or masculinity are somehow impaired.

Another finding in these studies was that psychological provision for SF men was problematic in a number of ways. For instance, Schover (1981) found that both male and female therapists were often ill at ease with clients' sexual material. So, it may be expected that some psychologists will find the sexually related sub-fertility issue difficult to handle. Similarly, Meyers et al. (1995) found that SF persons attributed to their condition much more importance than American family therapists. In addition to the lack of knowledge that seems to have hampered psychological professionals (i.e., psychologists, psychotherapists, etc.) it also seems that no consistent or established theoretical framework for the provision of therapy to SF men exists. There have been some attempts to formulate such approaches. For instance Kikkendal (1994) used a discrepancy theory model to explain the differential distress rates he found as a function of the gap between the ideal and actual self concepts of his participants. However, as yet there is no widely accepted methodology or therapeutic guidelines for this domain of therapy.

With few exceptions (e.g., Mason, 1993), few of the studies discussed directly asked participants about their experiences. Hence, in the hope of finding an indication of what are the psychological distresses and needs of SF men, the present research was designed as an investigative exploration into the concerns and experiences of this group whose aim was to learn directly from participants about their subjective experiences as SF men. While the entire range of their experience was of interest, three aspects were of particular interest, i.e., self, their experience of themselves, changes in their self evaluation and their cognitive accommodation

of those changes; social, including but not only, social identity and perceived social reactions to their sub-fertility; and therapy, their experience of it if any, their evaluation of it and their ideas about how its effectiveness for SF men could be enhanced.

Method

Sample

The sample consisted of five adult men all of whom were diagnosed by male fertility specialists. One participant was recruited through an advertisement in a relevant charitable organisation's newsletter and the others responded to leaflets circulated in fertility clinics. Although separation and partner loss often affect and exacerbate the effects of sub-fertility these were seen as secondary for the purposes of the present circumscribed research and therefore, only participants whose relationship status has not changed (i.e., were still living with the same partner as when diagnosed) were interviewed. For the same reasons those diagnosed as suffering from a recognised mental health syndrome before being diagnosed were excluded as were men who had fathered a child or those diagnosed over ten years ago and whose sub-fertility experiences, while still valid, were perhaps less immediate and ongoing.

While the meaning of using only five participants is discussed elsewhere is perhaps noteworthy that despite advertisements in relevant news circulars, internet newsgroups and fertility clinics, response rate was extremely low with only seven men responding. Participants' mean age was 37.2 years (range 33 - 45 SD 4.3) and mean time since diagnosis was 4.2 years (range 1-6 years SD 1.9). All participants were married before diagnosis and were still with their wives at the time of the interview. Mean marriage length was 8.6 years (range 4-15 years SD 4.6). Three participants had academic and two had tertiary educational qualifications. All were in paid employment (two engineers, one accountant, two executives) as were their wives. The participants' sub-fertility was the sole or main symptom of a medical condition only diagnosable by specialist tests so that none had prior concerns about their fertility. All participants were British citizens although two were of Mediterranean extraction.

Procedure and materials

Data were collected in single session taped interviews lasting from forty to a hundred and ten minutes and executed at the participants' homes. All names and locations were changed to preserve participants' anonymity. At the start participants signed a consent form detailing confidentiality procedures (appendix 1). Demographic data was recorded and a semi structured interview schedule was then administered (appendix 2). This format was favoured because it enabled participants to speak about the issues they considered relevant, yet allows researchers to address those aspects they find interesting (Silverman, 1993).

Hence interview questions were open ended and concerned the participants' experiences and emotions as sub-fertile men. Questions were drawn from the issues identified by previous research (i.e., anger, self appraisal, social responses), but left ample space for the participants' contributions (i.e., Could you tell me about your experiences since diagnosis?) They were supplemented by requests for clarification and reflective statements e.g., can you tell me more? Participants' comments about the interview schedule's ability to address those issues they were concerned with, were solicited and the points they raised were incorporated into the findings. The interviews' open style meant that on various occasions participants provided answers before being asked specific questions. These issues were raised again later in the hope of gaining further insights.

Ethical issues

The issues of explaining the research aims to participants and minimizing ill effects were approached by sending potential participants an explanatory letter prior to participation (appendix 3). However, there was a possibility that the interview's potentially painful topics may have had a deleterious effect on some participants. Four steps were used to forestall such occurrences. First, by excluding SF men with existing mental health diagnoses. Second, all participants were given details of organisations and groups that provided psychological help in cases of sub-fertility. Third, following the recommendation of Breakwell (1995), the

interviewer offered all participants further sessions for their benefit in which his therapeutic skills would be utilised to help them deal with any issue that may have arisen following the interview. Lastly, following Coyle and Wright (1996) if participant distress was to become apparent during the interview, this would have been discontinued and the interviewer would have attempted to re-engage the participant in a therapeutically oriented encounter followed by the steps already listed. However, none of the participants required these steps to be put into effect. To maintain confidentiality, tapes were transcribed by the researcher and identifying details were altered.

Analytic procedure

Turpin, Barley, Beail et al. (1997) suggested that qualitative research was particularly apt for learning about meanings, for exploring areas in which little research existed or for health related issues. Since the present topic involved all three criteria, Interpretative Phenomenological Analysis (IPA) (Smith 1996; Smith, Flowers and Osborn 1997) which emphasises engaging the participants' thoughts and actions while attempting to embrace their point of view - abilities Silverman (1993) considered essential in qualitative research - was used to analyze data. IPA follows symbolic interactionism (Denzin, 1995) in considering the meaning individuals give to events of paramount interest to researchers yet recognises such meaning can only be reached through an interpretative process. IPA recognises

that many do not consider verbal reports to be directly linked to cognitions and that cognitions do not become transparent in verbal reports. However, it assumes that the analysis of these reports facilitates understanding participants' thinking (Smith et al., 1997). In this study using interview material meant that data consisted of the participants' accounts concerning their experiences, information whose subjective nature means it is often considered suspect in mainstream quantitative research. Moreover, IPA entails a process that is subjective by definition, using the researcher's frame of reference for interpretation. Therefore, both data and analysis could be deemed biased by positivist critiques (Silverman, 1993). The present researcher does not claim that his data or his results are objectively true but agrees with Brown and Sime's (1981, p. 164) claim that, 'An account is neither naive nor an apology for behaviour, but must be taken as an informed statement by the person whose experience is under investigation.' This point of view is consistent with what Silverman (1993) termed a partisan stance, i.e., a position where the objective stance usually adopted by social scientists was eschewed in favour of one where data were collected to support a particular cause. In this case, the 'cause' was, finding about and understanding the participants' subjective experiences of sub-fertility in the hope of using these to suggest possible refinements to current interventions. Thus, rather than attempt to circumvent the inescapable influence of their interpretative framework on the analytic process they believe that their ability to decipher and represent the participants' cognitions should be measured in terms of credibility and evidence (Chenitz and Swanson 1986) and that these will show that theoretical and critical transparency were

achieved through a close connection between the interpretations made and the material cited.

Following IPA methodology, repeated reading of the transcripts was used to gain an incipient understanding of emergent themes, i.e., issues participants presented as central, within each. Those themes were then examined within each transcript individually with similarities and differences examined within and in contrast to the group. This was repeated cyclically extracting new themes as they became salient. While frequency of thematic expression was a clue, it was felt that reliance on quantitative indices in qualitative research was contra indicated, given the small sample used (Krueger, 1994). Thus, adjectives and descriptive phrases were the main classificatory criterion in evaluating the importance of themes. Especially here, where response diversity was as important as response commonality (Krueger, 1994). While the experiences and material contributed to this study by each participant were unique to him, two factors became evident once all interviews were analyzed. First, although their particular details and relative importance varied, seven main themes appeared in each narrative. Second, each theme was open to various multiple-level interpretations. For instance, while many of the participants' perceptions of their condition could be interpreted as a reaction to their treatment by society, they could also be seen as expressions of pre-existing notions about probity, ethnic prejudices and just world expectations, or as strategies for coping with loss. Since analyzing data at all these levels meant that data had to be presented as snippets, losing both its context and meaning, or an

unwieldingly long report was prepared, the researcher decided to sacrifice some analytical finesse and limit his interpretations to the material's most discernible aspects, in the hope of preserving the data's context and enabling readers to better appreciate the participants', admittedly subjective, experience.

Sample story

To contextualise the participants' experiences, Pete's story serves as a good example of their experiences. Married in their late twenties he and his wife have been together for fourteen years. They started trying for a baby three years into their marriage, but for the first two years did not consult a GP. When they did so, they were told to lose some weight and try for another six months. Only after this period were they sent for specific fertility checks. While Pete's wife was found to be healthy in that respect, his sperm sample contained only a few non-motile spermatozoa. At the time they were told they should consider donor insemination, as Pete's sperm was considered of too poor a quality to even try IVF. They considered this but deferred their decision. Four years later, they read in a fertility newsletter about a new technique where a single sperm cell was injected into an ovum. Although their health authority and GP refused to fund attempts, they decided to go privately and despite costing about three and a half thousand pounds per trial (plus a thousand pounds for drugs), have tried six times to date. The reason for this was that although fertilisation had been achieved, embryo implantation did not. When interviewed, both were employed but because, all their spare income was spent on twice yearly attempts, they were living sparingly. They

had also become socially distanced from their friends and as they felt that their families did not empathise with their need for their biological child, relations with them have soured too.

Analysis

The analysis proper begins with look back in anger, i.e., the participants' emotions following diagnosis and the damaged man, i.e., the sense of diminished worth that all reported having experienced at that time. It continues with the importance of being fertile, i.e., the meaning that participants gave to their (sub) fertile situation, followed by problem solving: the only way? I.e., the solutions the participants pursued. The analysis then continues with acceptance: an unwanted solution, an examination of the participants' difficulty in accepting their sub-fertile status, goes on to the social outcast, experiences of rejection and derision, revisits look back in anger and ends with therapy, what is the point? The participants' experiences of psychological interventions.

Look back in anger -- 'I exploded.' (Pete)

The participants' emotional responses to sub-fertility.

Echoing findings discussed above (e.g., Mason, 1993, Edelman et al. 1994)

diagnosis as SF, was reported to have various emotional effects on the participants:

Stupefaction, depression, isolation and persecution were four of them.

There wasn't any grounds to think there was such as thing. (Bob)

I became really depressed and had this for months and months. (Al)

As far as you're concerned you're the first person ever. (Jim)

I felt that maybe I was punished for things I did in the past, I felt lost as if the earth beneath my feet was non existing. (Luke)

Jealousy was another emotion felt by them, and may have contributed to what was the most frequently and vehemently expressed emotion, anger.

You start actually feeling jealous of healthy people, they don't have to worry about such things, you get angry at people. (Jim)

According to Breakwell's (1986) model of identity their anger and surprise may well have been defenses against the noxious nature of the diagnosis induced changes in the participants' self appraisal.

One day you're hundred percent of a man and the next day you're not, you're half a man. (Al)

Anger also intruded on the participants' conjugal relationships.

There is this anger which has come between us as if each one of us isn't doing their part properly and of course there is blame. (Luke)

However, besides these emotions most of which seem to have risen immediately after diagnosis, other responses appeared later, sometimes years after the initial diagnosis. The most common of these were despondency and bitterness which participants attributed to the often recurring failures in their struggle to reverse their status.

I lost my hopes. (Jim)

I became bitter. (Luke)

Luke said,

Each time we fail in the treatment although we've reached the point of fertilisation, it's like you don't want to continue with all this, you just want to wake up and see that it was all a bad dream and that's it.

The ebb and flow of the participants' treatment fortunes made them feel tugged by emotional tides. Al said,

We have the most terrible yo-yo.

and Pete stated,

It (treatment) makes me feel absolutely brilliant, when it fails I get the fall as well.

The participants believed that these changes were all encompassing.

It (sub-fertility) affected me in everything I do, everything I want. (Jim)

Atypically though, he and Al were the only ones who saw any positive side to their condition.

I gotta say I've become less arrogant. (Jim)

I'm a better person because I've been kicked but not given in. (Al)

Interestingly none of the participants mentioned grief echoing Lee's (1996) observation that SF men rarely acknowledge grieving.

The damaged man -- 'I failed the most basic thing on the planet really.' (Pete)

The participants' damaged self concept.

Anger has been suggested as a common defense mechanism against acknowledging other more threatening affects (Sandler, Dare and Holder, 1992). It is possible that the participants' anger was a defense against another pervasive feeling, that of being a defective male. Al indicated this saying,

You feel you're no good, you're a shit and then you become angry.

Whatever its aetiology, the feeling of being a damaged man of having lost part of your value was indicated by Pete in no uncertain terms,

(Sub-fertility) made me feel not like a man, I felt useless.

As Glover, Gannon, Sherr and Abel (1996) found, their sense of diminished value was not restricted to their virility but influenced the participants' self esteem as a whole. This was expressed by Jim as,

I value myself less, I see myself as less of a catch.

By Luke as,

I felt like half a person.

And by Pete as,

Anything I tried to do will fail anyway because I'm a failure.

Their devaluing tendency seemed linked to a tendency to objectify themselves, as if one was a (fertilizing?) object rather than a person.

(I am) less valuable to others, (I am) faulty manufactured, in need of urgent replacement. (Jim)

The possible link between their self value and ability to fertilise could be seen in Pete's statement,

This thing between me legs is no good.

Immediately after saying,

Yeah, yeah, I feel like that, (shoddy).

Al too used an object as a simile for himself,

Like a car all shiny outside but with a crappy engine inside, busted.

Their self objectification may have also been aided by the loss of self concept coherence reported by three of the participants. As if by losing their fertile status they lost part of what defined their individual essence.

This not feeling oneself was just what I was talking about, yeah, I sometimes get the feeling that my body is not mine any more, sometimes I feel happy but inside I don't. (Jim)

A possible clue to participants' self objectification may be found in Al's answer when asked why he felt the way he did,

Still being in this situation, that's what causes them.

Perhaps, as will be later discussed, the participants were encouraged to see themselves as damaged and since as Gilmore (1990) reported, the ability to fertilise was so intimately linked with a male self concept, they could only lay claim to a lesser, object like, self concept. Additionally, their objectified self concept may have been an example of what Breakwell (1996) refers to when speaking of distraught identity. A state of being where assumptions held about oneself are shaken and adaptive processes have yet to compensate for these changes.

The importance of being fertile -- 'Because I can't produce a family, I can't do it, I'm no use, I've got no value, I'm no use. (Pete)

The meaning of being (sub) fertile.

Lee (1996) spoke of western infatuation with 'the cult of fertility' (p. 98). Some participants did speak of fertility as if it were a key to happiness, perhaps the only way to happiness.

I feel that if we have children then everything will be all right. (Luke)

For Pete restoring his fertility was the way in which he could,

Give my wife a family, what she wants.

Luke saw it as what would save his marital relationship,

If we stop it means we gave up and we gave up on our marriage as well. There is this anger which has come between us as if each one of us isn't doing their part properly, and of course there is blame.

All participants had expected to be fathers and saw parenthood as part of the natural flow of life, fulfilling their destinies. Moreover, they spoke of parenthood as if they were entitled to it. Pete considered this essential if he was to be,

Like everybody else and be normal. Because in a family you are living natural family life, just normal, normal, totally, totally normal.

Parenthood was for him not only seen as completing oneself, it was completeness in others,

She's got a child so she's a complete person.

Pete also expressed the natural conclusion of this view, i.e., that not having children was an anomalous way to live in turn making him aberrant.

We haven't really achieved this. As though we're camping, we're not settled, an empty life, we're incomplete in a sense. It's unnatural.

Living what they and society (Miall, 1994) saw as un-natural lives meant to Pete that they could either withdraw from life's arena or pretend they were involved in it,

We keep to ourselves, it's Christmas, green paper everywhere. So you play you actually play the part, it's quite sad isn't it?

Bob, however, did not share this view, he thought that sub-fertility was a significant loss,

You expect to have children.

But not tragic,

People live with without, with much bigger things and they get by in the world, so it doesn't seem to me that big.

Problem solving -- No, I don't think we seriously considered any other option. (Bob)

How did participants tackle their sub-fertility?

All the participants also considered various ways of overcoming their unwanted situation. Al described this thus,

First we did check all options, we considered adoption, donor insemination, donor eggs, donor embryos and childlessness.

Still, they seemed to share Pete's dichotomous view of life as fertile or sub-fertile,

It (sub-fertility) colours your life black and white, gray we don't have.

They all went to great expense and effort trying to find a cure for their condition,

We spent our savings on it, we skimp on things like holidays. (Al)

The participants' zeal in pursuing this road differed though. Of the five only Bob whose ardour seems to have been the least, reported being able to regulate this pursuit,

Once in a while we check the medical journals to see if there's a new option or an option that hasn't been tried yet.

The other four participants were far more resolute in their pursuit of a cure.

Luke's response was,

Once we found out that there is a possibility that we might have children we went for it full steam ahead, it gave us a reason to carry on.

Al felt that,

It is the only option we really want, having our biological child.

And Jim said,

I'm always on the look maybe there are new cures, if you have a price for it, then I'll do it.

Even Pete who seemed to realise that his zeal might have been excessive,

I over compensate for it now.

Felt obliged to proceed in this direction,

I want family and I'll do whatever is necessary, going with that kind of mumbo-jumbo, do anything to improve the situation.

Of course rather than denoting a fear of sub-fertility the men's problem solving approach may have originated elsewhere. Indeed Abbey, Andrews, Halman and Jill (1991) claimed that gender related differences in responding to sub-fertility mirrored general gender-characteristic responses to stressors.

Trying for a cure was not easy. All participants admitted that this pursuit exacted a heavy psychological and financial toll. Pete summed this up saying,

That carried its risks, you've got to be on top of it, otherwise you've got no life, you focus on it too much and you let it rule, it'll ruin your life.

Even if this effect was avoided, second thoughts and despair often arose. Luke described his feelings after a failed treatment cycle.

When they found enough sperm I, we, were over the moon. We felt like everything's going our way. Then the next day that horrible telephone call when they told us that out of seven eggs none were fertilised. It was like someone took a gun and shot me again. And I couldn't understand why, why, how can this be, it's impossible. I just cried and cried and cried, there was no point in living, for what? I was lost again, alone.

Interestingly, Luke used the plural we when speaking about the emotions he and his wife experienced when sperm was found, but used the singular 'I' to describe his despair after fertilisation failed despite there still being two of them. Perhaps he felt that to parent he needed a partner but to be SF was a lonely experience.

Acceptance: An unwanted way -- 'coming to terms was a survival need.' (Jim)

The participants' notion of acceptance.

Whatever their zeal in trying to solve their fertility problem, all participants seemed aware that at some future stage they may have to conclude that they are unable to do so and have to come to terms with sub-fertility, accept it and attempt to build a life as sub-fertile men instead of their present life as men fighting sub-fertility.

The passage of time brings a realisation that it won't go away, give up completely and let life take its course. (Jim)

We'll have to learn and accept living with no children. (Al)

However, they all preferred not to give this possibility too much thought, as if avoiding the thought could avert the need.

I guess we may have to opt for donor sperm, but this is an issue we don't have to consider yet. (Jim)

Maybe we have not fully digested this, If science doesn't help us there won't be, children, but we haven't thought of any other thing. (Bob)

Some said they already tried to come to terms with their condition, but acceptance was impossible to sustain, a finding similar to those of Mason (1993), or was more painful than the present struggle.

I've tried that and it made me feel even worse, I wasn't able to think of anything else. (Jim)

Even when I have a nice thing going on I feel, yeah but what the fuck, it's not worth it, why this thing yes and kids no. (Al)

The reason why choosing to give up their struggle was unacceptable, might have been linked to participants' unfaltering view that life without children was incomplete.

The basics are not there, you come round to an empty house, you've got no life in it. (Pete)

Perversely this focus on parenthood that prevented acceptance may have also been the reason they all said they will eventually come to terms and also why coming to terms meant for them, adoption or having a donor child, rather than living without children.

You come to terms in some way otherwise you go crazy. (Jim)

We'll adopt children, it's not like having your own natural child, hobble along life.
(Pete)

Social outcasts -- 'Some (people) you can see the look of disgust on their faces. (Jim)

The participants' social experience.

In keeping with Miall's findings (1986, 1994) the one theme that all participants were unanimous about appeared in their accounts of negative social responses. As Jim said,

Society is not geared for people who are not perfectly healthy, if you have a health problem, boom you're dropped like a lead balloon.

Participants reported negative reactions from wives, relatives, friends, acquaintances, co-workers and organisations. Wives were described as wavering between support and rejection at different times. According to Jim,

The only support I had is my wife's,

but Al saw things differently,

She cared nothing for me, only to get her effing child.

This however was untypical. The other participants as well as Al elsewhere, agreed with Bob's description of his wife's role,

Her will to carry on and not give up, I think that that's what has helped us.

While wives were generally seen as sources of positive response, opinion differed about other relatives. Some thought they helped, certainly more than non relatives, but others thought that they cared little, or did not disclose their condition at all.

We received support from family, blood is thicker than water. (Al)

If there is a gear box or engine problem (in the family), it's a great big monstrous problem, everybody rushes around, I think prats, take a real interest in a real issue.
(Pete)

It's not a subject that you go and talk over a glass of wine. (Bob)

Their friends failed to give much support or acceptance, perhaps because the participants realised their needs were greater than what they could provide.

You don't ask more than a person can and will give, you don't get disappointed.

(Al)

Jim thought that they could not understand his plight,

(They) were not aware how much effect it really had.

Still, participants were disappointed and expressed diminished belief in the value of friendship.

You find who really cares for you and who doesn't. (Al)

Bad as their experiences among family and friends were, their representations of responses by society at large were far more negative. Participants described disbelief as well as pity and ridicule,

Some think you're moaning for nothing, disgust, pity really and maybe would feel I'm not a man really. (Jim)

Bob would not disclose his condition,

I don't want to see their reaction so I don't tell them.

Perhaps because he dreaded what he believed would be people's reaction to it.

Pity and all that. I don't want to experience (it). I prefer not to confront them if you don't have the courage.

The participants described the medical and psychological establishments they turned to for help, as the least sympathetic.

I was a specimen, nobody ever in the medical establishment ever asked me how I feel. (Jim)

The participants believed that the public sector, the NHS and GPs were uninterested in their plight, ignoring them unless they begged for help and even then often responding negatively or refusing help and support,

You've got to actually moan and complain for anyone to take it seriously. (Jim)
They got their children and their new practices, they don't care about you. If they can't cure it with a Paracetamol, they don't want to know about you. (Al)]

Participants also believed that the private sector was only interested in profiting from their misery, a belief supported by Lee's (1996) claim that fertility treatments have become a lucrative industry with specialist centres offering SF men and women hopes tailored for each wallet. Pete described his first encounter with this phenomenon thus,

We went into that hospital.. this white coat, and he said, well for another twenty-five or fifty pounds you can have an injection of, whatever it is he said, I was absolutely gob smacked at hearing such a thing.

Three of the participants reported being tricked by faith healers or so called practitioners of alternative medicine, but this did not deter them.

After you've been quacked (duped by quacks) you become wary. (Jim)
We've been tricked, conned... I'd go again. (Pete)

One type of non familial social interaction singled out for praise by those participants who had come out about their condition, was meeting other men like

themselves. Pete said that knowing that, showed him he was neither a freak nor singled out for punishment.

Somebody else is trying. It's not just me.

Jim too spoke of not being alone.

Sharing your experience with others who have done it too, really helps a lot.

This experience, they believed, helped them because it was an opportunity for open dialogue with an understanding audience.

I've been able to talk openly to discuss it and that's something that really does help a lot. (Jim)

Look back in anger (again)

The participants' anger: reaction to betrayal, externalised jealousy, or a defense against identity threat?

That anger and aggression are common responses to feeling marginalised and discriminated against is almost a given in contemporary thought. Some writers justify them (Kitzinger and Perkins, 1993). Hence, faced with these negative reactions it is perhaps understandable why anger and wariness were such central themes in the participants' narratives. If like Jim and Pete, they felt that more support was their due,

I should have had more support.

There should have been a lot of people (supporting).

Then anger was a natural response to their milieu's repeated failure to provide the support they perceived to be rightfully theirs. Pete justified this by saying,

We've helped my brother in the past, and it hurts that he doesn't reciprocate really.

The problem with anger though was not whether it was justifiable, but its insidious nature. Even justifiable anger could overcome participants and impair their ability to enjoy the positive in their life. As Luke said,

There is this anger that has come between us.

Al expressed anger at those he saw as being treated undeservedly better by society and at those who did so,

If I was a hooligan, a criminal, I'd be sent abroad on a safari, courtesy of social services, but if me, a tax payer needs medical help with my condition, then it's fuck off, no money for you mate. Effing Blair and his poof parade are spending billions, on asylum bloody leeches.

Despite the participants' belief that their anger was merely due to their perceived shabby treatment by society, some clues in their material may indicate that this was a convenient fiction for them to believe. As Al said,

First you feel a shit then you get angry. They (ethnic minorities, the unemployed, the socially irresponsible) make them like rabbits and you can't.

Similarly, others expressed their feeling that life wasn't fair to them,

Why me? (Luke)

Hence, it is not impossible that reported externalised anger functioned as a buffer against self directed anger as well as an expression of jealousy of those perceived as luckier. Looking at Jim's words, perhaps both processes were intertwined?

Social response doesn't affect the way I perform, but it affects the perception of yourself.

Being seen as lesser men by society could seemed to have made participants see themselves as lesser men and this in turn fuelled their anger, as if those they saw as inferior or no better in some way were undeservedly more fertile, as if social probity should be matched by fertility, (perhaps to check the social undesirables'

profligate reproduction). Jim like others also reported that his anger made him lose some of his concern for others.

I think, what the hell they're complaining about.

Unusually, he indicated that he was moving beyond anger and began rebuilding his social relationships albeit with mixed results,

Some people feel sorry for you, some people let you know they care, relationships become far less awkward.

Interestingly, Breakwell's Identity Model (1996) mentioned above, posits that individuals strive to maintain a positive self evaluation. If as seems to be the case, sub-fertility was incompatible with a positive male self appraisal then both the participants' frantic attempts to reverse this condition and their anger towards those who made its reality all the more tangible, were to be expected.

The unbearable lightness of being, in therapy -- 'Counsellors are just a complete waste of time. Pete

The participants' experience of professional psychological help.

If little is written about male sub-fertility even less seems to have been written about psychological interventions in such cases. A situation that as Edelman and Connolly's (1987) study showed was not due to lack of interest in therapy by SF men. In the present study, participants' responses concerning the use they made of therapy, their experiences if they did have some and their reasons not to if they did not, were diverse. Yet those who did seek therapy, had similar tales to tell. Some reasons for seeking therapy seemed to apply to all therapy-using participants. A

wish to tell, yet keep one's affairs confidential, be unconditionally accepted and marital help seemed common to all.

My wife a bit, but I couldn't tell her all this (feelings), someone to come and tell me I'm still OK. (Al)

It's so personal you don't like people in, like brothers or sisters, and mother and father you don't let them in. (Pete)

My wife and I went to Relate because it got to a stage where it was make or break. (Luke)

Other reasons seemed more personal. Pete said that sometimes he wanted lies.

What you really want is some lies.

At other times he wanted someone to reaffirm his decisions.

Someone to say, yeah go for it.

He also found it hard to open up to professional helpers perhaps because those he used (clinic funded) were less empathic,

And they (SF people) give it all (feelings) out, you need some support in order to help them come out.

Luke said about his motives that he wanted his weak points found and repaired.

I wanted to find why it hit me like this.

Bob and his wife did not consider therapy at all. In fact they seemed to recoil at the thought.

I don't think I felt I needed it at any stage, maybe if I didn't have a choice, if I would have broken, collapsed.

Jim was amenable to the idea but never got round to seeking it. He said that the public health sector had no interest in psychological difficulties.

For the psychological problems that it causes you're on your own.

And as far as private therapy was concerned he and Al felt that,

I didn't know anyone, any counsellor.

I thought it would cost more money.

Luke, Pete and Al who had all made use of therapy were unanimous in that public provision of the same was uneven to say the least and access to it necessitated efforts on their part.

I asked the GP to send me somewhere, they (GPs) sure won't offer you therapy.

(Al)

The counselling services which fertility centres are mandated by law to offer, were used by both Pete and Al. They concluded they were badly advertised, staff were poorly prepared and willingness to help was deficient to say the least.

We only found out about it (counselling service) on the second attempt. She (a counsellor) didn't bring anything to the meetings we had. You know, I need to come and talk, and they respond; well so and so is on holiday, at the moment we only got one and we can't, you know, can't get in touch, well I looked in her diary maybe June the 14th is all right? But this is April. (Pete)

Private therapists were used by both Al and Luke who found them helpful.

She (the therapist) helped me feel better, accept myself. (Al)

They also agreed that the psychological professionals' empathy and ability to understand were the key elements in their effectiveness.

She understood me, she was there and listened. (Al)

Both Al and Pete joined Jim's assessment of private therapy as too costly, only Luke who used therapy more extensively than the others made no comment on its cost.

There's no money for this either, because we have to save it for the trials. (Al)

I went for therapy straight after the diagnosis because I was depressed. At first I went to a group therapy that I didn't feel was useful to me so I stopped. My wife and I went to Relate because it got to a stage where it was make or break. A few years ago I went to assertiveness course because I lost my confidence. Now I've

been seeing a therapist for two years and that helps me. So yeah, all in all I do believe in therapy. (Luke)

Overview

An evaluation of the present study's findings depends heavily on the evaluator's theoretical stance. On one hand there can be little doubt that the small, self selected, sample used was unlikely to be representative of SF men and assuming that those who have favourable experiences tend not to come forward, may have had un-characteristically negative experiences. Nevertheless Turpin et al. (1997) considered a sample of five, particularly when participants are hard to find, as acceptable if not desirable, for qualitative research. Moreover, on the other hand, the present methodology gave to the participants an opportunity to voice feelings which judging by their robust articulation they felt strongly about. Because of this robustness and because the participants repeatedly raised the same pivotal issues before being asked about them, their themes could be seen as being central to them rather than to the researcher. Moreover, if the sample was indeed composed of men whose experience was negatively biased, then the study's stated aim of improving therapeutic succour, could be at least partly achieved by examining those negative experiences in an effort to change the quality of care offered. Another, perhaps inevitable, shortcoming in an interview based study is that of establishing linearity between statement and feeling (Coolican, 1990). For instance, all clients spoke of donor insemination positively and said they will opt

for it, albeit not until all other means were tried. None however, showed the reservations and the ambivalence that according to Lee (1996) are often aroused by it. Hence, one may speculate whether this seemingly easy acceptance was a faithful expression of their feelings or a socially desirable response. Perhaps their insistence on fighting and overcoming sub-fertility and their definition of acceptance in the active terms of donor parenting indicated compliance to social dictates about what constituted suitably male ways of coping? Did they feel that they had to behave in a typical male manner (Abbey et al., 1991) to negate their damaged maleness. Or perhaps their choice of donor insemination - nearly always a secret according to Lee (1996) - was a trade off where in return for accepting that they will not become biological fathers they became social fathers and thus restored their status as worthy members of society (Miall, 1986, 1994). In a not too dissimilar context it is regrettable that further enquiries were not made into the question of how the participants' adaptive processes were affected by the repetitive, time consuming, low success treatments they underwent and by the slow development of new techniques upon which they seemed to pin their hopes. Although offering hope, these effectively meant an open ended treatment that perhaps encouraged them not to come to terms with their condition but to regard it as temporary, thus making it unnecessary (in their eyes) to seriously engage in the painful process of acceptance.

Findings also showed some feelings of alienation and marginalisation. According to Fewtrell and O' Connor (1995), these may have indicated the existence of a

vulnerability in the participants' self experience as a cohesive, distinct and integrated individual and thus exploring these aspects of their experience in future research may be beneficial. However, these may have been caused by the issue participants presented most vehemently, that much of their perceived suffering was due to negative social responses and social indoctrination.

While psychology can provide crucial support to the SF until the day Persaud's (1993) recommendation for social change as a suitable response to discrimination becomes feasible, material from those participants who asked for therapy clearly indicated that they did not perceive psychologists and counsellors as possessing the ability to understand their needs and communicate that understanding which they believed was essential for effective psychological support. Moreover, if the earlier mentioned dearth of research in this field is anything to judge by, they seem to have been rather accurate. Lee (1996) suggested that adapting a pre-existing model to account for the processes sub-fertile men undergo may improve therapeutic intervention and suggested using bereavement models for this purpose. However, many of the sub-fertiles' problems seemed to revolve round identity issues as well as social readjustment. Thus, despite their circumscribed nature, adapting appropriate identity formation theories, particularly social identity ones, which by definition incorporates a strong input from one's milieu (Bandura, 1986) may be an appropriate step. Men whose self evaluation is negative or whose identity is not secure, as the participants seemed to indicate may be in greater need of positive social reinforcements (Lee 1996). Indeed Kikkendal's (1994) findings of lowered

self esteem and of feeling that one's life has no continuation and thus no meaning led him to suggest that the therapeutic focus in infertility counselling should be the discrepancy between ideal self (parent) and actual self (childless). Valuable as his suggestion was, adapting a model such as the aforementioned Breakwell's model of identity formation (1986) is perhaps a more suitable answer to the needs identified above. According to her model, people possess a fluid identity comprising private and socially defined elements with specific negative or positive values appended to them. While their totality amounts to a person's identity and self evaluation, there is a desire to reach an end state that is deemed desirable and whose desirability is culturally mandated. If following change in these elements, evaluative and assimilative processes fail to accommodate the change without affecting the end state's desirability, a threat to identity is said to occur. Since sub-fertility was clearly a negative change to participants then as found, Breakwell's model would infer that participants would experience distress. Breakwell posited that such threats could be dealt with by inter group, interpersonal and intra-psycho coping systems. Some of the intra-psycho ones: denial, transient de-personalisation, disbelief in one's reality and fantasy were indeed found in the participants' material, while others such as acceptance and reappraisal, which she believed were more successful were seemingly desired by them. Although, Breakwell did not suggest concrete steps to help persons whose identity was threatened, work on the participants' inter-social and interpersonal skills seems indicated. Moreover, embedding the participants' experiences within such a model

would enable psychological professionals to be mindful of their need to reassess themselves and positively redefine their identity.

Another issue raised by some participant narratives was age related haste. Only one participant seemed not to share his fellows' view of sub-fertility as a major affliction nor to express urgency concerning finding a solution. This may have been due to a different outlook on sub-fertility, or an even stronger need to deny his plight, but perhaps being at thirty-three the youngest participant, he unlike those married to older women, may have lacked the feeling that his biological clock was ticking inexorably. If support could be found for this conjecture it may indicate that clocks tick for men as well as women. However, since men's clocks are usually much slower (and may last a lifetime) the sense of urgency women nearing forty are said to experience, may be absent in males of the same age and appear only in situations when men feel time limits apply to them too.

Conclusion

Time and again human psychological research finds that much of what is wrong in human experience is due to what humans inflict on each other. This research is no exception. However, until and if social changes improve the human condition including that of sub-fertile men, psychological professionals can and should encourage them to take responsibility for their own responses to events, without blaming them for these responses or holding that environmental issues are to blame (Dryden, 1994). However, for this they need to develop a greater sensitivity than that described by participants and both sides will benefit if their knowledge and understanding of male responses to sub-fertility are enhanced.

References

- Abbey, A., Andrews, F. M., Halman, L. J. and Jill, L. (1991). Gender's role in response to infertility. *Psychology of Women Quarterly*, 15, 295-316.
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Breakwell, G. M. (1995). Interviewing. In G. M. Breakwell, S. Hammond, and C. Fife-Shaw (eds), *Research Methods in Psychology*. London: Methuen
- Breakwell, G. M. (1996). *Coping with Threatened Identities*. London: Methuen.
- Brown, J., Sime, J. (1981). A methodology for accounts. In M. Brenner (ed.), *Social Method and Social Life*. London: Academic press.
- Carmelli, Y. S., Carmelli-Birnbaum, D. (1994). The predicament of masculinity: toward understanding the males experience of infertility treatment. *Sex Roles*, 30, 633-677.
- Chenitz, W. C., and Swanson, J. M. (1986). Qualitative research using grounded theory: In W. C. Chenitz, and J. M. Swanson (eds), *From Practice to Grounded Theory: Qualitative Research in Nursing*. Reading, MA: Addison-Wesley.
- Coolican, H. (1990). *Research Methods and Statistics in Psychology*. Sevenoaks: Hodder and Stoughton.
- Coyle, A. and Wright (1996). Using the counselling interview to collect research data on sensitive topics. *Journal of Health Psychology*, 1, 431-440.

- Denzin, N. (1995). Symbolic interactionism. In J. A. Smith, R. Harre and L. Van Langenhove (eds), *Rethinking Psychology*. London: Sage.
- Dryden, W. (1994). Comment on Persaud's. *Journal of Mental Health*, 3, 431-435.
- Edelmann, R. J., Connolly, K. J. (1987). The counselling needs of infertile couples. *Journal of Reproductive and Infant Psychology*, 5, 63-70.
- Edelmann, R. J., Connolly, K. J., Bartlett, H. (1994a). Coping strategies and psychological adjustment of couples presenting for IVF. *Journal of Psychosomatic Research*, 38, 355-364.
- Farhy, E. (1997). The psychological sequelae of male sub-fertility. *Unpublished*.
- Fewtrell, D. and O' Connor, K. (1995). *Clinical Phenomenology and Cognitive Psychology*. London: Routledge.
- Gilmore, D. G. (1990). *Manhood in the Making: Cultural Concepts of Masculinity*. New Haven: Yale University Press.
- Glover, L., Gannon, K., Sherr, L., Abel, P. D. (1996). Distress in subfertile men: a longitudinal study. *Journal of Reproductive and Infant Psychology*, 14, 23-36.
- Kikkendal, K. A. (1994). Self discrepancy as an important factor in addressing one's emotional reactions to infertility. *Professional Psychology Research and Practice*, 25, 214-220.

- Kitzinger, C. and Perkins, R. (1993). *Changing Our Minds: Lesbian Feminism and Psychology*. London: Onlywomen press.
- Krueger, R. A. (1994). *Focus Groups: A Practical Guide for Applied Research*. Newbury Park, CA: Sage.
- Lee, S. (1995). Factors in male infertility. In S. Jennings (ed.), *Infertility Counselling*. Oxford: Blackwell Science.
- Lee, S. (1996). *Counselling in Male Infertility*. Oxford: Blackwell science.
- Mason, M. C. (1993). *Male Infertility: Men Talking*. London: Routledge.
- Meyers, M., Winshel, M., Scharf, C., Kezur, D., et al. (1995). An infertility primer for family therapists. Medical social and psychological dimensions. Special section, Infertility. *Family Process*, 34, 21-240.
- Miall, C. E. (1986). The stigma of involuntary childlessness. *Social Problems*, 33, 268-282.
- Miall, C. E. (1994). Community constructs of involuntary childlessness: Sympathy, stigma, and social support. *Canadian Review of Sociology and Anthropology*, 31, 392-421.
- Pengelly, P., Inglis, M., Cudmore, L. (1995). Couples experience of counselling in treatment centres. *Psycho-dynamic Counselling*, 1, 507-524.
- Persaud, R. D. (1993). The career of counselling: Careering out of control. *Journal of Mental Health*, 2, 283-285.

- Sandler, J. Dare, C. and Holder, A. (1992). *The Patient and the Analyst*. London: Karnac Books.
- Schover, L. A. (1981). Male and female therapies response to male and female clients sexual material: An analogue study. *Archives of Sexual Behaviour*, 10, 477-492.
- Silverman, D. (1993). *Interpreting Qualitative Data*. London: Sage Publications.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271.
- Smith, J. A., Flowers, P. and Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (ed.), *Material Discourse of Health and Illness*. London: Routledge.
- Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith J. B., and Walsh, S. (1997). standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, 108, 3-7.
- Whitworth, B. (1996). *Infertility*. Shaftesbury: Element Books.

Appendices

1. Consent form
2. Interview schedule
3. Letter to potential participants
4. Recruiting advertisement
5. One verbatim interview transcript
6. Notes for contributors to *Journal of Health Psychology*

Appendix 1. Consent form

I the undersigned give permission for Eldad Farhy to use this recording of an interview about my experiences for research purposes. This permission is given on the understanding that neither he nor anyone who may examine the recording, will reveal any information concerning me to any other person.

Signature:

Date:

Appendix 2. Interview schedule

Remarks for the interviewer

Explanations to interviewee

Main questions

prompts/continuation questions

* It is intended that all Main questions (**Bold type**) listed in the interview schedule will be asked and that supplementary ones (underlined) will be asked only when replies to main questions would seem to have been laconic. It is nevertheless possible that participants' material may make some redundant. In such case the questions will be either eschewed or reformulated in an attempt to elicit more information.

Before the interview proper, the interviewer should introduce himself to the participant, summarise briefly the material contained in the information form previously sent, explain again about confidentiality and inquire about any other queries the participant may still have. Demographic and consent forms should then be filled in by participant and interviewer.

Sub Fertility

I'd like to start this interview by getting to know about your experiences from the day you found out about your sub-fertility until today.

Would you first tell me how you found you were sub-fertile?

Did you have any prior suspicions that you might be sub fertile?

Could you tell me about your experiences since diagnosis?

Thinking back to these times, could you tell me what changes, if any, have you experienced in yourself or your experiences since?

can you describe the changes that occurred since then?

What sort of domains?

Changes in the way you see yourself?

The way you feel about yourself?

What would you say caused these changes? *Find out about timing motives external and internal causes long term effects.*

Dealing with SF

People deal with sub-fertility in different ways, Could you tell me if and what you have done about it?

What made you choose this option?

Have you considered any other steps

How do you feel about the steps you mentioned?

How have the steps you chose affected your life?

Find out about targest of their feelings, relationships, the procedures, their selves.

What if any thing you plan to do about the SF in the future?

If this doesn't come through what will you do?

Can you tell me more about?

Social Support

when you were trying to deal with the sort of issues and experiences you've talked about,

Have you turned for support to someone else?

If yes. Who have you turned to?

What did they do or say that proved supportive?

In what way was it supportive?

If not. Was the reason you didn't turn to any one else to do with you or with them? I mean, were you unwilling to ask for support or did you believe that no one could provide it?

To both. **Support is not always forthcoming when we need it. Were there any people that could or should have supported you but failed to do so or did not do as much as they could?**

Have some people stopped providing support since or perhaps come forth?

Could you explain what more could they have done?

How would this have been supportive?

How did your need of support change since diagnosis, if at all?

Partner

Could you tell me how did you partner react to the diagnosis?

Do you think it changed her view of you?

In what ways exactly?

How has this issue affected your relationship?

Could you elaborate more?

If hasn't told others. **What do you think would be people's reaction if you told them about your condition?**

Self concept

From what I've read it seems that people often have an idea of who and what they are, a self concept, and that seems to change through life, particularly after important events.

Since your diagnosis do you think you've changed in terms of how you see or think about yourself?

In what way has it changed? *Positive or negative.*

What do you think caused these changes?

Part of our self concept is our physical self, has this aspect of your self- view changed at all? How do you think these changes have affected you/ your life?

Depersonalisation

Lastly there is an effect I'd like to ask you about, its called depersonalisation and means a feeling of not being oneself in a quite concrete form.

Do you feel that you're looking from afar even at things nearby?

Can you tell me more about this?

Do you find yourself wondering whether you really exist?

Can you tell me more about this? When was the first time you felt this?

Do you feel like your arms or legs are no longer attached to you or your face feels like plastic?

Can you tell me more about this? Do you remember the first occasion you felt this?

When you feel happy about something do you feel out of touch with the feeling itself?

Can you tell me more about this?

How long have you felt like this?

Experience with therapy

As you know this research is part of my doctoral course in psycho-therapeutic and counselling psychology. I therefore would like to ask you about any experience you might have had with therapy. By therapy I refer to any form of psychological help counselling or talking with someone who is a professional or volunteer rather than a personal acquaintance.

Have you had any therapy concerning or following your diagnosis?

If yes. Could you describe the experience for me?

How useful did you find this?

To what do you attribute this? I.e., skills, training, approach, personality, etc.?

What were you hoping to achieve in therapy?

To what extent was it achieved?

What or who so you think was responsible for this?

What was helpful about the therapy? How could it be improved?

If not. **Did you consider going for therapy?**

What stopped you? Why didn't you?

Would you consider therapy under other circumstances. What are they?

Why then?

Is there any other material you would like to speak about or that you think I should be aware of?

Have you any questions?

Appendix 3. Letter to potential participants

Dear _____

I am currently reading for a Psych. D in counselling and psychotherapeutic psychology at the university of Surrey. As part of my doctoral training I am required to construct and carry out a piece of research relevant to the practices of counselling and psychotherapy. As a sub-fertile man myself, I have had first hand experience of this condition and believe that there is a discrepancy between the actual psychological effects it has on men and between psychologists and therapists' beliefs about them. This belief was supported by the results of previous work that established that although up to half a million men in the UK are sub-fertile, little is known about their feelings and experiences. In an attempt to redress this situation I am currently interviewing men who have been diagnosed as sub-fertile and who have not fathered a child yet, to learn from them about their experiences and feelings.

If you agree to be one of these men you will be asked to participate in an interview expected to last between an hour and two hours that will take place at your home or at a place of your choosing. The interview will be will be taped (audio) but identifying details such as your name and address will not be recorded in any form. Moreover, any potentially identifying data will be altered to protect your anonymity. In the interview you will be asked about your feelings and experiences

after diagnosis and about the way in which you view yourself and your relations to others. Although none of the questions is believed to be difficult or intrusive, I realise that some of the experiences I will be asking you about may prove painful and you may avoid answering any question or terminate the interview altogether at your sole discretion. Similarly, if you have any questions or doubts please feel free to raise them at any time. In addition, please feel free to call me or one of the support groups whose details I will supply after the interview if any doubt or problems arise at a later stage.

Although I am unable to pay participants, I hope that by learning from you I will be able to become a better therapist and that if published, this work will help improve the support given to sub-fertile men elsewhere. If you wish, once it is completed you may receive a copy of the research for your use.

I hope I have answered all your questions but if you have any further queries please do not hesitate to contact me. If you are willing to be interviewed please contact me so that a mutually convenient time could be arranged. If I do not hear from you within one month, I will assume that you chose not to take part in the research and will erase your details from my records.

Thank you for your attention.

Yours sincerely

Eldad Farhy

Appendix 4. Recruiting advertisement

Published in dedicated Sub-fertility newsletter and posted on Internet Sub-fertility sites.

Volunteers required for psychological research on men's experience of living with a fertility problem. I am looking for men who:

A: have fertility problems.

B: have not yet fathered a child.

C: live in the south-east or the Midlands.

If you answer this description and are willing to participate in an interview lasting one to two hours, please contact me for further information and without any obligation at the following address:

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

No traveling required - No testing involved - Strict confidentiality

Appendix 5. Transcription notes and sample transcript

The notation used when citing participants' comments (adapted from Potter and Wetherall, 1987) was as follows:

Material in square brackets is classificatory information:

E.g., A few times he (counsellor) got so frustrated with me

Round Brackets () indicate inaudible material or whose accuracy was doubtful.

Q: Interviewer

R: Participant

C: Participant's wife

Interview.

R: So we are all here, hello Eldad.

Q: Yeah, I just want to see.

R: No problem

Q: I found that it is not a very good one. OK. To start this interview by getting to know.

R: Ah yes ahm , by me having semen analysis which was done by a doctor in the UK ahm the poor motility and my feelings ahm are on discovering that made me feel not like a man it made me feel useless, hopeless it made me feel a failure ahm generally made me feel dreadful ahm and then I worried about it continually all the time and that I think made it worse. Ahm and I don't say that ah I felt responsible that I wasn't able to get my family. Sorry to give my wife a family you know that what she wants that's what we both want and I felt that I was the weak link and

not being able to do it. Ahm the other thing was especially, there is my brother who has got four children and my wife Mel's sisters, there we are we are done so its made me feel absolutely dreadful absolutely () that there is no real research that I could see on men's infertility. Lots and lots and lots of work has been done on women but nothing on, on men and that's the reason I'm happy to do this interview because I feel its about time that ahm come forward with these problems and then get it sorted and maybe if we could get some results, maybe you know we'll have a family now. You know in that respect.

Q: Just want to?

R: No I didn't, I, I didn't think so. In fact, when I realised that I got a problem, no I didn't think so. I think, I think it, it I found it made me lose my confidence in a lot of things. Ahm I felt that I, I wasn't ahm, fully, in that respect. That ahm that anything I tried to do, it was going to fail anyway because I'm a failure and it made, that's it, that is it, what summarises me. Ahm I cannot have family, I cannot give a wife a family, therefore I failed the most basic thing on the planet really and I just ah ha ha, I know to, to, to create children and we can do many things but I mean that's very very basic isn't it, in in ah life and in me. Very deeply, that's my approach to everything and I mean everything has always been oh it wont work, that's no good then why bother and that in itself I think you convince yourself that ah that you're just not going to get there. Ahm and I think that's very, very bad. Only these few years or I rather should have said there was a point by which I didn't want to tell anybody I didn't want to know. I didn't want to tell me family and I didn't, we had during the hospitals and such things and I didn't want me

mum and dad or anybody to know about it. Ahm and then progressively over the years I tend to think when I when I perhaps been with other people that have children and hear the way they speak about them as though they are just a matter of cause and that ahm you know they are just a damn nuisance. It made me think oh sod this, excuse the expression. I'm going to come out and tell the people, yeah I cannot have children, yeah I cannot. Yeah we cannot have children, you know. And and that's I think in some way enabled enabled me to feel better because I've not hidden it. I mean, I've only been in the company I'm working at the moment I've only been about three months or so and people know that we are going through IVF. Perhaps years ago, I've wouldn't have said, said a great deal about it. But what the weird thing I found that that ahm people that I talk to they say, 'oh yes we know someone who is going through IVF' and its the majority and not the minority ha, I thought it was a minority but to be perfectly honest, this nearly everybody that I talked about IVF they say '*hey they had an experience*'. On the weekend I was talking to somebody a young a lady and just talking to her and she said '*oh yes*' she said '*I've been through IVF*'. Every other person you speak to has seem to have some association with it somewhere along the line. And I think that the work that you are doing in, in sort of investigating male infertility in that respect then. Ahm trying to establish you know why perhaps men don't come forward with these with these problems, I think fantastic research and I think ah (laughs). Yes well, I've taken that many drugs () and vitamins, we have been taking for years we've spent ha, ha, we've spent or have done we've spent something like two hundred and fifty pounds on drugs and vitamins, all manner of,

of supplements, we have taken. Ahm, we've even gone along to I've gone along to yoga classes, try see if I can do something about any stress problems that I'm suffering. And then, I remember that because it was a yoga class with lots of women in there and of course it was rather unusual for ah (laughs), ahm man in between all these ladies trying to do legs in your air, in the air and I but, it was that sort of well I don't give a damn anymore. I want a family and I'll do whatever is necessary to have a family. Ahm, the others things that I've done is that we've followed up leads on television for example if there has been a faith healer that's been on television, normally speaking we wouldn't consider going with that kind of mumbo-jumbo, but to be perfectly honest, if you hear anything like we think well, should we go and spend another seventy pounds then and we do we just go along we want to know about it my wife Mel and I and generally speaking, we just try and do anything to improve the situation. But the other thing I find and that is just going on to perhaps not the tan() to your question but when we succeed and get fertilisation, it makes me feel absolutely fantastic and its a total opposite to the way I feel anyway because I feel bad because I cannot produce children but suddenly to have fertilisation it's absolutely brilliant and then we live on our nerves because (laughs) it's more than likely to go in and fail and when it fails I get the fall as well. So it's ahm, someone will be () in Stafford and I'm afraid they, they just took our pretenses and our experiences in that order. So if there is anything if it meant if it meant going to the north pole, we'll go to the north pole, literally. Ahm, ahm I've listened to people at work have told me about something they've heard on the radio or some, some interview they heard with a doctor for

three minutes on, on a program and this new breakthrough and I want to know what it is so I quizzed them about it and then they bring a newspaper cutting and then I chase the newspaper editors and then they put me in touch with the journalist that did the report ahm maybe I've spoken to a BBC commentator for (laughs) () this or I'll come back and I'll say to Mel, 'oh so and so said such and such I'm going to do this here is the telephone number', and I'll spend, ahm a long time sort of trying to find out who they are I'll route them out and I'll find where they are. Ahm the other thing I've done, I've spoken to drug companies. There is a drug I'm not sure what its called now but something like Tomoxiphen, that is the one, thank you yeah tamoxifan and I, I'm told if you take this Tomoxiphen what it does it increases the motility from what ever it its you know to what you need an eighty percent mark and ahm so I ring up some of these drug companies to find out that this marketing on different brand names and eventually I get through to a to a sales rep a drugs sales rep and you find eventually that its no good to be taken by injection for example it has to be taken by in a Pitery. Pitiry dish is it I think. Ahm, so you think yeah, yeah great I found this new drug and lets go for it (laughs) and to be perfectly honest its just fails. Dogs again, you just, you just all these animals and areas that you look in usually they just they do IVF again. And IVF I find very, very stressful because underneath I'm just want a family myself and I think when you have a family I'll get over my problem because I got a family so the family has gone away and I could then feel better about meself and you know you could be hopefully, be like everybody else and be normal and you've got a family and, but Mel hurt and upset and I think, god, you know this thing between me legs is no

good. And I'm afraid that's how I think about it now I, I speak plainly like that so I feel if feel angry about it but there is nothing I can do! I'll do anything but I just cannot do it and time's ticking away which is another worry because another thing we come up and ring up one of these IVF clinics and I'll say 'yes you need to come in for consultation, but we are fully booked at the moment, if you could like to give me call at the end of the month' so that's another month we've got to wait. You give them a call and they sit you in and you find yes that's six weeks. So then you have to wait that month plus six weeks now two months and you haven't even got anywhere near taking any drugs or actually getting there or even have a word with you know. Semen analysis for example, you haven't got anywhere near any of it ahm and all the time we found we've been told that also for reasons and an awful lot of books and literature and publications from issue ahm, its says that really the conditions of eggs and sperm in such high all changes I think a logarithmic scale so if you're twenty two then you get say twenty eggs, you get sort of twenty eight and you get fifteen eggs and it really then it drops off considerably. But ahm, really it's the time that you spend waiting its really detrimental and repeat in the technology they don't seem to have grasped the urgency so they seem to be wondering why they been doing it I think and this fact that yes we got to get you in pronto quickly tomorrow morning and that such of urgency that I mean we both know. They don't have.

Q: So, how do you feel about that?

R: Disappointed grossly disappointed because I thought that at least one of those steps, one of all those we've taken thought, one of them will be fruitful. Excuse the

expression there. But I thought that if nothing will work, we will just keep going if we do this and do that, if we keep calm it will work and we both thought it and each time we just got over all of the hurdles that we had in the last treatment. For example, going for the IVF treatment and you thought it was in now. Well finally it was and you experience disappointment and with all the drugs we take, it costs a lot of money, we've been conned, tricked, that's the same thing and and throughout the country and we stayed in hotels up in Yorkshire, we've gone to seminars. And I think people seen Mel in the respect was not interested in the people in the past and in what people have done before in that respect (). It's, it's very, very hard, like I come home and I say to Mel, oh it make someone through IVF and its, its not gone right for her. In some ways its, its as if she can think well somebody else is trying and well we got its not just me its not you know try and feel that she's not alone but ahm really speaking, I think its very personal, isn't it? I mean, having a family is your own thing and ahm I think, what people do ahm its you know. I think what you're trying to do is always in your background there is always this ahm, cloud that hangs over us both and and that cloud were going to go through some type of treatment again, we've got the money together so the stairs carpet and we wont perhaps do this and we wont perhaps do that what we'll do we will save and we have really identified a date and we've identified a target and we just know we live with this sort of, of expectation, ahm this expectation of taking some further treatment and ahm. So what we tend to do, we tend to do, what's the word, colour your life black and white. Does that sound strange? The things I'm saying, if you know what I mean, goes black and white, grey we don't,

we don't have an interest, we don't, sort of, we don't have any friends as it were. We don't really rich, we're too involved and we're too focused on our family and we don't really, we don't go to play squash and not play football, we don't go. Its sad really, because its, its another its bad enough not having a family and a normal life to not, not go out with friends and live like that ahm you know there's no recreation at all. It's just work, you're in it and were not happy with it at all and we just want change, think if we could just change, wouldn't it. You know all I tend to do is just to keep me eyes and ears open and always, always, you know new treatments any breakthroughs that happened. Sometimes I hear, you know, a treatment on a television again in America and when that's over, I investigate. Probably what's its all about or sometimes realise that its just the same it isn't really an advance you know it's not going anywhere really. So I keep looking, but as far as I can see at the moment ahm, we keep taking vitamins and vitamin E, its supposed to feed the sperm, all manner of things.

Q: Now if nothing comes through what will you do?

R: Say again, if?

Q: If nothing works?

R: Oh if it fails, if it fails. Then I think I'd have said to Mel in fact if we cant have a family of our own, what I've said is rather than go through life and try to hobble along in a sense because this is what we want we both want a family both definitely want a family. I've said to Mel that perhaps we will look at a compromise and the compromise would perhaps be give a nice home to some children this and adopt children, that's what we would do. And they are, there were here and think if we

wouldn't call it an empty life. Yes I would, it is an empty life we don't, we haven't got, how can I put it, we're in a, we're incomplete family in a sense, because its, we want family, we can't have a family and therefore its unnatural. Ha, if you follow and so all I wanted to do is to find compromise and meet that if we possibly could by adoption and we will take this way. I think and it's not something, it's not something that you can just go from ahm go from say all right we wont, to our own children, we'll have somebody else. It's quite a hard thing to do in your head and I think, I'm right in saying I'll (). First it just hit me one day all, all the weight of the failures of everything and all the ongoing of stresses and strains of it all, I just, one night I just, taking my dog for a walk and I just thought, that's the answer. Do it, don't mess around, don't waste your life anymore. Both of us do waste time, don't waste your life compromise and within a year or what ever it might be or what ever time it takes it there will come a time where my, you know, you've forgotten about the IVF treatment and you put all your effort into the adopted children that you have and that's me view. Whether I'm right on it, I don't know (laughs). That's me views on it, that's what I think ahm. You know, I think would happen, compromise at the same time you've given a home to a child or a couple of children. In that respect helping them in life. So I'm fulfilling a parent role. I suppose in that respect and I think, that's a good decision to come to. I think, she's come a long way around to it, but it's hard, hard for her. More so than it's for me, because there is more, you know, its more as a female. The mothering aspect of it and and a lot of it is not going to be there she's got to generate that because if we take ahm a child at the age of six or seven and its not

like having your own natural child a baby and you've got all the instincts everything that works in that way so I think it will be very, very hard in () in view of that feeling I, I have, I don't know whether if its to do with this question, but ahm I feel extremely angry of a, almost on fire, that's a strange experience, I'm really, really angry pen () of and very angry with it all and when I mentioned about the adoption of a young girl who got a degree and I think, she was qualified by age and I told her, I tried to get it across to her the fact that we've been through the machine, we've been through the chopper, you know, we've been through it. And here we are sort of fortyish, forty-four, forty-one, this sort of ages and this young bint and she got a child, so she was a complete person yeah. And I was trying to sort of explain to her because she was speaking rather natural fact and they go from this point, to that point, to the other point, to the next point and I tried to explain to her that the sort on , terrible experiences that we had, explain this one situation and then she said to me, she says, (mimics). 'Oh' she says, 'I can see you're angry, you got a temper.' She says, 'you'll have to drop that.' She says, 'if you are going to adopt.' She says, 'yes, I'll make a note of that, you can't.' The clinic two days before D day insisted that, or, or said to us, 'you must go out and get some drugs' and yet you'd said we are said to have paid five thousands pounds which is a lot of money to get all the suffering and sweat to get that and then a doctor to turn around and say 'oh we haven't got the drugs they are not in the country, you could try these two numbers if you like and give us a call when you got some and come back Saturday morning'. Ahm, she failed to see, to make the connection. That, that was (laughs), that was anybody like in their right mind

absolutely livid. But she said (mimics). 'Oh no, I can see you got some an anger and you'll have to drop that.' And I, Mel sort of nudged me as if to say, calm it Pete, you know you'll have to just nod at her and that I find distressing. I'm angry hurt now (laughs).

Q: I, I can hear that actually, this actually brings me to that.

R: Oh no. Yes is the answer, I suppose, but, but its been its been on offer but only from a token point of view for example on quite a number of occasions I've gone to see the doctor and I've said look we need to, 'you know, we need some support' I've gone alone and said 'Mel needs some support' 'yes we'll send somebody out' and , we'll, we'll , 'I'll write to you' and you say 'oh that's no good' I can't wait three months I can't wait three weeks', you know, ' come on this is serious do something about it' and from that element that element of it it's been quite reduced the clinic that we go to they're very good there is no question about it the, the, clinic that we are going to at the moment ahm they do a good job they are the best we've been to and I wont mention the name they except that, they actually offer a counselling service but unfortunately this is so contradictory what we just said, we didn't know about it till the second attempt ahm. When you consider going to through all this treatment you need every little bit of support that you can get from anywhere and because it's, it's, it's ahm, an experience to go through, because there is always that failure problem at the end of it and how are you going to deal with that failure and the other thing that I have found and that is that the doctors. We have spoken to in the past and perhaps even preceding the, the treatment for example. And they'll say, 'well, there is no guarantee, there is no

guarantee things. (mimics) Well, oh looks a bit bad, looks a bit awful, looks a bit,' and what happens is, you already feel bad in yourself, so last thing you want is someone that says they understand how you feel to actually say, 'yeah it's pretty awful and your chances are what? Work? You know what you really want, is some lies (laughs) you want someone to say, you want someone to say 'yeah go for it. Just get in there, just go for it. Yes Mel, you'll be all right, just go for it, go for it, we'll hold you hand, we'll help you'. Instead they say, 'well you can do it and we'll ahm ahm. It's all like that and I found that, that is so destroying. In a sense, you come out feeling as though you have, down on your bottom, somewhere you know you feel really yuk with it. And ahm and I think that, it's, I think they need some education, I think they need to actually people and not, not to be so mater of fact about their business.

Q: Do you?

R: At one point ahm, I suppose we talked to me mum and dad about it really, but I don't think they got quite an idea as to what we were saying and we were saying something (laughs). In a big way it was quite difficult, that was an area which I found ahm you know sort of son to father, you know, look father your son is a failure and I, I, you know, sort of brazen that out in a sense. He, he doesn't think of it that way, I don't think. But on the other hand, I'm sure he would like me to have some, he would like to have some grandchildren via me. Ahm so I feel the failure in front of, you know, in front of me father in that respect. And I don't think he quite understands it all, but she, she tries to get her head around it and she's spoken to me, what they have tended to do, me mum and dad, they've tended to

sort of speak to me without speaking to Mel, they wanted to know how Mel feels but have not said anything to her (laughs when says that), because they are frightened of, of upsetting her in saying the wrong thing and its, that's easy done you can do that especially if you are going through a treatment. Ahm you know they, they don't know, they don't know which, which, which sort of stepping stone to step on (laughs) in case they fall in the middle you know and upset us. And so they're put in an awkward position situation really and then they supported to a degree to a degree as far as that could possibly be.

Q: What eh.

R: Basically showed an interest they haven't been along to the hospital and and at the bedside they never have come with flowers, they haven't done that kind of thing and they, they tended to rather than confront them, they tended sort of just keep in the background, but keep a watchful eye on it in the hope its gonna work. So ahm they've also, ahm you know, () through me dad he feels quite upset when he sees Mel upset. Or he knows that she's upset, (laughs) he'll talk to me. But then Mel will say, well I didn't know they've noticed, I didn't know they knew why didn't they speak to me? Then I'll say, well because they did'nt want to upset you and she'll say yeah, so then I have a problem trying to convince Mel that, that you know, they do care. Ahm but ahm, what we have done, we've ahm, we've tended to carry this weight by ourselves, you know, we don't and it is a ah, a gearbox or an engine problem in the family, everybody wants to know about that gearbox or engine problem on a car and its all a big problem its a great big monstrous problem, that that, everybody rushes around, oh Kevin's gear box dropped on the

floor again, oh dear, oh dear, you know, where are we gonna get two hundred and fifty pounds when really! I think, prats, take a real interest in a real issue from a family point of view and another sort of comes along and says there you are here's three hundred quid, would that help? It does nag me a little bit if I can use that expression, because we've helped my brother in the past financially, when we've been overseas and, and things and its, it hurts that he doesn't reciprocate really. I think it's one minute to twelve now for us and ahm I feel, I've reason to be upset that everything we have to do, you know you have to sort of carry the weight of it all and and that's been hard because you still get electricity bills through and you still get problems with your vehicle, you get problems with work and with people and difficult times and things and its just, its just a weight on your head, its just another weight you got to carry with it all. So I find it ahm () it's, i'ts really what I'd like to, I suppose you know just see the end of this IVF treatment and yet, I don't want to see the end of it. I mean you got mixed feelings because you tend to say, well if you go, if you go in five years treatment and it fails, maybe the next time that you go it will work, so lets do it again. Then and then you think, but then again we've got to put our lives on hold again, were not anywhere, you know, we're not going forward, you still got to live like this so, you then think, fuck up no, we wont, no we'll carry on, but we'll have another go and then you put yourself through it all over again, you know, the saving up and ah and other areas as well, I'll tell you. Just recently lately, I tend to let people especially my boss at work to keep him in the picture with regards to IVF and I've found that he's got no interest in children, he doesn't want any, but then it will be difficult for me to

say to him oh by the way, next Thursday I wont be in and he would say, oh I'm not
() yet but I try to keep him aware of the fact that were going trough an IVF
treatment and if you like try to, try to ahm, try to ahm, see where his where his
sympathies lie in that respect, you know, and when I ask for a short leave when we
go for the treatment and yeah OK off you go no problem, that's what I want but
there's another little pressure, you know, so when we look in all in any direction
that you look, you tend to find that there's difficulty like the menopause, the
doctor at the surgery he wont help you out with the drug. The fact that you want
to advertise for ahm donor eggs, oh no we can't do that, oh no, no, no, it wouldn't
be, it wouldn't be the right thing to do, I don't want to do that. He's got two
children, I've asked him, oh he's got his children so he doesn't feel nasty yucky
feelings that you feel yourself and I would love it, I'd love to change places for
uhm a good hour, yes make him suffer. (Laughs)

Q: You pre-empted my next question which would have been.

R: Oh sorry.

Q: Oh no its very good I didn't have to ask you.

R: I've got me soul in here.

Q: Yeah because it would have been.

R: Perhaps I should mention from, from the clinic that I mentioned a few minutes
ago about Change sides () yeah from the clinic, yeah this is good, we went along
for the second treatment and there was, I think , ah support group that sort of
thing. I said to Mel, I said, I think we ought to do everything, go to the end degree
to a. We went there, chit chat, chit chat, chit chat nothing happened. People with

big problems like we have, big problems, no real exchanges of any value, ahm. So we didn't really bother going, it wasn't therapeutic as that. The right word I think, ahm, what we needed is a counsellor and we'll look at her diary and we'll ask her if you would come out and talk to you. So we said, all right then. () Whatever it was, I can't remember what length of time we get a phone call and she'd say, 'oh I will come out and talk to you about this new treatment,' they come out and they, she would speak to us both. And what we found, was that she covered the areas and tackled the issues in exactly the same way that we did and solved anyway. So, so in other words we have turned all the sounds we've looked at it we've bottomed it out. And I felt that she didn't bring any, anything to the meetings that we had. And this discussions would probably go on from, she'd probably arrive sort of seven and just do till something like quarter to ten, half past nine or something in that order. And at least we got some sympathy and she was very nice ahm. Excuse me, ahm we didn't really get anyway and what we also found was that you go through the treatment and there wouldn't be any, there would be no follow up kind of thing, there wouldn't be a phone call, 'can I come up and see you? Yeah, OK fine, when would you want to come? What about Thursday? What about Thursday?' and that didn't happen. What you had to do is to ring her up again and say, 'oh can you come and see us again' () whatever support we could. It was just a waste of time. Just a complete total waste of time. That I found disappointing. Ahm , it was just naughty of the clinic not () anything like in that respect somewhere you can just get this off your chest properly but some one that can relate to you not someone coming along, 'oh they are nice flowers' and give them a cup of tea, chit

chat, chit chat, two hours gone. Because what happens is you got the problem now, when they go the problem is still there. Its not gone. You know. And then I mean (stutters), the other thing that, that happened when () failure that we had I thought ahm I needed desperately to get some support, someone for Mel to speak to or someone that could speak, someone that could be warm and and friendly and, and show a genuine, real interest and real caring. That something, I have not seen anywhere, I haven't seen that, and I'm disappointed in that. I thought, I thought, sorry what I'm saying is that I found that I had to ring up the clinic and say, 'Can you get out. Can you send someone to come out? You know, I need you. And come and speak to my wife, come and talk to her.' 'Well so and so is on holiday at that moment, we only got one, and we can't you know get in touch'. 'Well, I looked in her diary and maybe June the 14th is all right'. 'Yeah but this is April' and I thought, well I got a great () wife, you know, dreadfully unhappy. Things just failed, you just dropped us, ahm I need some support here, I can't. Because, because the other thing is I got my own , grief is the right wrong word, my own feelings to carry and perhaps I'm not carrying Mel. But because its so personal you don't like people in like brothers or sisters or whatever, and mother or father, you don't let them in, you can't really let them in to that, in to the marriage in that respect, I can't let them come in there. It's, it's something that that you, something between yourself and your wife really, really speaking. Ahm, you can't really show, and then when they arrive on the scene you probably dry your eyes and then you and you know, you sort of make a cup of tea and think and think that's the problem. And that's no good because its inside you need someone to come along

and force they way in, force the entry come in to the, 'come on, lets have a look what can we do with this?' be friendly and warm about it all, but that kind of thing is just not there, its just, it just. The counsellors are, well the one the one we've seen, its just a complete waste of time. You just go out get to the pub and have your five pints of beer and come in home and go to bed, you know. You'll be more relaxed (laughs), isn't that right?

C: () emphasis emphasis.

Q:(), and?

R: Tend to question, its always a case of you have to prise information out of them, so the action the actual, what's the word ahm, ahm the actual motivation comes from us, me, us together, you know, it would be a case of if you hear as I mentioned earlier, if you hear of something that's that's on the market or a new drug you () who it is. Its never, its that way around ahm I mean we do receive magazines or publications on, on terrible accounts of people that have IVF and who, and then again you know perhaps the only way the information comes to you really (laughs).

Q: No I was thinking more of the support in the sense of psychological and failures.

R: No, no.

Q: Friends?

T: No.

Q: That come and you know.

C: Can I, can I just add anything, I know that.

R: Basically because the chemical reaction, the chemical, ahm, exchanges that take place in the body, they definitely, they do, definitely do. And his chemical exchanges have taken place naturally therefore he can't measure, I'm not making excuses I'm actually going the other way, ahm he can't measure the feelings that, that you want otherwise have. And again I would like to put him in my shoes for a good eight hours (laughs). I think suppose I want, you know, take that have a good feel of that see what you reckon then, you know. See, see what they would have. I mean, there is an older brother and they've got four children, they're all boys, but they've got girlfriends and they go canoeing, and they got a life. That's another thing I haven't mentioned actually, but if you don't mind me saying it, that is, that's my. I'm going to explain this () when you have, so I view it anyway, when you're, how can I put it? A woman is a woman and then when she has a family, she turns into a mother, she's still a woman, she's still a lady, but she goes that, she completes her circle in the life, doesn't she? Like, like a man does as well, we all do together. What I'm saying is that, you enter this life where you got this family and you got schools and you're too busy to worry about other things, you got to take the kids to the school, you got to do this, you got to do that, you take them on holiday so you must get some clothes and things. You actually, in a family you are living a natural family life and the brother and his wife, looking at that as a point, they've got all that. They've got, the lads have girlfriends and of course me brother is very sort of 'ha, my lad and his girls' they think that, its, its, what's the word, it's ego, ego thing. When we are struggling on the edge of our

limits as it were, trying, trying to get us all a family and he has no idea you know of the agonies that he would go throughout, what, what he would suffer.

Q: Ah ahm.

R: () and awful but this is why I'm giving this interview because I hope that the results of it when you publish it that more men perhaps like that or look at it, 'maybe I ought to go to the doctors? Perhaps its not the wife? Perhaps I ought to go', you know, 'when she comes back and the tests they are OK for her and not OK for me. Oh maybe it's me then' and I hope that that's what needed and I think that ahm. I know I digressed a little bit there, but does make me basically very angry, you know, that people like that, they've got this family and they just got no appreciation what's it like not to. And, so they got a life, I mean they got a situation where the sons are perhaps canoeing or something so they'll go stand there they'll take the picnic basket they'll all go watch him row its only up and down the river, which is you know which is what you do. The other things I noticed, we both noticed I suppose its Christmas for example ahm and there are lots of, where the shops are full kiddies and Christmas things and that sort of things, we find it hurts that we haven't got any children, that we can get little things for, you know, it's always disorientated and I think we both make an effort between us to ahm, make it. The Christmas presents are very nice and we try, try and make it, try and make it something. Really speaking, like Mel said this year or last year, I think she said, 'why bother, what's the point', you know, so I can view, I know how she feels. Ahm, what we did is we had Mel's sister coming down, ahm, we thought that if they came down from Leeds and she's got these

kiddies, these little kiddies come and there was noise in the house you know. It was noisy and there was green paper everywhere and there was Christmas tree and just, it's, it's quite sad isn't it? You know, to have to do that kind of thing and then they all go they all leave then. And then you think 'oh', we are, we are used to this kind of rough, aren't we? So what you tend to do you play at, you actually play the part, you go along with it, really speaking what you like to do is to scream you head off. And you can't you just , I'm probably not explaining myself very well, but I'm.

Q: Oh no, you are doing very well.

R: Am I? I hope so.

Q: Actually it sounds to.

R: No, no.

Q: Just put it sort of a week early, ().

R: Yeah, yeah, I'm fine, are you all right?

Q: Yes, we're getting quite well through it I'd say.

R: It's all right, I'm trying to give you as much as I can.

Q: Yeah. The next question is about your part, your wife, (to her) sorry we are still not asking you.

R: Yeah.

Q: Sorry, could you tell me how did your partner react?

R: The diagnosis. Ahm, to be honest I think () I think Mel, she's, she's got a lot to things, but she was very supportive, I think deep down, I mean I would be if I was Mel, or anybody like that I would say, 'oh bloody hell, oh Christ, we've got a

problem (), I wonder if we're ever going to have a child, you see' and you think well I do, she, she has supported me with ahm, you know, she gives me sort of confidence and that things will work out you know and 'you'd be OK, OK, try again this month, it will be all right this month, come on' () OK, so she's got faith although deep down with something like this and if it's our problem there is not, you know we're not, as far as we knew at that wasn't a great deal that you could do about it. So I think she must have felt ahm very sort of, 'oh god this is not going to work', you know, she must have felt this fear. It will work, it will happen some day, so don't worry so much about it, it will work. And ahm, I think what happened over the years and quite rightly so is that, you know, (stutters), the confidence of that and the fact that the drugs never seem to do any good, my drugs, vitamins and things I used, take Tetracycline and Monocycline and () didn't make any difference, never even. I mean () it would have been nice even a miscarriage, wouldn't it? (laughs). What an awful thing to say, I don't mean it like but just to show that the things would work, what an awful thing to say isn't it? but there you go () hopeless, bring my luck just that other people, keep into the point. So what I'm saying is. And so there was a point by which I think we felt that it's just not going to work, it was hopeless. And I think, we've put the idea of having a family, us knowing that we were still in our thirties round there, with the advance of ICSI we thought 'ah yes this is going to. Disappointed that we have gone throughout ICSI, embryos which was absolutely fantastic and yet we haven't got anywhere. So it could be now that the eggs have passed, you know, the 'sale by date', it's the way they put it over. Ahm, you know, we have cured my problem

or secured it, we have found a remedy for it not cured, ahm but now we perhaps have a problem in the female that, you know. So that's, so that's, that's awful you know for us both. Yes, yeah, that's what I mean yeah, yeah, because ah it has, because I think, with reference to Mel as a wife (laughs), you don't mind do you? No, but yes, I think so, because looking at it from a female point of view, you (stutters) you look to your husband maybe, I would think you would, (), you know, male dominance get out the way, we can do it sort of attitude it's always portrayed that way, isn't it? Look at () you look at people at work, they do that. So in some ways you know things, I think for me to be virile and this is a family bang and it works. We have two daughters, you know, or something like that. The sad bit I think, is that there is nothing I can do, it just doesn't, seem it wants to work and.

Q: As I was saying, my next question was, ahm.

R: Well I think its an emotive subject IVF treatment and ah, and, the fact that we, you can't have a family, we can't have a family. And I think it puts a, it's got to put a strain on a marriage its got to, you know, I, I think it even though a couple is married or together at the end of the day you're both, you're both individuals and ah, I think you both got your own wants and desires and views about things.

Personally, even though you're married, I mean obviously you're individual people and I think, that those kind of thoughts are kept very, are kept personal. And I think, when they get ahm, interfered with or and that person realises that its not actually going to happen, I think it strikes very, very hard at that individual. Very, very hard and I think its only possible to vent some of that to, to your partner. In a

sense, you can't really ahm, describe all of the feelings that you feel inside so I think whilst you feel damaged and very hurt ahm its not always possible to see all of the damage and all of the hurt that a person feels. So I do think that, ahm a couple going through this kind of thing, ahm I think they so suffer, ahm because of it. It does put a tremendous strain on the marriage and you've known in the past where people have been married and they can't have a family and they split up. And I'll be perfectly honest, we've got to that point before, ahm several times, where we find that because it might be because, because I can't produce a family, I can't do it, and I'm no use, I've got no value, I've no use, so what's the point of staying with you. And there is a point, but when you are looking at it through, ahm you know, very dark of grey colour, you know, glasses, then really it makes every thing else look black, you know. So you don't, you don't, ahm you have no value, so what's the point of me staying with you. Like I said, I have known people in the past where they've actually had a divorce, because of it, you know. I mean that really must get to their ah right into their inner most feelings and destroy them with their feelings toward one another, must just be destroyed, because they can't have that ahm bond between them. On the other hand it should be said that ahm a couple should be together because they want to be together for those reasons and not rely on a family to keep them together. So (laughs) you know, there's ahm, there's probably weaknesses that become amplified I think by the fact that there is a missing link there. If that sounds right. Ahm, ah, it just puts a strain, I mean it's, it's quite it's quite severe really, it's not just aahm, moan or a groan, it's, it's a

really, you know, terribly upset. And, I certainly feel for anybody that can't have a family (laughs).

Q: (), well I can imagine.

R: Yes I know, I know.

Q: (), you're () talking pretty much for me.

(talk together)

()

()

Q: It doesn't matter, if doesn't record my question because I have (loud cough) () but basically its trying to improve the availability of therapeutic help.

R: Yes, yeah aha aha.

Q: In addition. When I say therapy I mean any counselling, psychological help or talking with someone a professional or a volunteer anybody except a personal acquaintance.

R: Yeah.

Q: So have you had any therapy concerning or following your diagnosis?

R: No. That's the answer to that. I can't, there is no. I would have liked it, very much so as I said earlier, ahm, and such is that term.

Q: ().

R: (laughs) Ahm, when, when you get to one minute to twelve in the treatment cycle. Ahm, you just scrape around and you search the bottom of the barrel, you'd do anything so.

Q: Aha, aham.

T: I, I'd go for any kind of treatment at all, ahm anything, anywhere I'd go for it if it was on offer but it seems to me that its, take for example the doctors, the doctors in Stratford know, as Mel mentioned earlier, that we were, ahm that we are going through IVF treatment, but no one has written some letters saying, 'how are you doing? Can we help? Can we provide you with counselling'? This kind of thing? Oh no, you have to go down and ask. And then its a six month, sorry exaggeration, it's a long time wait. For weeks at a time, you've gone the three months or the two months, you've got over of the problem because you've had, you've had (stutters) you've got to carry on living. And so whether they come or not you've still got to get through it and you've get through it yourself, that's another thing I haven't touched on really. And that is, I mentioned earlier about, ahm, ahm there are emotions and feelings that people feel inside and they are going to vent some of these feelings and emotions, they can't always give it all out. I, I don't think its possible it's, it's, still, still keep your most inner feelings and thoughts to yourself, just because it's just how you are, its just natural that you don't come out with everything. And ahm, I think really that you know, you need some support in order to, to help that come out.

Q: So from what you are saying I understand that you have considered therapy of some sort. But what exactly is it that stopped you?

R: Ahm, well I think its just basically its been ahm, we've been along to the doctors and its been a rigmarole, its been, you know, trying to generate their ahm, what's the word, support and if you happen to and that's another thing, if you tended to bump into a doctor these days, we don't have one particular doctor you

just, you just get called by a particular one, don't you? in the surgery. Does that, does that doctor really, doesn't is busy, doesn't really want to know about IVF treatment or he, you just, you just get shuffled around, you just get pushed our the door and there is no really interest there. And you tend to think 'well I've got to carry this myself' so you just, so you just go through the treatment without any support in that respect. Which I find appalling really. I think if we were in America, I think it would have been different there.

Q: () OK, () I mean it, if perhaps.

R: Elevate, yeah.

Q: Or elevate or you become, become, () inside your (), but its not only that people see themselves more (), it () when it happens and () guilt and suddenly realise they have in them what they never believed they had and it can have an everlasting effect.

R: Ah ahm.

Q: Ah. The opposite also, there is an accident occurs and rather than doing something they stand there.

R: They freeze.

Q: And that changes their self concept also quite dramatically. But these are dramatic inklings to show what I mean by self concept. So, since you were diagnosed do you still see your () about yourself?

T: Yes I have. Ahm I am just trying to put it into words really. I have quite a difficulty doing that but, ahm, I think I mentioned earlier that, that because of the diagnosis it made me feel, ahm feel that, that I'm a failure, you know. So hopeless

and then, I think as the years have gone on, I've been starting to think 'well damn it, I'm not going to fail at this' through the areas of it, all the areas in life and I think 'well sod it I'm, I'm not just going to be quite, I'm going to stand up and shout my mouth off' and I do, do that ahm, and it does get me into trouble. But its, over compensating for it now I want, I want, let sleeping dogs lie, you know. Ahm I actually stand up and say something, although I didn't do this week I () difficult ahm so it does do, that is, it does make me try compensate for failing in other areas, its a natural thing, its not something that I'm conscious of, but ahm years ago I would have perhaps taken it, taken it. Now, I don't, I'm all, all mostly complain and, and sometimes when I'm doing this, I think, 'oh I don't want to do this, this is not what I want to do, I don't really want to say what I'm saying' but I feel that somehow I feel that I got to. I suppose really its to account, it's, it's to be account, you got to account for something, you know and you've got to feel that you've got a worth, you know. My opinion is valued, I've got an opinion here, you know and. But from another area, coming from another angle, ahm kind of person, I think, I would like to be, I just wanted to be married, some children, a bit of a job that I can, got an interest in and just basically be happy and that's something that I speak for Mel as well I think. Just say if I'm wrong, but we're not happy. We struggle and we fight so hard to get happy and we push and we push and we spend and we push and we save and we push and spend all these sort of things and still we're unhappy. And when you pick up bad days, bad weeks, bad months, bad years and you know tempers fly and we get, and it gets unhappier. And then you think, 'hang on, what's the point of all of this?' And then it gets unhappierer

(laughs) excuse me (laughs) excuse the English. And then it starts to go into a dive in and then there comes a point when you think, 'ah come on this is stupid' and you have to pull yourself out. What I'm really trying to say is that the fact that we've not got ahm, a proper, haven't got a family, haven't got a normal unit, haven't got a normal carry on. We find that we have to compensate for it in, in a lot of ways, whether it be at work the work's got to be interesting otherwise there is no point in doing it. Ahm the house's, you know we don't put a lot of effort into the house as I mentioned, because of the cost of IVF, but we would like a nice house, but, but this has been like this for seven years. And we're sick to death of it, you know we, we, if we could we'd spend the money and say, 'right let's get a decorator in and fix it'. Wont we? We, we, it gets us down. I mean Mel will say to me typically how she will feel she would say () totally un homely that doesn't fit that doesn't fit nothing doesn't seem to fit anywhere, it's the wrong colour, the paper wants changing and I might argue yeah, we'll, we'll do it oh but we can't. All right then. So, so we use.

Q: Sounds familiar.

R: You, you live in a hell because nothing, everything is out of order. You go to work do a job you take the hassle in the job and you think, 'well if I got two kids to, to look after, if I was coming home from work and I've wanted to come home'. I come home for Mel anyway but, 'I'm coming home from work and I'm gone have two kiddies running and jump up at me, then I'm going to forget all me troubles about this gratification about the meeting, about the fact that there is a bit of traffic on the road. But instead what happens is the traffic on the road winds me

up, because I don't want to go to work anyway, because there isn't a lot of point going into work, because, I haven't got any children to support, because I haven't got a family which is the same thing. So well what's the point? So you tend to question what the hell are we doing this for? And we both as it happens are in jobs that have turned into, ahm starting at seven, or starting at quarter past seven, or quarter to eight, some duff hours and we travel the country and we don't get back till seven, or eight, or nine, or ten, whatever a time it is. And its just expected that we've got to do this day after day after day after day. Now, I appreciate that other people are in the same boat, but we sort of look at it and think, well we're rushing our arses off, excuse the words, () where the hell are we going and what are we doing. And what all we are driven by ahm emotion emotionally but feelings, I don't know how you would explain, express it we just think 'well, if we keep on doing this we can keep saving, if we keep saving we can get nearer perhaps having what we want' or having what we need not what we want and and we're just driven by it and it gets you. It really gets us down, you know, you think, Christ why are we doing this. Lets just stop. Lets just get off this. And then you think, well if we get off it what are we going to do? So there is nothing there, we just avoid, there isn't, I mean we could turn the tables the opposite way, we could say OK damn the IVF we'd not want any children, what we gonna do is, we gonna buy a nice big house, we gonna get a great big mortgage, we gonna go pay the mortgage and we gonna get a red car and we gonna go to Torremolinos twice a year and then fall out with each other, because the, the basics are not there, the fundamentals are not there. You come round to an empty house, you've got no life in it. Mel takes this little

girl for a couple of hours and as part of a course she mentioned or something like that, and little kiddies and the privilege to () terrific good and ahahha and what it does to her it that when she comes into the room she makes it live, you know, the place is alive and it's, it's what you've missed, but its false and it's almost like a most () sense, you know, you've got, you've got, you've got something, you know, something in one nest and something in another. (*Change tape*).

Q: Switch that on, here it goes. Then the next question is. Part of our self-concept is our physical self a view of () at this aspect of yourself have you changed at all?

R: Ah, I don't understand the question but () are you saying that () more physical with.

Q: No.

R: No.

Q: How do you see yourself as a physical being?

R: I think I probably let meself go a bit.

Q: Ah, ha.

R: That's the truth of it. And because.

Q: So you think () perhaps, , what do you think of your body? Your opinion?

R: I'm not impressed (laughs).

Q: You're not impressed.

R: No I'm not impressed with it no, I, there was I point were I thought well me stomach is getting a bit fat I thought well, I'd do something about that because you want to try and keep yourself in-trimmed to look light. I'm not saying, I look fat, but you want to look right. Ah and now, I've just reached that point where I

think, I don't care, I think I've got so many, so many other things to occupy my mind.

Q: Ah ha.

R: Ahm () taking all me troubles and problems and what have you so, I don't really, that's the last thing on me mind really.

Q: So ahm. Some people have described after being diagnosed () is like shoddy goods, they suddenly think of themselves as you know what sort of a, if it was a machine I would have returned myself to your shop.

R: Yeah, yeah, I feel like that, yes I feel like yeah definitely because it's, it's not. I mean this is my body that hasn't shown me what kind of a child I can have. You know its that that just, what I, you know, I, I can then digress in that but the () question is what the hell am I bloody doing. Why am I here? What's, what's the point of it all. And I think, Mel feels the same I think to some point. I think she thinks 'we'll hang on a minute what sort of a', (laughs), you know. 'Why can't I have my own children, you know what's, why can't I?' Ahm and you start to question what the bloody hell are we bothering for? Why, why the hell am I here? Ahah, there must be some kind of purpose. But of course there's a big question mark and you can't, you can never, you can think any answer you want and it'll fit, you know. Because you don't know what the right answer is.

Q: OK do. I'd like to ask you about now you might have () a complete form like.

R: I'm with you, I understand you.

Q: And do you feel sometimes that you are looking from afar even at things nearby?

R: ().

Q: In plain English, it means, do you feel detached sort of? I mean really detached from things.

R: Yes I (), I very, I feel detached. The word I want to use was excluded is a is a feeling of I feel ahm excluded. I, I think, ahm I don't feel whole, ahm we both don't do we? We don't feel as though we're, we've you know evolved, we've gone through adolescence, we've gone through the boyfriends and the girlfriends and that sort of thing and you've evolved onto a plate where by you think, OK here we are, we're married we've got children, and, and we've got this that and the other and, and, you know the basics even if not all of, but even the basics we we feel is if though we you know we haven't really achieved this all being foremost, its almost like as though we're camping (laughs), you know, what I mean, we haven't settled yet. Not there it's, it's. And then, everything that you do is perhaps not permanent you know, you, we might move into Bristol. Oh yes, for how long? You might move to London, oh how long? We moved to Stratford on Avon. For how long? Because if you had, we had a family, then your anchors are through then at both directions, you're stuck, you say, I can't move because that school is great and I've got to do this, I've got to that and and some good neighbours next door that do, whatever. And you know, really you don't want to move so this is really home isn't it? But it doesn't, although it is a home it doesn't feel a hundred percent like one, it feels like ninety-eight percent. If that makes any sense, I don't know. So I do feel detached from, from a lot of things like that. Ahm I've got ideals but I don't know how I'm going to change it, but I've got ideals, ahm I think

I've mentioned to Mel the other day when we, talking about what the ideal would be, to be in a village and and maybe at bonfire night for example, and, and ah you know you get a knock at the door and there's some friends from down the road with their three kiddies that would come and, you'd, you'd get your things and get your cool box and and we're taking this on the barbecue, and its just a silly ideal which I've got on me mind about, and I think what I'm really trying to say, express, is that family thing you know? Where, where, where there is a lot of fam, fam (stutters) familiarity you know what I mean? And it's just isn't there. What we have is an insular kind of existence, which we're sick of, you know. We've, we've, you know, the other thing that I find and I'm di, digressing and that is that. Some of the, some of the friends that we had, have being long sympathetic towards this course and they tended to have their, they've had their family, you know. They'd done that, been there, got it, its gone wrong for them so therefore, don't do it. Ahm since time began, people have been having offspring, people families, haven't they? Ahm it doesn't always work out. And ah, you know, we've had, I don't know, uncomfortable conversations with other people and we think (), if only, you knew how we actually feel or could feel inside. But of course they've been done it, its not a big hassle and they are doing other things now and they're not hung up it like we are. Ahm, ahm, yeah.

Q: Do you find yourself wondering?

R: I don't think, () I try not () I don't like to get that hard or that deep but ahm not really. I'd, I'd, it popped into me mind sometimes, when I'm mindlessly driving to work and I think what the, what am I doing this for? Because when I get there its

only a dose of pain and then you come back and then you got to, another dose of pain the next day and then it gets better (laughs) ahm so you just sort of do this mindless thing from week to week. Ahm it sounds pretty sad, doesn't it really? But but ahm I suppose really don't, really attach any real purpose to it. I mean, you go along, ahm some times I'll be confrontational, you know. I have been today and I thought, well why were you like that? And I thought, well damn it why not? Why not? You got to account for something. Ahm, if the person doesn't like what I've put down, well, stuff you. Excuse the expression. But, but that is me. How I would be if I was complete. That I would, I, I would be protective and think, 'oh yeah, OK I'll change that for you, sorry about that' you know. I might be a little bit, wont say subservient but, but I, I wouldn't be so, I wouldn't be aggressive (laughs). But I find that I can be and I don't want to be. That's odd, that is odd. And I think, 'oh dear why did I say that? () Why bother just say nothing. And I hear me and I'd say and I think to meself 'don't say any thing' and it can happen and that's why () before that, I gotta say it. Then I'm in trouble, wow.

Q: Ah ahm.

R: Is that right Mel? (Small giggle)

Q: When you feel unhappy about something do you feel out of touch and.

R: No I don't know. I don't know, quite a bit. No I'm not quite sure what you mean there? But no, I don't, I don't ahm, (). There are times when, when this problem can get the better of you. And what, what we, both of us trying and do is, I, think keep that feeling at bay as best we can. Ahm you know we, we always try and look at the positive side if we can, but generally speaking, we are on the

negative side anyway. So it's, it's, so it's always a fight all the time, all the time to even get into the neutral position. (laughs) It sounds, you know. Whereas take me brother for example, with other such people ahm, they're always in the positive they're in zero or positive position all the time, you know. Its going for them, it's happening, you know, it's, it's, we're going to go and do this, we're going to do that. Whereas we're still on the negative side, trying to get to the positive side. I don't know if that makes any sense. Yeah? You know () Christ () come on. I mean, Mel said to me, we've talked about it when we were saving this money up and she said it ahm, when all you know, you could go do that, it don't matter. It'll probably wont work anyway. And I said, well come on if we don't do it, it wont happen.

Q: Ah ahm .

R: If we don't do it, no one is going to do it. So let's do it. So then, I'll bring Mel around it and then there, There'd be another day when she'll say, 'well it aint going to work anyway'. And I'll say, I know it wont but lets give it a go. So there is both of us negative then, you see. So. But there is no one there with the arm round you sort of saying, 'go on you two, go for it'. That's, its constantly. Perhaps I'm looking for something that's never going to be there, I'm sure, I am. But ahm, we, we lack a lot of support like that, we're left to () (stutters), you know () (stutters) on our, you know, we get on () to drive, you know, a lot with these kind of things. So whenever we do, we have to motivate each other. I mean, Its quite hard, quite hard to do, you know, it's, it's easy to, to give up. I mean there are six attempts of IVF we had now, ahm we've had some struggles and Mel said, 'oh I' I've done the

drugs, I don't want to do this anymore. I'm not doing it again. I don't want to go through it'. I know, I don't. I know we don't, but if we don't go through it, it wont happen.' 'Yeah but it's this, this,' and I said, 'I know! So just give it another go, just, 'we'll, we'll see.' And then, somehow from underneath, privately going on with Mel, is that she's saving the money or she's saying it. Although she is saying, 'I am not going through it', she's just put another fifty quid away. I, that's why I was going back to what I said earlier about this, you can be a couple, you could be together, but you're individual. Of course you are, you're not joined at the hip and and you know and the other person is thinking deep down, 'I want a baby, I want my own family. And I'm not going to let what's going today, even though I'm saying to you, I don't want to do it. (Laughs) I'm not going to let that, stand in the way for me'. Does that make any sense? It's ahm, its like saying I don't want to but I do really. You can't make, that's not logical. But, but the way I think this current, this is so deep an emotional really, that you can actually, you can actually, ahm, you know. Ahm be like that, you can be black and white, all in the same time. And ahm, that's confusing. And then you still got to carry on your logical day to day existence of people. Ahm, Mel is the same to some extent, she is non-confront, non-confrontational, she wont ahm, she will avoid an argument with anybody if she can, she'd rather say, 'oh don't, leave it, I wont say anything'. But I've noticed through the past five years, she will be like that, if she's got something to say she will damn well say it. And that's not, I don't think that's her personality. Perhaps she's hidden it all this years? But I don't think she wants, she just wants a happy carry on, you know, a bacon sandwich and a sit outside in the warm, read

the paper and feed the kiddies and take the dog for a walk kind of thing. Just normal, normal, totally, totally normal. And, so to have strange feelings where you think, 'oh I'm not going to go on, I'm not going to do this, I am really, I'm not going to go through it, but, but I will. I'm not going through it again'. It's not logical. And that's how we got past these, these past six attempts. Ahm, I can't pick the bones out of that lot really, but either we're mad or we are mad I don't know. Probably mad. We. (to his wife) Are you there?

C: () want to have kids now (both laugh).

R: () what do you think?

Q: No, go on, ask, can you think of anything, ().

R: Oh right, I was just trying get Mel to jolt me memory. Ahm, I think, ahm and I think, I might have touched on it really, but I think the medical profession, no matter how much they would say, I'm trying to (), I do understand your predicament, they sure as hell don't. And I stand up straight and say that. Because they do not, they do not. They haven't got one idea of what its all about. But ah think they do their job and they follow their career but when it comes down to the to, to the understanding the human, the humanistic aspect of it ahm, I haven't come across one yet, that really understand. And even the people who sit by the side of you ahm, nurses and such like them, they are brilliant people, they are brilliant people. They ain't got a clue.

Q: Ah ham.

R: Ahm if they did, they wouldn't have you charge the country looking for drugs that aren't there. I think that has ahm, that's awful, thing to do to someone. To

take their money, I mean money is (stutters) its a foul thing to talk about, I think when it comes to do with treatment. I think , it, it turns to ahm put, ah what's the word on it, it makes, its a bit vulgar, I think. Really I mean, ahm there was one, the hospital we went to in Bristol, we sat there in front of this white coat as we call it, that's what we regard them as, white coats and he said, 'well for another twenty-five, or it's fifty pounds, I think, you can have an injection of whatever it is'. He said that across the table to us, and I thought, 'hang on a minute, what, what, what a rotten way of saying, we can provide additional medication, medi, medication that could, could perhaps help your success rate. Instead, he said 'for another fifty pounds we could do.' (stutters) I was absolutely gob smacked at, at hearing such a thing you know. I think it's a, it's all to, tend to be that way ahm, the other hospital thing that we went to ahm, people have used and abused the system so it's not, it's not all, you know, all the medical profession that, ahm, tended to be that way. But we've supported ourselves and ahm, one of the hospitals we went to ahm, at one point you could just get green card, your go card before you get your cup of coffee and go and have your treatment. Not anymore, because other people have done that, and they've not paid ahm and its been on eight months or so and they still haven't paid their bill. They've now said, you know where people haven't paid up the money, may have not paid up the bill, ahm we've sort of been, you know, its on demand. You go in there and you got to pay the pounds notes over the, or a cheque, over the table before they'll. It's, it's part of a vulgar taste, nasty taste to the business, it's bad enough, it's bad enough as it is. But ahm, you know to have, to have it coloured by the money aspect of it, you know, its just distasteful,

distasteful. I think, ah I think, I refer to it as ahm dogs on beaches syndrome. What I mean, is at one point, every one can go on the beach and and ah, walk the beach and take the dog. Because if they let the dogs go on and mess on the beaches, it now means that they keep dogs off the beaches, which is logical. If people would have been responsible in the first place, then everyone could have enjoyed it, but ah, that's what's happened you know, that's what happened, isn't it?

Q: I don't have anymore questions, do you have any?

R: Ahm, I just hope that this would be a record (). How, how will you issue this?

Q: Ahm Basically this is going to be a report to find men's feelings, to () problem. This () of my doctoral degree if it's published. Now publishing is the first part of it, which was a literature study. Before asking people, I sat there and said 'OK what do we know about the way men feel'?

R: Ahm.

Q: I sat down and I looked and I came up with particularly nothing. Quite a bit about women. By the way, I noticed you both couple of times answered my questions.

R: Yes.

Q: Those questions I actually collected from research about the feelings that women have about and I said, maybe men, because some of the questions were very open like, 'tell me about feelings you had' and some were quite specific. Have you ever felt you know even when you're happy, you're detached from the feelings itself?

C: That's right.

Q: These kind of questions were from women's studies.

C: From women ()

Q: And that's why () actually confirmed that.

C: () yeah, I said yeah felt exactly what you mean there.

Q: () and so, in the first one I went over the whole stuff and saw there is nothing.

This is maybe to be published in a journal called, ah Medical Psychology.

C: Ah ham.

Q: And it just goes to psychologists that specialise in working with people who have medical problems.

C: Yeah.

Q: Ah, the second stage would be if this is accepted, is to publish this research which basically says, I have spoken to five people, that's no proof. Because five could be a sample. I mean, I could have spoken to the five people who happened to be angry and by the way anger is a very common.

R: Is it? () I feel it yeah.

Q: It's very common, because many men feel they have been let down by mother nature.

R: Ahm.

Q: And been let down by their own bodies and the established medical, psychological, even people around. I mean, if, if you are sitting in a wheel chair everyone sees it and at least sympathises it.

R: Yes.

Q: Because we look fine () men and all that.

C: Yeah.

Q: Nobody in a way sympathises it. Also there seems to be that women take it in a way easier, because much has been done about it and in a way women know to expect that maybe problems. Do you, the possibility always exists.

C: Yeah and I think also the other thing is that, () each other. But, but () when you don't, don't ().

Q: ().

C: Yeah that's, that's right.

Q: Is a man. A man is someone who, pardon my French fucks women and makes children.

R: That's right

Q: And when you can't do one of the two things, you feel, how many jokes have you heard.

R: ().

Q: About, he can't get it up, can't to that. And I've spoken to someone who was, what was the name his friends used to call him? Jaffa.

R: That's right.

Q: () Seedless.

R: Seedless, yeah somebody oh years ago, I think made a joke there and.

C: () The people on television ahm ahm.

Q: Probably ().

R: Oh there is something I wanted, sorry to butt in, there is something I wanted to tell you. That is both of us, we don't sit and analyse anything, we don't sit and

think oh what's he on about we don't do that. What it seem to do, is the, is the offence.

Q: Ah ham.

R: Somehow it seems to materialise itself.

C: ().

Q: ().

R: It jumps, that's right it jumps, we don't look for that, it jumps out of the television and it talks. We've on occasions, we've, we've been offended by some of the advertisements on television, ahm haven't we? I forget what they are. So much so, that Mel has gone in the other room. And I'd ask, 'oh what happened'. We've written a letter and sent the letter off. A letter comes back with a free bottle of gas and a thing and a five pounds voucher () for whatever it is ().

C: I think, ahm ().

R: () () apology but sorry we've got to do it but.

C: ().

R: You're a minority.

C: I got a catalogue through the post one day.

Q: Ah ham.

C: And it was addressed to me personally.

R: Boots.

Q: Ah ham.

C: And I was so offended by it.

R: She was upset yeah.

C: I wrote a letter.

Q: Ah ham.

C: You know the sort of () about () anyway.

Q: Ah ham.

C: And I wrote a letter.

R: Don't care.

C: And normally I would never () through it in the bin, but if felt so, I'm not going to this., So I wrote the letter and I said 'look' I said 'I think your clothes are absolutely wonderful' and I said, I'd love to be able to buy the clothes, I'd love to be able to need to buy the clothes but I can not have children. We have been trying for a family and bla bla bla' and we went into all these details.

They sent back and asked me if you don't () said they're very sorry but their, obviously the marketing people can't cover everybody.

Q: Ah ham.

C: You know.

R: They should.

C: And that ahm they'd like to offer me a, a hundred pounds towards the () at the () find offensive.

Q: Yah.

C: I don't people understand it.

Q: Back to what you said, it will be published, it's not general publishing it's for people who deal with that but you spoke of the counsellor women that you came to.

R: Ahm.

Q: Sat two hours and much didn't do.

R: Ahm, I suppose.

Q: It's for people like her, that it might give her an idea of what's going on with people like us.

C: Yeah.

Q: Hopefully ().

C: It might change their attitude towards.

Q: Knowledge, handling () and again particularly with men they say, 'ah men they take it easier'.

C: ().

Q: If they kids or not and we're as its literally a kick in the gullies.

C: You're right.

R: Yeah it is it is but ahm.

C: ().

Q: It doesn't matter so it goes on taping. Actually I got a bit more information from him.

C: Yeah, yeah.

Q: Like that so it is. So any other questions? Sorry I digressed my self.

R: No () no, no, no, it's ().

Q: Why it's.

R: () keep the refinement.

Q: Thank you and finish the interview by that. I have to make it official.

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Psychological Therapy and Psoriasis:

Understanding the therapy experiences of a group of people with psoriasis

Abstract

Objective. Psoriasis has traditionally been linked to psychological disturbance. Thus psychological therapy has been occasionally used to treat it. However, little is known about the circumstances, processes and qualities that may determine its outcome. This article investigated what factors people who had psychological intervention to treat their psoriasis, believed were influential in determining its outcome.

Design. The present research utilised grounded analysis, a qualitative technique, to examine the narratives of fourteen participants with psoriasis who had engaged in psychotherapy.

Results. Participants believed that a number of elements were central in determining outcomes. These included therapist's and client's qualities as well as process facilitating factors. Transpersonal constituents were described as having primacy.

Conclusion. A theoretical model representing the cumulative and inter-dependent effects of these elements was proposed. Tentative suggestions for further research and therapeutic practice were made.

Keywords. Psychotherapy-Psoriasis-Grounded Analysis- Self Reports

Introduction

Psoriasis is a non contagious recurrent skin disorder estimated to affect over one and a half million people in the British isles (Psoriasis Association, 1995) and over eight million people in the USA (Dungey et al., 1982). While characterised by red lesions covered in silvery scales, there is considerable variability in its symptoms and severity. For some, the disease is primarily a cosmetic defect; for others, it is a severe disability (Taylor et al., 1988). However, for nearly all who are affected, psoriasis is physically disfiguring, anxiety producing and a stressor to their psychosocial equilibrium (Taylor et al., 1998). Moreover, psychological distress is not restricted to those with moderate or extensive disease, but includes many with mild disease (Ramsay and O' Reagan, 1988).

The causes of psoriasis are still unclear as is its prognosis. While most commonly believed to be a multifactorial disease where individuals with inherited psoriatic vulnerability develop the condition when exposed to diverse factors, the exact nature of these remains elusive. Nevertheless, ethnicity (Caucasian incidence is three to five times that of other ethnic groups), environment (summer remission) and familial (significantly higher risk among first and second degree relatives) factors, are known to play a part in its aetiology (Jobling, 1988).

The involvement of psychological factors in psoriasis has been suggested by a number of studies that have established that various psychological disorders were

more common among psoriasis patients and that compared to matched controls they attain significantly different scores on various personality tests (Lemme et al., 1995, Van Der Shaar and Wouter 1977). Because of this evidence, suggestions that psychological intervention may be appropriate in its treatment go back some seventy years (Zachariae, 1996, Folks and Kinney, 1995, Engels, 1982, Zweig, 1931). However, some researchers believed psychological ailments, particularly stress, were aetiologically linked to psoriasis (Al' Abadie et al. 1994, Harvima et al., 1993, Gupta et al., 1987, De la Brassine and Neys, 1986, Shannon, 1979), while others claimed these were a consequence of the psycho-social stress caused by suffering from a chronic skin disorder (Morgan et al., 1997, Jowett and Ryan, 1985). While it stands to reason (and indeed has been found) that suffering from a disfiguring and often disabling condition such as psoriasis (or other ailments) can lead to increased discomfort and stress (Harvima et al., 1993), impair socialisation, lower mood (Jowett and Ryan, 1985), inhibit sexual expression (Medansky, 1986) and cause stigmatisation (Ginsburg and Link, 1993) and that these factors in turn may exacerbate the condition (Seng and Nee, 1997), it is also possible that stress and traumatic life events (Al' Abadie et al., 1994) play a part in its onset.

Significantly, Lyketsos et al. (1986) found that psoriasis patients were substantially more neurotic, stress prone, self punitive and hostile than matched patients with other skin conditions.

The subjective suffering of people with psoriasis has been recorded elsewhere.

Potter (1986) a writer and psoriasis sufferer, wrote,

Most chronic dermatological patients are on tranquilisers or antidepressants, you know, almost as a matter of routine. The skin, after all, is extremely 'personal' is it not? The temptation is to believe that all the ills and the poisons of the mind or the personality have somehow or other emptied straight out on to the skin. Unclean! Unclean! you shout, ringing the bell, warning us to keep off, to keep clear.

Similar feelings were expressed by the American writer John Updike (1976) who referred to his own condition in these words,

The name of the disease, spiritually speaking, is humiliation. They glance at me and glance away, pained.

One of Jobling's (1986) participants wrote,

It is not easy to live with psoriasis because it is in some way a reflection of ourselves, and we feel that we must be eternally on show as being miserable, wicked creatures, with visible signs of our inner wickedness.

However, it must be noted that not all research supported the notion that psychological distress was associated with psoriasis. For example, Harari and Shani (1997) who studied seven hundred and forty patients undergoing a four week balneotherapy program at the Dead Sea, found that seventy per cent of patients showed complete remission irrespective of psychological factors and interventions.

Despite various therapeutic approaches being mooted as alleviating psoriasis - including cognitive behavioural therapy (Zachariae et al., 1996), stress management techniques (Price, et al., 1991), group therapy (Seng and Nee, 1997, Jobling, 1978) and insight oriented approaches (Koblenzer, 1995, Seville, 1977) -

research concerning the efficacy of therapy in alleviating psoriatic symptoms is somewhat scarce. This may be because, as with all research on therapy, it has been hampered by the lack of reliable or even widely accepted methods of analyzing therapeutic encounters, not to mention the ongoing disagreements about the components and processes they encompassed. For example, while stress is widely believed to be among the factors causing or at least exacerbating psoriasis, what is it exactly? Can it be measured and comparisons made across therapies (Heckrath and Dohmen, 1997)? Would such comparisons be meaningful (Hand, 1991) or logically sustainable (Gallo, 1978). Moreover, practically all this research has been quantitative. No one seems to have asked people with psoriasis whether therapy alleviated their psoriasis and if it did, how do they think it did so. Also, remarkably little data concerning the use and efficacy of psychological interventions in cases of psoriasis was derived from British studies. This is hardly surprising, considering that while psychological interventions are regularly prescribed in the USA (Ginsburg, 1996) and Scandinavia (Jobling, 1988), only one out of twelve London hospitals' dermatology clinics offered psychological counselling to patients (Hunt, 1996). With no indication that practices varied elsewhere, the dearth of relevant data, whether due to politico-cultural reasons or to medico-financial ones, means there are inadequate grounds for either justifying or changing this situation.

Research aims and questions

When formulating the aims of this study, it is important, to note what they are not. The intention here was not to test formal hypotheses derived from existing theoretical propositions against data collected specifically to test their validity (Emerson, 1983). Rather, this was an exploratory qualitative study, which aimed to provide a careful account of what a group of psoriatic participants had to say about their experiences of psychotherapy. In so doing, it hoped to identify the important meanings, themes and patterns of beliefs that emerged when participants were asked to describe their experiences and beliefs. It particularly looked at their perceptions of which, if any, aspects of their therapy were, in their view, central in alleviating their physiological condition and psychological distress. These it was hoped would enable the present researcher to formulate a tentative theoretical model explaining the processes that were said to have taken place in their therapy and hopefully link it to existing research.

Method

Choice of Methodology

The aim of this study was to provide a careful account of what therapy processes people with psoriasis believed were helpful in alleviating their psychological and physiological condition. Moreover, because the mechanisms linking psychotherapy

and change in psoriatic symptoms are yet unclear (Jobling, 1988) it also aimed to move beyond description towards a more theoretical account of its findings. For these reasons, a qualitative methodology was seen as suitable since it represents an approach to studying social phenomena that allows participants to speak about their therapy and its processes from their point of view (Bryman, 1988), allows the development of general theoretical analyses and ensures they remain close to the participants' specific accounts, (Taylor and Bogdan, 1998).

Although the decision to employ a qualitative rather than quantitative research method was a technical matter whereby the choice between them was to do with their suitability in answering the research's questions (Bryman, 1988), it also involved epistemological issues beyond questions of data gathering, analyzing and reporting (Henwood and Pidgeon, 1992). In attempting to investigate the meaning and significance people with psoriasis attributed to their therapy experiences, this study ill-fitted the positivist tradition of identifying reliable and objective facts. Its aim was not to test an *a priori* theory via the hypothetico-deductive method. Rather it was to allow concepts to emerge from the data, generating working hypotheses rather than immutable empirical facts (Henwood and Pidgeon, 1992). Its emphasis on engaging the participants' thoughts and actions while attempting to adopt their point of view (Silverman, 1993) seemed particularly appropriate in research guided by counselling psychology's ethos. With this in mind, Grounded Theory (Glaser and Strauss, 1967), also known as Grounded Analysis (GA), a technique which was found useful in similar work (Strauss and Corbin, 1993) was

chosen. GA seemed particularly appropriate because 'it is a way to conduct a qualitative investigation of a topic on which existing theory is, incomplete, inappropriate, or entirely absent' (Henwood and Pidgeon, 1992, p. 102).

Because it does not restrict participants to a preset list of factors or limit their ability to express all that they think is important, individual accounts of therapy experiences could provide the rich and dense data required for GA's generation (Glaser, 1992). Thus a semi-structured interview schedule was chosen (Appendix 1). This inquired about the participants' beliefs' about her/his condition, the mechanisms involved in the changes they had experienced (e.g., what was helpful about the therapy?) and the type, length and role of therapy compared to that of other experiences in their life. The first four participants helped pilot the schedule but since their recommendations did not induce substantial alterations, their material was incorporated in the final data set. All interviews took place at either the participants' residence or at a (secluded) public location of their choice.

A sample of adult individuals with no known probable physical cause to their psoriasis, e.g., metal workers' psoriasis, was recruited by placing advertisements (appendix 4) in various community settings (libraries, health centres). Sampling criteria were purposive in that they excluded people whose psoriasis had a probable physiological cause because the study focused on individuals for whom psychological factors were possibly involved in their condition and those who suffered from additional chronic medical conditions, so that their narratives were

not influenced by experiencing other ailments. As with all sampling criteria these may have affected responses somewhat, but there was no mention in existing literature to indicate that this was a likely occurrence.

Analytic procedure

In accordance to Pidgeon's et al. (1991) recommendations, transcription and repeated readings of transcripts were used to gain an incipient understanding of emergent themes. Data was divided into units of meaning, coded and indexed with the following question in mind: what categories, concepts or labels do we need in order to account for the phenomena of importance in the unit (Pidgeon et al., 1991). Concepts were constantly refined, extended, checked against further data and related to each other. When further coding meant that concepts were re-labeled, their previous labels were noted down to provide a record of the analysis' progression. This procedure was repeated until concepts reached saturation, a stage when further coding added no more relevant information. In a parallel process, concept interrelationships were recorded on theoretical memoranda, later used for theory genesis. Thus a constant comparative analysis of data was used to simultaneously develop concepts, identify their multiple properties and explore their relationships with other concepts. The links between concepts were derived from two criteria: either participants had identified the link or the connection was made because data related to one concept could be classified under the related one.

Those instances of a concept that clearly identified the nature of that concept, were cited as quotations in the results section below. The weaving of linked concepts into a theory was also subjected to the primary criteria of respondent suggestion and multiple facets, while their fit to patterns suggested by previous researchers served as secondary criteria (Strauss and Corbin, 1993).

While numerical data concerning the demographic characteristics of participants will be included in the results, the other findings will be presented without reference to numbers or percentages. Instead, the findings will be presented in terms of impressions gained, as hypotheses rather than firm conclusions. The results will therefore be structured accordingly, presenting the themes and concepts that emerged relating to each question. Verbatim quotations will be cited in support of each theme.

Ethical issues

Participation in this study was not expected to constitute an onerous task, primarily since psoriasis is by and large, publicly visible, so that sufferers are used to dealing with it openly. Still, the possibility that the interviews may have had a deleterious effect on some participants could not be wholly discounted. Hence, four measures were used to forestall such occurrences. First, participants who had been diagnosed with mental disorders not believed to ensue from or to have been

precipitated by their psoriasis or with a history of psychotic or severe depressive episodes were not recruited, thus excluding most of those at high risk of adverse response to being interviewed. Second, all participants were given details of organisations that provided psychological help and psoriatic support groups. Third, the interviewer offered all participants further sessions for their benefit in which his therapeutic skills would have been utilised to help them deal with any issue that may have arisen following their participation in the research. Fourth, following Coyle and Wright (1996), if participant distress had become apparent, the interview would have been discontinued and the interviewer would have attempted to engage in a therapeutically oriented encounter, followed by the steps already listed. Participants' confidentiality and informed consent were safeguarded by handing potential participants a pre participation explanatory letter (Appendix 2.) and a consent form (Appendix 3.) recording only limited personal details.

Analysis

Participants

The sample consisted of fourteen participants, nine women (mean age 33.1, range 23 - 51, SD 8.24) and five men (mean age 30.6, range 35 - 27 SD 4.12). Mean time since diagnosis was 16.5 years, range 9-25, SD 5.55. Two had psychoanalysis lasting three years or more, four had hypnotherapy lasting only a few months and the rest described generic therapy/counselling by therapists or

counsellors. Mean length of therapy for this group was 12.8 months, range 6-23, SD 3.9. Three participants were still in therapy and two had two different courses of therapy. All the participants were white, one participant was a student and the remainder were currently employed in white collar occupations. Two lived in Surrey, three in Hertfordshire and nine in London. No participant requested an early termination of the interview or reported feeling particularly distressed after its completion.

Emergent concepts

Psychological distress and causality

Psychological distress was believed by all participants to be linked to their psoriasis.

When I first found out that I had, I was having panic attacks at the same time and I was thirty years old, and I was diagnosed with high blood pressure around the same time as well. I was under enormous strain. (Sue)

It develops out of some kind of a trauma. (Helen)

A few participants drew supportive evidence for this notion from other experiences.

After my father died, I was prescribed a very mild tranquiliser which actually had more effect than any other treatment, creams or otherwise I had since. So that sort of indicates

to you, OK there must be a psychological, mental aspect of it but it's never been suggested to me. That is, I never had an NHS doctor or dermatologist or anybody suggest psychotherapy or any other form of coping treatment. (Doris)

The participants' descriptions of two relationships between primary psychological stress and psoriasis, mirrored the findings described earlier. Psoriasis was believed to be the visible aspect of somatically expressed existing psychological stresses and emotional needs and experiencing psychological stress was believed to exacerbate it (Al' Abadie et al., 1994, Harvima et al., 1993, Gupta et al., 1987, De la Brassine and Neys, 1986, Shannon, 1979).

I think, before I was eleven, I did have stresses, but I think there is a combination of stresses at that time. That have done it I think. Yes, yes, that (threshold) have been pushed. (Dee)

Like I said, I, I'm really, really stressed, I don't feel stressed, It just comes out in psoriasis instead. (Byron)

I'm one of those people that says ahmm, you know if you can't change it, don't worry about it, but my body doesn't say that, I get more psoriasis instead. (Jane)

Stress that I might experience today wouldn't show for two, three, four, months, but if there was a big enough upheaval today, then there would be an effect in three months on my skin. (Bob)

It (psoriasis) never improves on its own, it always improves with like creams and stuff, but if I'm really, really stressed using the creams, the creams won't work. But if I'm not stressed and I use the creams, they work. (Zoe)

Also paralleling Morgan et al. (1997) and Jowett and Ryan's (1985) findings, the participants clearly differentiated this stress from the psycho-social stress they attributed to suffering from psoriasis.

Yeah, it gets worse instead of better. I'm trying, I'm wishing it away and then it doesn't go, it just gets worse because I'm thinking about it all the time. (Sue)

Interestingly, only one participant explicitly said that psoriasis may have caused a closed loop, where the distress it caused contributed to its continuation.

I was, I was more bothered about the aesthetic side when I was first told about the condition and I was, I used to worry about being? Oh what's that guy called? Somebody on the television doing the singing detective thing? So I used to have visions of becoming like him eventually, so every tiny pimple that I saw, that burst, would turn into psoriasis in my mind. (John)

Psychological effects of psoriasis

All participants identified a range of psychological effects they attributed to psoriasis. These included distress, fear, shame, worry, lowered hope and bitterness. Participants believed these effects were due to both the emergence of the physical symptoms and professionals' inability to remove them. As was expected from previous research (Ginsburg and Link, 1993), public reactions towards participants were also identified as painful, leading to various, self imposed, avoidant behaviours.

I don't wear short sleeves if I can avoid it. I don't, mmm, care much for swimming or ehh I, I don't, I prefer not to go swimming or to go to a pool. I don't take holidays, I don't

usually take holidays where I'd be required to take my clothes off or to sunbathe, but when I do, I'm conscious if people look, and people do look. And at work I have to wear short sleeves and mmm, an, an alarming number of people including the medical profession, professional people, don't know what it is. And don't, aren't aware of what it is. [They think it's] Contagious, which is a ridiculous thing to think, because they're not going to let me work in that situation. And I, I'm constantly aware of it. (Doris)

I've been told in public for example, I shouldn't be handling a child with hands so diseased. The fact it's my child and I want to know who would handle it if I didn't, but that and people who try not to touch you because I have the lesions on my hands. Sometimes people avoid shaking hands or make it a very brief shaking hands. It's very obvious that they don't want to come into contact. So that's what I mean when I say that it's not accepted, that people don't accept that sort of obvious thing that I'm in. (Doris)

All respondents bar one, said that their psoriasis was not too bad compared to other people's.

I feel fortunate that its not really severe and I'm grateful for that. (Pat)

While this evaluation may have been factual, it may have also been one of the mechanisms by which participants coped with their condition, accepting its existence but refusing to see it as disabling. Supporting the notion of this evaluation being positively biased were expressions like this;

It doesn't bother me much now, because I haven't got it bad and I can hide it. (Helen)

Therapy goals

While all participants' primary reason for attending psychotherapy was to deal with their psoriasis, their immediate goals were different. Some who were treated by hypnotherapy hoped for the removal of its symptoms in a quick and direct way.

Mostly it was to approach the psoriasis issue and get rid of it. (Jane)

Those who had problem-solving or cognitive therapy chose to focus on the psychological stresses, they believed, were the cause of their condition, as if knowing about their condition and its causes would enable them to escape it. Some were taught to physically relax, as if by lowering physiological distress markers, their psoriasis could be alleviated.

It [recovery] was a task and we set to complete it. (Pat)

Some of these participants said that they tried to let psoriasis become part of their existence and learn to live with it.

Accept the fact that I have to live with it for the rest of my life. (Bob)

Interestingly, no-one reported specific offers of stress management, despite their belief that stress was linked to their condition.

Oh I've heard about the link between stress and psoriasis but I've never heard anything about help available for stress for psoriasis. (Jim)

Efficacy of therapy

Psychological symptoms

Therapy was clearly regarded as having contributed to the amelioration of these symptoms. Participants spoke of an improved ability to cope with their life stresses in a direct manner. This applied equally to those who had cognitive behavioural therapy or psychodynamically influenced therapy and to those stresses that were believed to lead to psoriasis and those identified as caused by the condition.

Not to get rid of problems because they are always there, but to be able to handle them.
(Dee)

Physiological symptoms

When discussing therapy's effect on physiological symptoms. Some participants said that they saw no difference whatsoever and others reported that there was only limited change in their condition.

You see, I don't believe that (therapy) helped my psoriasis. (Nin)

I'm disappointed because it hasn't [helped]. (Byron)

C'os it was nice and relaxing, but I didn't find it to be the most helpful thing in the world, except that I got a hour off school every two weeks. (Sue)

Nevertheless, during the interviews the same participants made comments referring to partial or temporary remissions. These they seemed to attribute to the effects of therapy even when they occurred many months after it.

I think ehmm, it halted the progression of the, it halted the ehmm spread of lesions for a short while. There wasn't an immediate result. Yes, at that point it was sort of, eh, () the skin lesions moving from the external fractions [digits] to () forearms and calves and I did notice that it went no further, six months or so after the therapy stopped. Now whether that was coincidental I couldn't really say. I suppose it may have been. But ahmm, it got worse for a while after that and then regressed to a sort of chronic state were it's been more or less most of my life. (Doris)

It's, my psoriasis just hasn't gone. But it has, it's not a complaint as it used to be. I used to call it angry looking when it was red and it doesn't look angry anymore, it just looks scaly, bright and scaly. So it [therapy] must have done. I haven't noticed, me not thinking about it until now. (Dee)

Although it was around that time [Therapy], I flipped my lid and really shouted and screamed and, and the psoriasis under my neck and under my chin went, which was just amazing, just a couple of days and it has never come back, I can't believe it. (Nin)

How therapy was said to have affected their condition

The one mechanism mentioned by all participants was stress reduction. This was consistent with their above mentioned belief that stresses were closely linked to their psoriasis and also with the findings of Al' Abadie et al. (1994), Harvima et al. (1993) and Shannon (1979). All participants' ascribed these improvements to various therapeutic processes and techniques characteristic to their treatment's theoretical direction. For those who had problem solving counselling or CBT, these included learning, i.e., the acquisition of information concerning psoriasis, stress and the various life situations conducive to it, an action that seemed to help them regain control or at least feel they were regaining it and thus experience reduced stress. A few spoke of this process as understanding, referring to their

improved conceptualisation of the link between their life stresses and their illness and thus being able to weaken it.

Understanding of what caused the problem. What, ahmm, what were the underlying stresses. I wasn't aware of them. They have been triggers for psoriasis' appearance.
(Rita)

Those whose therapy did not attend to stress directly, stated that in retrospect they felt this marred their therapy.

The therapy seemed to be to try and engender a feeling of well being and relaxation and that was it. It wasn't aimed at dealing with the stress of it. I think therapy at that time must have been quite primitive, by today's standards, so there was no attempt to ahmm, give me any coping mechanisms or, ahh, anything other than basic relaxation. (Doris)

Learning and understanding were often believed to have been precursors to acceptance, that is, the realisation that psoriasis was part of their selves and that their identity has undergone a permanent change. However, some said they achieved acceptance without recourse to learning but by re-evaluating the emotional meaning of having psoriasis.

Well I can accept that, well I can accept the fact that I'm not, that I have to live with it for the rest of my life. (Lily)

Looking at the steps described as helpful before and during or after therapy, a model of identity formation such as Breakwell's (1986) may help explain why participants felt that minimizing their condition's severity and re-evaluating the

importance of good looks were helpful steps. According to this model, people possess a fluid identity comprising private and socially defined elements with specific positive or negative values appended to them. While their totality amounts to a person's identity and self value, there is a desire to reach an end state that is deemed desirable. If following change in some of these elements (health, appearance) the end state changes negatively, a compensatory adaptive process is set in motion, lowering the relative importance of the now negatively loaded elements and thus restoring the balance. As could be discerned in the participants' material, Breakwell's model predicted that less successful compensatory processes such as denial and disassociation would take place in the early phase of the re-adaptation process and that acceptance and reappraisal would be used later with greater success.

Not surprisingly, the lessening of negative emotions such as panic, fear and shame led in the participants' view to an improved sense of well being and a concomitant lowering of their psychological distress. An important aid for this, was relaxation exercises, that helped participants experience physically, the state they sought psychologically.

I think the relaxation helped [to lower distress]. (Sue).

Both they and those treated psychodynamically believed that the expression of emotion was helpful. An increase in their ability to express affect, particularly

negative emotions, was linked in the participants' mind with improved self states and with improved health.

Right, because for the first, for one of the first times in my life I could really, absolutely feel how I felt without covering it up to myself or other people. I felt it, I couldn't contain that feeling and it came out. I didn't hold back. That what was made it go, I'm convinced. I had to go up to counselling and the counselling helped me uncover what I was feeling bit by bit. I didn't have a clue before then. I was taught not to feel. Yeah it freed me, it freed me to feel what I was feeling. Well, I think that is what, that's my experience, what happens in therapy, yeah. (Helen)

Here too, mention was made of other events as supporting the belief in the close link between emotional expression and improvement.

There was one incident where I was, ehmm, I just flipped my lid, and shouted at my husband, my partner, ehmm and I screamed and I lost control and then, a few days later, the psoriasis under my chin disappeared and it's never come back. Now that's the only dramatic thing in all the years that I've had psoriasis. (Nin)

Lastly, their looks, a sore point to these participants whose blemished unattractive skin was contributing to their distress, became less important to some.

Not as bothered about my looks as I was. (John)

The qualities that mattered in therapy

A number of qualities were identified by the participants as central to the efficacy of their psychological treatment. These were shared between them and their

therapists and to some extent were dependent on circumstances. At its simplest this point was summed up as;

I think perhaps the chemistry between us. (Rita)

Looking at their descriptions it seemed that participants had clear if not firm ideas about what they felt were the important qualities in therapist and themselves.

Participant qualities

Most participants pinpointed two characteristics as central, trust and psychological mindedness. They said that when, due to previous experiences or to situational cues they found it difficult to offer trust, there was relatively little progress.

Similarly, those who reported doing relatively well as a result of therapy, said that to a large extent, this was due to their ability to trust and confide in their therapist.

[therapy works] Because I trust her. (Jane)

The other important quality was their psychological mindedness and understanding of therapy's role in alleviating psoriasis. Some of the patients who had relatively unsuccessful therapy as teenagers, said explicitly that they were too young and inexperienced to understand and believe in the link between psychological stress and psoriasis and therefore were unable to make full use of the therapy. During the interview they stated that being more aware of this link, they believed that further therapy would be far more successful.

I think I was being too, too much of a cynic and I, I wasn't ready for it, like, I wasn't ready for it in my heart. Ahm, so I don't believe that I got the best results out of it. But then, I had to put a little bit more effort on my behalf. (Sue)

I think on reflection it might have been that I was too young to gain much benefit from the hypnotherapy and it might be more appropriate twenty years later. But ehmm, that was the useful part to be aware that not all is as it appears on the surface, there are underlying triggers, yeah and the ability to, to take in and understand what's happening. (Doris)

Therapist qualities

The qualities that participants identified as most important in their therapists were more varied. Some spoke of clarity, that is, the ability to communicate with them, to express ideas and make meanings clear. Understanding was another quality they mentioned in this context.

Very, very aware of what needed to go on and aware of the subjects that mattered. (Jim)

Others mentioned containment and space, the ability of the therapist to make them feel that they were in a situation where opening up and venting their thoughts and feelings were both possible and safe. Being given the opportunity to unburden themselves and the right to take centre stage, to be paid attention and to express all aspects of themselves, not only those they were usually allowed.

Well, I think the biggest thing is having somewhere to meet. To go to where I can talk about absolutely anything. Things that I've told her that I wouldn't tell, ehmm, my partner. Ahh, right yeah, just to say being able to go there and talk about anything I want and not hide my experience. (Dee)

An important aspect of this was said by a few to be the therapists' ability to believe, to show their concern and empathise with their distress.

I think it, yeah, it was important that somebody listen to me and believed that I really felt it [distress], rather than just snubbing me off with, don't be silly. (Bob)

These qualities seemed to go together with a more widespread feeling of acceptance, that elusive Rogerian quality of non judgmental positive regard that bestowed on the participants a feeling that whatever their issues, the therapist would not recoil, a point perhaps doubly poignant amongst psoriatics who elsewhere, experience others flinching at their presence (Ginsburg and Link, 1993).

Even though she is a human being and she's got her problems too, but she accepts mine. (Nin)

Some spoke of their therapists' sensitivity and sympathetic nature.

I thought she was really lovely, friendly and approachable, very approachable. (Jane)

One drawback mentioned by some participants was a feeling that when therapy did not go to plan or they did not respond in the manner their therapist expected, the later became frustrated and expressed that frustration in a counterproductive way.

[explaining why second therapist was better] A few times he [counsellor] got so frustrated with me and I, I could see that, whereas the, the therapist never does. [Dee]

Others, particularly those treated by hypnotherapy reported a medical like attitude that was felt to have been unhelpful.

He wore a white coat. He was very pragmatic, I mean, ahmm, ahmm, dignified and methodical and it was not, I wouldn't call it a relationship. It was ahmm like a consultation with a doctor but it didn't go beyond that particular condition. You couldn't call it a therapeutic relationship. He ehmm, had an agenda that he was pursuing for the hour and that was it. He never said how was it for you? To me, it was a consultation, he gave me that treatment. No interpersonal relation I would say. (Doris)

The therapist qualities they described, bore a strong resemblance to those therapist skills Nelson-Jones (1997, 1999) suggested were essential to successful outcomes. For instance, he suggested that communication skills and mind skills were equally important and as was seen, both sets were believed by participants to have been important attributes of their therapists. However, when describing themselves, participants' beliefs only mirrored his suggestions partially. While their descriptions of psychological mindedness were reminiscent of his suggestion that the clients' cognitive clarity and problem solving skills were important to the therapy's outcome, they clearly attributed more weight to the transpersonal qualities such as trust suggested as important in transpersonal research (Clarkson, 1996).

Situations

These seemed to play only a minor role. When referring to circumstantial factors beyond those emanating from the therapeutic approach, most participants found therapy reasonably easy.

It [therapy] was not at all intimidating. (Byron)

About half of the participants indicated that they believed that if they had had more encounters, this would have reinforced the therapeutic bond.

How it can be improved? Perhaps me going more often. I don't know! Yeah perhaps me going more often. (Dee)

The cost of therapy was universally felt to be a hindrance.

I'd like to try hypnotherapy again. I wouldn't do it here [London], I can't afford it. (Rita)

It's (therapy) very expensive. (Jim)

The unavailability of psychotherapeutic treatment through the NHS and medical practitioners' apparent difficulties in dealing with psychological factors, were also identified as problematic. Of course, since participants had sought therapy privately, this feeling may have been exclusive to them, but research on patients' experiences in medical settings indicates this was a wide spread phenomenon (Paykel and Priest, 1992, Mumford et al., 1991).

When I went to see my GP at first with psoriasis, ehmm, and high blood pressure, ehmm, he asked me if I'm under stress, and I was in such a state and I was crying. It was obvious I was and I just said, I don't know and it seemed to me because I didn't know any different way of living than what, eh than, than the stressful way of living. I didn't have the experience, of life without stress, ehmm. So I wasn't really sure what he meant. Which sounds crazy but it's true. And he said, well, you're not under stress and dismissed me. (Sue)

Theories

Three main relationship patterns were discernible in the concepts derived from the participants' data. These were: the role of therapy, personal and situational elements within therapy and processes within therapy. This section presents these patterns diagrammatically. Concepts are represented in these diagrams by a letter and their interrelations with other concepts by numbered arrows. Since these patterns encompass smaller conceptual relationships, one of these, the therapeutic value of changes in self-image is also presented diagrammatically as an example. The diagrams are accompanied by a short description of their constituent elements and interrelations, but a fuller explanation of both the diagrams and the use of data based theorising in Grounded Analysis are presented in appendix 5.

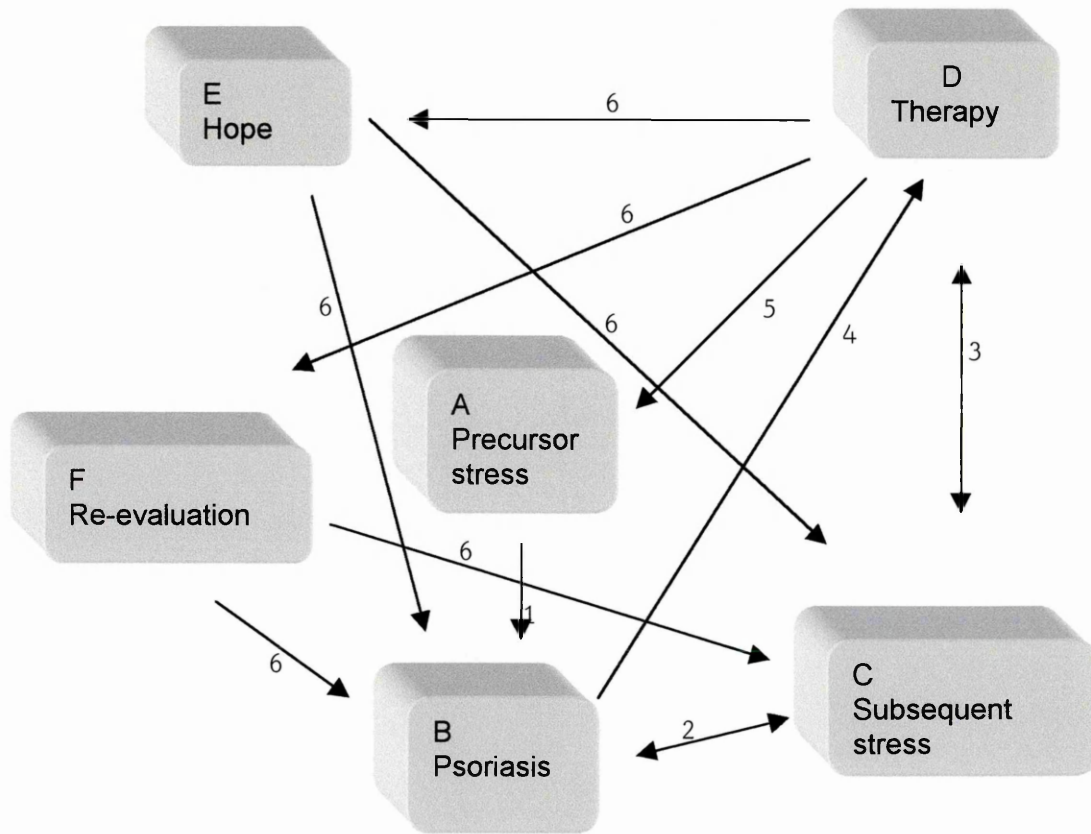


Figure 1. The role of therapy in alleviating psoriasis

Precursor psychological stress (A) was among the stresses leading (1) to psoriasis (B). The condition itself led (2) in turn to further stress (C) which correspondingly caused its exacerbation (2). Participants turned to therapy (D) in an attempt to alleviate this stress (3) and the psoriasis (4). These changes were sought through three main routes: directly through lowered precursor stress (5) and lowered subsequent stress (3) and indirectly (6) through hope (E) and re-evaluation (F).

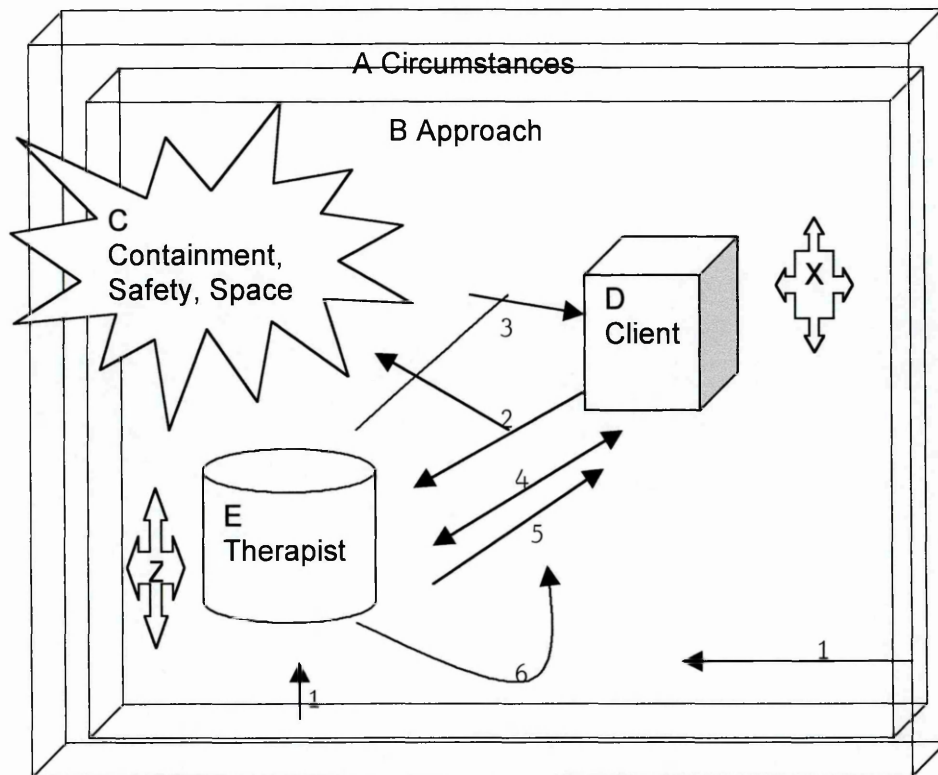


Figure 2. Personal and situational qualities in the therapeutic encounter

Therapy was seen as taking place within a matrix created by global factors such as circumstances (A) and approach (B). These only obliquely impacted on the personal elements although the approach affected the therapist's demeanor (1). The space within the matrix (C) was itself imbued by qualities such as containment, safety and space. Within the expanse contained in this matrix, the participant (D) and therapist (E) engaged in therapy, a primarily dynamic exchange between both although the interplay between entities (participant, therapist) and expanse was acknowledged (X) and (Z). The participant's contribution to the therapeutic exchange possessed two qualities; each expressed differently, i. e., an outgoing, trust giving (2) and an accepting, psychological mindedness (3). That double aspect was also seen in the therapists' contributions. On the one hand, they influenced the participants in a direct way such as communicativity (4) (but on the other, they used the basically inward directed qualities of concern, empathy and acceptance (5) also further the therapy's goals. The effect of these was mitigated by the existence of negative feelings such as frustration (6).

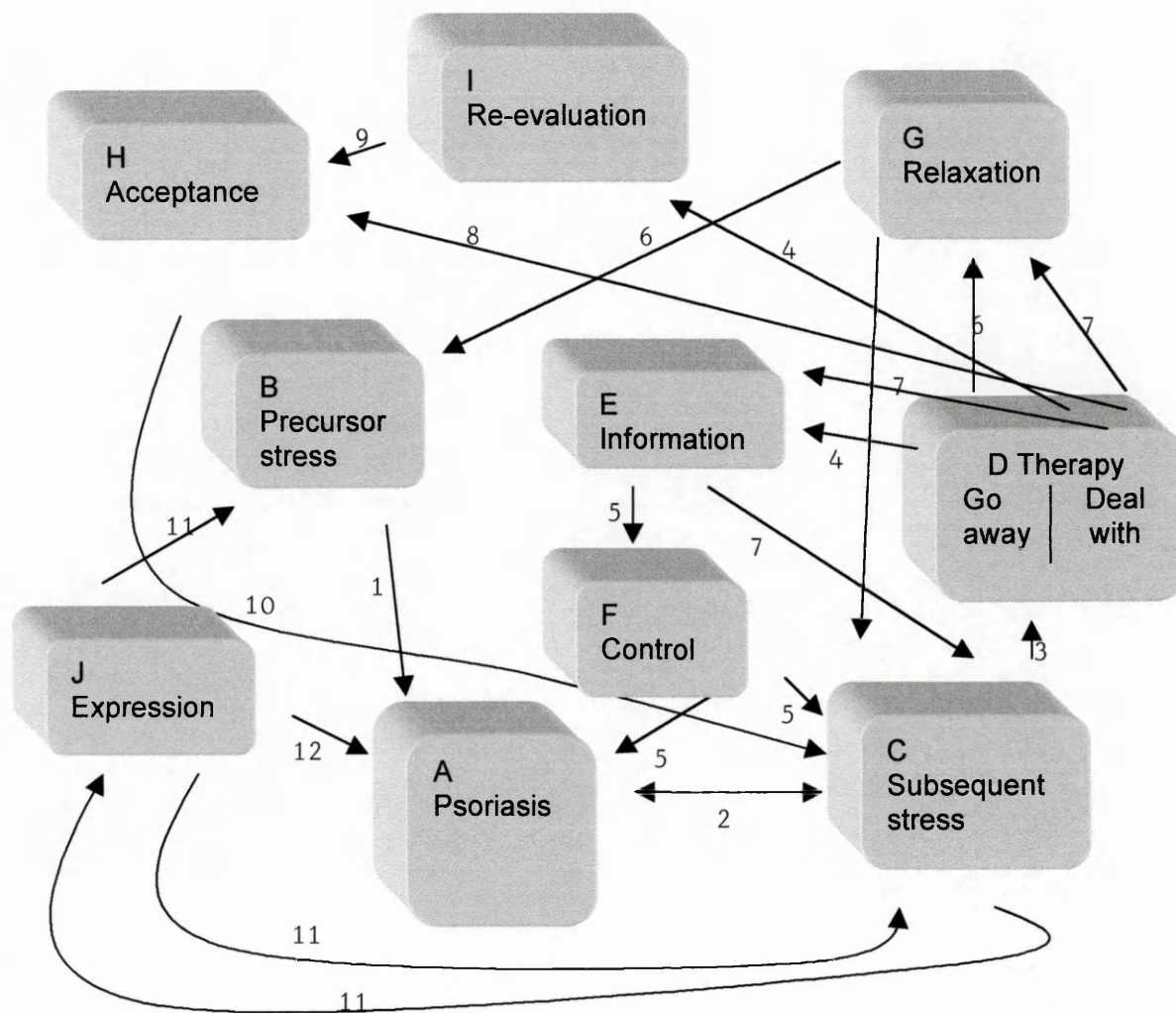


Figure 3. Sub-mechanisms within therapy

Psoriasis (A) was believed to be caused 1 by precursor stress (B) and cause and be exacerbated (2) by subsequent stress (C). The experiences of psoriasis and subsequent stress made participants seek (3) therapy (D), either to make it go away or to learn to live with it. Those who wanted it to go away sought (4) information (E) which by making them feel more in control (F) influenced their subsequent stress (5). These participants also utilized relaxation techniques (G) to attempt to alleviate the stress believed to have caused psoriasis (6). Those seeking to learn to live with their condition seemed to rely on slightly different mechanisms. For instance, although they also used relaxation techniques and information, these were intended to lower consequent stress (7) and thus make psoriasis easier to live with. They also attempted to achieve acceptance (H) of their condition either directly (8) or through (9) re-evaluation (I) of the meaning ascribed to being psoriatic, because they thought it may alleviate their subsequent distress (10). A third mechanism they employed was the expression of emotions (J) which they believed affected both their stress types and their psoriasis (11).

Of course there were many smaller stages within each of the processes delineated above. The following figure illustrates the role of what was perhaps the most salient one, self-image.

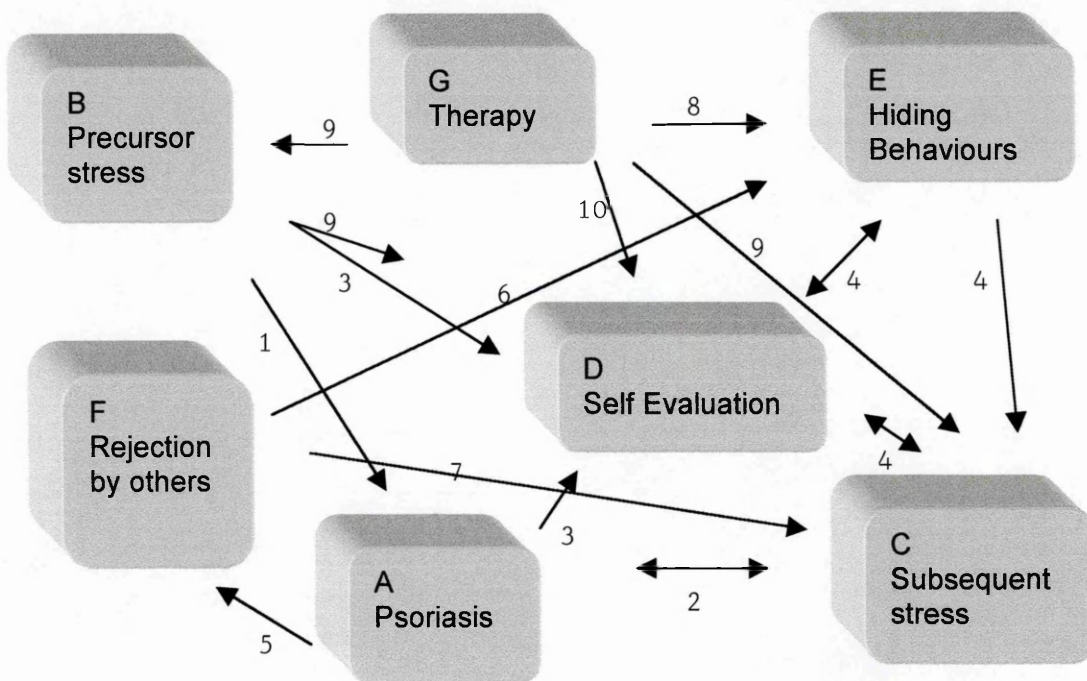


Figure 4. The therapeutic value of changes in self image

As before, psoriasis (A) was believed to be caused (1) by precursor stress (B) and to cause and be exacerbated (2) by subsequent stress (C). This however, was not always a direct process. It occurred through smaller sub-processes such as self-evaluation (D), which was negatively influenced both by psoriasis and stress (3). Their negative self-evaluation also led to hiding behaviours (E) which in turn led to further negative self-evaluation and stress (4). Psoriasis also had a direct effect (5) causing participants to feel rejected by healthy people (F). This increased hiding behaviour (6) and stress (7). Therapy (G) was perceived as having a lowering effect on hiding behaviour (8) and its effects, as well as also lowering subsequent stress, precursor stress and their effects (9). It also had a positive effect on self-evaluation (10), weakening the negative processes described before.

Overview

Qualitative methods such as the one used in the present study are committed to explicating the participants' interpretations of social reality. The question has been raised (Bryman, 1988) whether researchers really can provide accounts from the perspectives of those whom they study and whether the accounts' validity could be evaluated. Also, since using interview material meant that data consisted of participants' accounts of their experiences, the questions of participant and interviewer bias/subjectivity arose. Qualitative methods dictate that the interviewer play a more interactive role than is usual in quantitative research. As a result they have been criticised for producing reactive effects - characteristics of the interviewer altering the responses of the participants and influencing the data collected (Emerson, 1983). Similarly, it is argued that the researchers' own backgrounds will radically alter their understanding and interpretation of the data collected (Goods and Watts, 1989). GA, using the researcher's frame of reference for interpretation, entails a process that is subjective by definition and could be deemed biased by positivist critiques (Silverman, 1993). However, all methods rely on subjective interpretation and research activity inevitably shapes and constitutes the object of inquiry (Henwood and Pidgeon, 1992). Yet, in recognizing this problem, the present research attempted to adopt what Reason (1988) termed critical subjectivity. This he defined as a quality of awareness in which, we do not suppress our primary subjective experience nor do we allow ourselves to be overwhelmed and swept along by it: rather we let it rise to

consciousness and use it as part of the inquiry process (p. 12). Concerning the data's possible biases, it was an understanding of the participants' perceptions within a theoretical framework that was sought in the present study rather than an elusive 'objective truth'. Thus while acknowledging that participants accounts were not factual data, GA sides with interpretative phenomenological analysis (Smith, et al., 1997), another growing approach to health psychology research, in making the fundamental assumption that while not being 'facts', accounts bear some relationship to the events and experiences they depict and thus accepts Brown and Sime's (1981) proposal that, 'an account was neither naive nor an apology for behaviour but must be taken as an informed statement by the person whose experience was under investigation'.

Because in qualitative research sampling decisions are not made on statistical grounds, the extent to which findings from a particular study could be said to have a more general significance has been brought into question (Henwood and Pidgeon, 1992). This concern may be justified if as in the present case, the aim was to make a contribution to wider theoretical developments (Bryman, 1988). However, the aim of qualitative studies is generalizability of data to theoretical propositions rather than to populations (Bryman, 1988). Thus, the intention was not to produce a sample that was typical of all people experiencing psoriasis. The critical issue was whether their experiences were typical of the phenomena associated with being a person with psoriasis undergoing psychotherapy. Similarly, qualitative work has been often criticised for only including snippets of data in

reports and because its readers were unable to formulate their hunches about the perspective of the people who have been studied and thus how adequately the researcher has interpreted data in the light of their explications (Bryman, 1988.) However, qualitative studies should be judged by their ability to represent and interpret target phenomena and form a close connection between the interpretations made and the material cited (Chenitz and Swanson, 1986) while laying a paper trail open to external scrutiny (Henwood and Pidgeon, 1993), rather than by measuring how closely they conformed to quantitative standards.

Thus evaluating of the present research's findings presents a mixed picture. Due to time limitations, the present study did not utilise GA's process of theoretical sampling to recruit new participants so as to expand and refine its concepts and theory. Also the effect of time on the recollections of those participants who had therapy many years ago, was not adequately accounted for. Yet, there is some evidence that the participants' narratives were linked to their condition, were typical of those expressed by people with psoriasis. In particular those concerning feeling stigmatised and believing that repressed emotion and stress were linked to their condition (Jobling, 1986, Potter, 1986, Updike, 1976). These emotions also corresponded to those reported as common in psoriatic samples (Harvima et al., 1993, Jowett and Ryan, 1985, Medansky, 1986).

Although, not surprisingly, the participants believed that psychology could provide support and alleviate their psychological problems and perhaps also their

physiological ones, their accounts, particularly the divergence between their various beliefs illustrated some interesting points for possible research. For instance, they believed that stress management directly addressed their needs, yet a point was also made about emotional release being a direct and effective way of combating psoriasis. This evoked Jobling's (1986) criticism of the onus therapy for psoriasis presently puts on managing the condition. Commenting that for patients, psoriasis as treated can be hard work, he noted that that this onus could add to rather than subtract from, the burden of psoriatic patients.

Another exciting divergence in the participants' data emerged from their beliefs concerning the mechanisms and processes that they felt were central in determining their therapy's success. Notwithstanding the questions about stress's nature, the participants' considered working on its management as pivotal and thought other active elements (relaxation, hypnosis) were useful. At the same time they described them as taking second place to the therapists' personal qualities and the relationship's nature. Voicing their belief that qualities such as acceptance, sensitivity and empathy were central to therapy's efficacy, they reflected the finding that therapeutic alliance strength was a major predictor of therapeutic outcome (Saffran and Wallner, 1991) and described the basic qualities, Fiedler (1950) and Rogers (1957) stated were the necessary (and for Rogers sufficient) conditions for successful therapy. For instance, Fiedler found that successful therapeutic outcomes were more likely when the following conditions were met: an empathic relationship, the therapist and client relate well, therapists sticks closely to clients'

problems, the patient feels free to say what s/he likes, an atmosphere of mutual trust and confidence exists and rapport is excellent. Unsuccessful outcomes were linked to: a punitive therapist, the therapist making the patients feel neglected, the therapist seeming to have no respect for the patient, an impersonal, cold relationship, the therapist putting the client in place, the therapist currying favour with the patient. As could be seen from the data, participants listed all Fiedler's characteristics of the ideal relationship as conducive, in their experience, to good outcomes and agreed with many of his definitions of characteristics likely to sabotage it. Thus testing empirically whether therapeutic relationship has a measurably consistent effect in the psychological treatment of psoriasis irrespective of the approach employed may be an interesting furthering of present work, as would be an examination of the role therapeutic relationship may play in the alleviation of other ailments where psychological factors are believed to be involved.

Conclusion

In addition to indicating issues that were important to the participants and perhaps worthy of further research, what can counselling psychologists or other professionals who will come into therapeutic contact with persons who suffer from psoriasis learn from this study? Answering this tentatively, one could point to how useful it was in the participants' eyes to have therapists who were knowledgeable about their condition. The importance given to stress management programs and their scarcity also pointed to a potentially useful area of development. But perhaps most of all, therapists may re-learn that regardless of the therapy's approach, what the participants believed helped them most, were not the techniques, nor even the therapist's overt adroitness in using them. What mattered most, was that the therapist should care about them, that s/he accept them as they are, and that rather than try to change them, give them the opportunity to be, to change and to accept themselves. Therapists may note that helping when help was required was welcome, but not if it felt like a script was being followed. In short, the participants' message seems to have been, never lose sight of the client as the reason for the encounter and always remember that therapy is primarily, (a special case of) an interpersonal relationship.

References

- Al' Abadie, M. S., Kent, G. G., Gawkrödger, D. J. (1994). The relationship between stress and the onset and exacerbation of psoriasis and other skin conditions. *British Journal of Dermatology*, 130, 2, 199-203.
- Brown, J., Sime, J. (1981). A methodology for accounts. In M. Brenner (ed.), *Social Method and Social Life*. London: Academic press.
- Bryman, R. (1988). Qualitative research in the study of leadership. *Human Relations*. 41, 1, 13-30.
- Clarkson, P. (1996). *The Therapeutic Relationship: In Psychoanalysis, Counselling Psychology and Psychological Theory*. London: Wherr Publishers Ltd.
- Coyle, A., Wright, C. (1996). Using the counselling interview to collect research data on sensitive topics. *Journal of Health Psychology*, 1, 431-440.
- De la Brassinne, M., Neys, C. (1986). Le psoriasis en tant que phenomene psychosomatique. *Acta Psychiatrica Belgica*, 86, 1, 36-41.

- Dungey, R. K., Buselmeier, T. J. (1982). Medical and psychosocial aspects of psoriasis. *Health and Social Work, 7, 2*, 140-147.
- Emerson, R. M. (1983). Introduction. In R. M. Emerson (ed.), *Contemporary Field Research*. Canada: Little Brown and Company
- Engels, W. D., (1982). Psychosomatic Illness Review: IV. Dermatologic disorders. *Psychosomatics, 23, 12*, 1209-1219.
- Fiedler, F. E. (1950). The concept of an ideal therapeutic relationship. *Journal of Consulting Psychology, 14*, 239-245.
- Folks, D. G. and Kinney, F. C. (1995). Dermatologic Conditions. In A. Stoudemire (ed.), *Psychological Factors Affecting Medical Conditions*. Washington DC: American Psychiatric Press.
- Gallo, P. S. (1978). Meta-Analysis, a mixed meta-phor? *American Psychologist, 33, 5*, 515-517.
- Ginsburg, I. H. (1995). Psychological and psycho-physiological aspects of psoriasis. *Dermatology Clinician, 13, 4*, 793-804.

Ginsburg, I. H., Link, B. G., (1993). Psychosocial consequences of rejection and stigma feelings in psoriasis patients. *International Journal of Dermatology*, 32, 8, 587-591.

Glaser, B. G. (1992). *Basics of Grounded Theory Analysis*. Mill Valley CA: Sociology press.

Glaser, B. G., Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Gupta, M. A., Gupta, A. K., Haberman, H. P. (1987). Psoriasis and Psychiatry an update. *General Hospital Psychiatry*, 9, 3, 157-166.

Hand, I. (1991). Comparative treatments studies: A critical appraisal of design treatment, contents and outcome interpretations. *Zeitschrift for Klinische Psychologie. Forshung und Praxis*, 20, 3, 280-285.

Harari, M., Shani, J. (1997). Demographic evaluation of successful anti-psoriatic climatotherapy at the dead sea. *International Journal of Dermatology*, 36, 4, 304-308.

- Harvima, I. T., Viianmaeli, H., Naukkarinen, A., Paukkonen, K. et al. (1993). Association of cutaneous mast cells and sensory nerves with psychic stress in psoriasis. *Psychotherapy and Psychosomatics*, 60, 3-4, 168-176.
- Heckrath, C. and Dohmen, P. (1997). On the empirical foundation of the highly significant superiority of the cognitive behavioural compared with the psycho analytic therapies. *Zeitschrift fur Psychosomatische Medizin und Psychoanalyse*, 43, 2, 179-201.
- Henwood, K. L. and Pidgeon, N. F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology*, 83, 1, 97-111.
- Henwood, K. L., Pidgeon, N. F. (1993). Qualitative research and psychological theorising. In M. Hammersley et al. (eds), *Social Research: Philosophy, Politics and Practice*. Milton Keynes: Open University Press.
- Hunt, K. (1996). *Should the Treatment of Patients With Psoriasis Take Into Account Their Emotional Needs As Well As Their Physical Symptoms*. University of Surrey: Unpublished Masters dissertation.
- Jobling, R. (1988). The experience of psoriasis under treatment. In R. Anderson and M. Bury (eds), *Living in Chronic Illness*. London: Unwin Hyman.

Jowett, S., Ryan, T. (1985). Skin diseases and handicap. an analysis of the impact of skin conditions. *Social Science and Medicine*, 20, 4, 425-429.

Koblenzer, C. S. (1995). Psychotherapy for intractable inflammatory dermatoses. *Journal of the American Academy of Dermatology*. 32, 4, 609-612.

Lemme, G., Paciaroni, L., Barbini, N., Mozzicafreddo, G. (1995). Studio del profilo psicologico del soggetto psoriasico adulto. *Medicina Psicosomatica*, 40, 3, 181-189.

Lyketsos, G. C., Stratigos, J., Tawil, G., Psaras, M., et al. (1986). Hostile personality characteristics, dysthymic states and neurotic symptoms in urticaria, psoriasis and alopecia. *Psychotherapy and Psychosomatics*, 44, 3, 122-131.

Medansky, R. S. (1986). Psoriasis and sexuality. *Medical Aspects of Human Sexuality*, 20, 144-149.

Morgan, M., McCreedy, R., Simpson, J., Hay, R. J. (1997). Dermatology quality of life scales- a measure of the impact of skin diseases. *British Journal of Dermatology*, 136, 2, 202-206.

- Mumford, D. B., Devreux, T.A., Maddy, P. J., Johnston, J. V. (1991). Factors leading to the reporting of functional somatic symptoms by General Practice attenders. *British Journal of General Practice*, 41, 454-468.
- Nelson-Jones, R. (1997). *Practical Counselling and Helping Skills: Texts and Exercises for the Life-skills Counselling Model*. London: Cassel.
- Nelson-Jones, R. (1999). Process models for counselling psychologists: The skilled helper and the skilled client. *Counselling Psychology Review*, 14, 1, 16-21.
- Paykel, E., Priest, R. (1992). Recognition and management of depression in general practice: Consensus statement. *British Medical Journal*, 305, 1198-1199.
- Pidgeon, N. F., Turner, B. A., Blockley, D. I. (1991). The use of grounded theory for conceptual analysis in knowledge elicitation. *International Journal of Man-Machine Studies*, 35, 2, 151-173.
- Potter, D. (1986). *The Singing Detective*. London: Faber and Faber.
- Price, M. L., Mottahedin, I., Mayo, P. R. (1991). Can psychotherapy help patients with psoriasis? *Clinical Experimental Dermatology*, 16, 2, 114-117.

Psoriasis Association. (1995). *Psoriasis*. Northampton: Seton Health Care Group PLC.

Ramsay, B., O'Reagan, M. (1988). A survey of the social and psychological effects of psoriasis. *British Journal of Dermatology*, 118, 195-201.

Reason, J. (1988). Stress and cognitive failure. In S. Fisher and J. Reason (eds), *Handbook of Life Stress, Cognition and Health*. Chichester: John Wiley and Sons.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-104.

Safran, J. D., Wallner, L. K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Psychological Assessment*, B, 2, 188-195.

Saville, R. H. (1977). Psoriasis and Stress. *British Journal of Dermatology*, 97, 297-302.

Seng, T. K., Nee, T. S. (1997). Group therapy: A useful and supportive treatment for psoriasis patients. *International Journal of Dermatology*, 36, 2, 110-112.

- Shanon, J. (1979). Psoriasis: psychosomatic aspects. *Psychotherapy and Psychosomatics*, 31, 1, 218-222.
- Silverman, D. (1993). *Interpreting Qualitative Data*. London: Sage Publications.
- Smith, J. A., Flowers, P., Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (ed.), *Material Discourse of Health and Illness*. London: Routledge.
- Strauss, A., Corbin, J. (1993). *Basics of Qualitative Research*. Thousand Oaks, CA: Sage Publications.
- Taylor, S. J., Bogdan, R. (1998). *Introduction to Qualitative Research Methods. A Guide Book and Resource*: New York, N.Y. John Wiley and sons.
- Udike, J. (1976). Journal of a leper. *New Yorker* (19 July) 28-32.
- Van Der Shaar, F., Wouter, W. (1977). Psychometric investigations in 48 Dutch patients suffering from psoriasis. *Psychotherapy and Psychosomatics*, 27, 3, 159-162.

Zachariae, R., Oster, H., Bjerring, P., Kragballe, K. (1996). Effects of psychological intervention on psoriasis a preliminary report. *Journal of the American Academy of Dermatology*, 34, 6, 1008-1015.

Zweig, H. (1931). Psychotherapy in the Czech literature of 1920-1930. *Zentralblatt Fuer Psychotherapie*, 5, 111-119.

Appendices

1. Interview schedule
2. Letter to potential participants
3. Consent form/biographical data
4. Recruiting advertisement
5. The diagrammatic representation of theories in GA
6. Transcription notes and verbatim interview transcript
7. Notes for contributors to *Journal of Health Psychology*

Appendix 1. Interview schedule

Remarks for the interviewee

Main topics of investigation

It is intended that all main topics (**Bold type**) listed in the interview schedule will be referred to and that supplementary questions (underlined) will be asked only when replies to main questions would seem to have been laconic, It is nevertheless possible that participants' material may make some questions redundant. In such case the questions will be either eschewed or reformulated in an attempt to elicit more information.

1. Introduction.

Before the interview proper the interviewer should introduce himself to the participant, summarise briefly the material contained in the information form previously sent, explain again about confidentiality and inquire about any other queries the participant may still have. Demographic and consent forms should then be filled in by participant and interviewer.

2. Specific topics

How did they find they had psoriasis?

prior suspicions that this might be the case?

changes, experienced in themselves since?

What sort of domains?

Changes in their self concept?

What made you choose therapy as a treatment option?

Other steps?

Experience with therapy

As you know this research is on the experience of therapy. By therapy I refer to any form of psychological help counselling or talking with someone who is a professional or volunteer rather than a personal acquaintance.

Please describe your therapy experiences.

Please evaluate its usefulness.

To what you attribute this? I.e., skills, training, approach, personality, etc.?

What were the goals of your therapy and to what extent they were achieved?

What did you think was responsible for this?

What was helpful about your therapy? How could it be improved?

What was unhelpful about your therapy?

Is there any other material you would like to speak about or think I should be aware of?

Have you any questions?

Appendix 2. Letter to potential participants

Dear Sir/ Madam,

Thank you for the interest you have shown in my research. As may know, in some countries psoriasis is perhaps the medical condition for which psychotherapy is most often prescribed. Nevertheless little is known about the therapy experience of people with psoriasis or about their feelings about it. I am therefore currently investigating the experiences of persons who had psychotherapy or any other psychological interventions for their psoriasis, in order to learn from them about their experiences and feelings.

As I have explained on the phone, you are requested to participate in an interview expected to last up to an hour. It will be will be taped (audio) but identifying details such as your last name and address will not be recorded in any form.

Moreover, any potentially identifying data will be altered to protect your anonymity. During the interview you will be asked about your feelings and experiences during and after therapy and how it has affected you and your life.

Although none of the questions is believed to be difficult or intrusive, I realise that some of the experiences I will be asking you about may prove painful and you may avoid answering any question or terminate the interview altogether at your sole discretion. Similarly, if you have any questions or doubts please feel free to raise

them at any time. In addition please feel free to call me or one of the support groups whose details I will supply after the interview if any doubt or problems arise later. Although I am unable to pay participants, I hope that by learning from you I will be able to become a better therapist and that if published, this work will help improve the support given to people with psoriasis elsewhere. If you are interested you may receive a copy of the research for your use once it is completed.

If you are still willing to be interviewed please fill the enclosed consent form.

Thanking you for your help

Yours sincerely

Eldad Farhy

Appendix 3. Consent form

I give permission for Eldad Farhy to use this recording of an interview about my experiences for research purposes. This permission is given on the understanding that neither he nor any one who may examine the recording, will reveal any information concerning me to any other person.

Signature:.....Date

Statistical data

Gender M / F

Age:

Occupation:

City/ County of residence:

Appendix 4. Advertisement

Psoriasis

Psoriasis is perhaps the medical condition for which psychological therapy is most often prescribed. Nevertheless little is known about the therapy experiences of people with psoriasis and their feelings about it.

If you have, or had psoriasis, have, or had: therapy, counseling, stress management, hypnotherapy or any other psychological help and are willing to participate in an anonymous interview concerning your experiences, or have further questions please contact,

Eldad Farhy

Dept. of psychology
University of Surrey
Guildford
Surrey GU2 5XH

or

TEL- 0181 952 9017

FAX -0171 328 5432

0181	0181	0181	0181	0181	0181	0181
952	952	952	952	952	952	952
9017	9017	9017	9017	9017	9017	9017

Appendix 5. The diagrammatic representation of theories in Grounded Analysis

Grounded Analysis' stated aim is the formulation of a theoretical matrix explaining and describing the participants' data (Taylor and Bogdan, 1998). In the present research, the intention was to provide a careful account of what a group of participants with psoriasis had to say about their experiences of psychotherapy. It was hoped that the important meanings, themes and patterns of belief that emerged when participants were asked to describe their experiences and beliefs, could be drawn out and identify the implicit theories underlying their perceptions of the efficacy of therapy in alleviating their physiological condition and psychological distress. It was also hoped to reveal the specific mechanisms involved in this process.

It is perhaps worth re-stating that the study ill-fitted the positivist tradition of identifying reliable, objective and repeatable conclusions. The aim was not to test an *a priori* theory via the hypothetico-deductive method. Rather it was to allow concepts to emerge from the data and generating working hypotheses (Henwood and Pidgeon, 1992).

As explained in the Analytic Procedure section (p. 233), a thorough understanding of emergent themes was gained through repeated readings of the transcripts. Data

were divided into units of meaning, coded and indexed with the following question in mind: what categories, concepts or labels do we need in order to account for the phenomena of importance in the unit (Pidgeon et al., 1991). Units were segregated into conceptual categories related to each other in a hierarchical (i.e., information gathering as a sub-category of coping strategies) or process based pattern (i.e., re-appraisal of the importance of one's appearance as a part of a psychological accommodation process). Categories and their relationships were constantly re-labeled in view of new data and their previous labels and relationship patterns were noted down to provide a record of the analysis' progression. This was repeated until concepts reached saturation. That is, when further coding added no more relevant information or led to no further changes in relationships. Thus the data analysis was used simultaneously to develop concepts, to identify their multiple properties and to explore their relationships with each other. Data units that clearly identified the nature of specific concepts, were cited as illustrative quotations. Theory genesis and links between concepts were derived from two criteria: either participants had identified the link themselves, or the connection was made by the researcher because data related to one concept could be classified under related ones. A resemblance of the putative patterns to those suggested in previous research was considered as secondary supporting evidence (Strauss and Corbin, 1993) but was not essential in itself.

Figure 1. The role of therapy in alleviating psoriasis (p. 251)

This figure gives a good example of the circularity of the participants' beliefs regarding their condition and therapy. Their narratives indicated that in their view, precursor stress (A) was amongst the factors that caused their psoriasis (B). Suffering from this condition caused them further stress (C). Because of their psoriasis and because of the worry their stress caused them to feel they sought therapy (D), which they hoped would alleviate both conditions. Therapy was believed to achieve this putative alleviating effect either through a direct lowering of precursor (A) and subsequent (C) stress or through the instillation of hope (E) and the commencement of a re-evaluation process (F). However, it can be seen that neither process offered an escape from psoriasis (B) but merely played a moderating role whose success was dependent on the issues illustrated in figure 2 and the sub-processes illustrated in figures 3 and 4.

Figure 2. Personal and situational qualities in the therapeutic encounter (p. 252)

Therapy was seen by the participants as taking part within a certain environment created partly by circumstances (A) and partly by the therapeutic approach taken (B). These imbued the encounter's environment with certain qualities (C), such as safety, containment and space (for self expression). Within this environment, the client (D) and the therapist (E) operated, influencing each other through their innate qualities while changing and being affected by their environment (Z).

Figure 3. Sub-mechanisms within therapy (p. 253)

As said, precursor (B) led to psoriasis (A) which caused subsequent stress (C). Therapy's (D) effect on these was mediated by a number of sub-mechanisms, determined by the direction participants chose to pursue in their attempt to alleviate their psoriasis. Those who wanted it to go away, saw the acquisition of information (E) as means of achieving perceived control (F) over their condition and this feeling may have helped by mitigating their subsequent stress (C) and thus their psoriatic symptoms. Relaxation techniques (G) were perceived as having a similar lowering effect on subsequent stress (C) and symptoms. Other participants said they sought to learn about their condition, so as to be better able to live with it. For them the effects of information and relaxation, although still important, were only means to make accommodation to their condition easier. They also sought to achieve acceptance (H), either as a direct result of therapy or as a result of the re-evaluation process (I) that their self-view as individuals with psoriasis, underwent in therapy.

Once more, these concepts are represented within an interrelated closed circle, since the participants did not believe any of them was able to cure their psoriasis altogether, but merely to alleviate it.

Figure 4. The therapeutic value of changes in self image (p. 254)

In the same manner that participants believed that the alleviating effect of therapy on of psoriasis occurred through various sub-processes, each of these was an opportune concept, conveniently labeling a number of smaller procedures under one heading. For instance, changes in their self-image were seen by the participants as beneficial due to several reasons. While their self evaluation (**D**) was negatively affected by having psoriasis (**A**) and suffering from both precursor (**B**) and subsequent (**C**) stresses, it led to hiding behaviours (**E**) because they feared rejection by others (**F**). Not only were these fears well founded, as they had already experienced rejection because of their psoriatic blemishes, but the very act of hiding exacerbated their stress and made them value themselves less. Therapy's (**G**) effect on self evaluation was multi-faceted. It lowered both kinds of stress and thus the urge to hide. It also made them question their self evaluation process and amend it so that a lesser role was given both to the importance of their looks and to the validity of other persons' rejecting behaviour.

Appendix 6. Transcription notes and sample transcript

The notation used when citing participants' comments (adapted from Potter and Wetherall, 1987) was as follows:

Material in square brackets is classificatory information:
E.g., A few times he (counsellor) got so frustrated with me

Round Brackets () indicate inaudible material or whose accuracy was doubtful.

- 1) T. () See how its sound, put it closer to you because your information that matter most.
- 2) C. OK.
- 3) T. Hello. Yes, now it seems to be working I just say.
(tape switched off)
- 4) T. I'm sorry, we do have to repeat just that bit about, you..
- 5) C. Right. I'm forty two.
- 6) T. Ahhm
- 7) C. Married with two children and I'm a nurse.
- 8) T. And, ehh the first question that I have is how long have you had psoriasis?
- 9) C. Since I was eleven, so thirty one years.
- 10) T. I understand. Could you give a general description of, ehh in what, ehh how did you experience it or how did it express itself?
- 11) C. Right.
- 12) T. Was it the scalp?
- 13) C. Yes. No the first, ehmm ehh, evidence was on the external flexures of the elbows and knees. And were relatively small lesions at the time to begin with. And

gradually there is extended to calves and forearms and one or two in my scalp, but not too many. And finally to my knuckles and the backs of my hands.

14) T. Are you still suffering?

15) C. Yes, yes.

16) T. From psoriasis ().

17) C. Yes, I still have them on my elbows, knees some lesions on my calves and forearms and the back of my hands.

18) T. I see. Now I understand that you've received some therapy.

19) C. Yes ehmm. It's ehmm, it's a long time ago now. And ehh from what you've explained to me that, that would have been unusual for the time, I think. My father, when I was fourteen, fifteen years old, took me to see a hypnotherapist. Now, I saw him for about six sessions, I think or once a week for six weeks and ehmm, he put () suppose it was a trance state and tried to encourage me to relax. Ehmm, I think it must have been fairly new () for that time. Ehmm and basically that that was it.

20) T. So you saw that hypnotherapist for six weeks.

21) C. Yes for about an hour at a time for six weeks.

22) T. Do you remember the sessions at all?

23) C. Some of them very vividly. I remember the first session, that we had. he asked me to remember the time that I caused my psoriasis as a matter of fact. As you are aware it is a family condition, other members of family had it when I () much younger than me. So he asked me to remember what had caused the first outbreak. And interestingly, I did. I was very aware what had first caused it, and

from then ahhh. On reflection he was asking me to visualise and experience, ahhm therapy to teach me to relax using, ahhm images and ahh, methods that were beyond me for that age. For example he asked me to imagine myself on a tropical beach, which at that time and that place, ehmm was completely out of my experience. Could not have imagine it. Ehmm, I think on that () it had very limited () certainly for me. But I did manage, I think, to be aware of what had caused it.

24) T. I understand. Do you remember any other sessions? Any other sessions stand out on ()?

25) C. I remember being asked to ehmm, imagine myself in sunshine. To imagine ehmm, warmth and I, I do remember that. I do remember the sensation of warmth and of being relaxed, and very comfortable. But really that's, that's all I remember.

26) T. Now () did you. () did the therapy or did the hypnotherapy help you as far as you're aware?

27) C. I think ehmm, it halted the progression of the, it halted the ehmm, spread of lesions for a short while. Ehmm, but I think because it wasn't going away and because it was a private therapy and then had to be paid for, I think the six sessions was all my father was prepared to, to try out and there wasn't an immediate result ().

28) T. Yet you said that ehh it halted the progression, can you be a little more specific?

29) C. Yes, at that point it was sort of ehmm, () the skin lesions moving from the external fractions to () forearms and calves and I did notice that it went further six months or so after the therapy stopped. Now whether that was coincidental I

couldn't really say. I suppose it may have been, but ahmm it got worse for a while after that and then regressed to a sort of chronic state were its been more or less most of my life.

30) T. So let me try and recap what you say. Ehhm, after psoriasis first appeared.

31) C. Ah ham.

32) T. The lesions slowly began spreading

33) C. Yes

34) T. And at one stage they've reached what you called the soft tissues.

35) C. Yes

36) T. After, at that period you received hypnotherapy.

37) C. Aham.

38) T. And it halted, it halted the progress.

39) C. Yes that could be it.

40) T. But only for a period of?

41) C. Only for a short while.

42) T. And than it returned.

43) C. Hmm.

44) T. But what process or what part of the therapy you think were helpful?

45) C. I think the relaxation. I think the ahmm, and () understanding of what caused the problem. What ahmm, what was the underlying stresses, but I wasn't aware of them. But according to the therapist, they have been the trigger for psoriasis appearance. I think on reflection, it might have been that I was to young to gain much benefit from the hypnotherapy and it might be more appropriate

twenty years later. But ehmm, that was the useful part to be aware that not all is as it appears on the surface, there are underline triggers.

46) T. Ahhmm, you say that it have might more appropriate twenty years on?

47) C. Yeah.

48) T. Yeah you.

49) C. Well I think ehmm, at fifteen if somebody tells you that ehmm, stresses have an effect on you, you're not likely to believe it at fifteen. Somebody tells you that at thirty five, you may well believe it.

50) T. Ahmm, but it has more to do with your awareness.

51) C. Yes I think so. Yeah and your ability to, to take in and understand what's happening.

52) T. () kind or perhaps that () more than you can take it at that particular.

53) C. Yeah.

54) T. Period.

55) C. Yeah, yeah. I think at that time ehmm, what was obviously came outward physical lesions I, I could not really appreciate how could any effects on my psychological state, I, I really didn't connect then the psychology of it with the physical at that time. The thought of managing stress that I wasn't aware I had, was an alien contact that I just didn't think () to me at all at that age.

56) T. So, so why are you saying, I, do you believe that psoriasis has a psychological cause to it?

57) C. I do now. Yeah. I do now. Stress leads ahmm, over the years I think that since I've had particularly stressful times have effected my skin and I'm therefore

made aware that the stress (). It takes the time, I might stress that I might experience today wouldn't show for two three four months. But if there was a big enough upheaval today then there would be an effect in three months on my skin.

58) T. So you're saying that psychological stresses are expressed later on, by a flare up or by.

59) C. Yes.

60) T. Exacerbation.

61) C. Of this condition? Yes certainly, yeah ().

62) T. Would you say that the opposite applies? I mean, if you had a nice period, an easy pleasant experience, would that be followed by a abatement.

63) C. I don't know, I don't know. That's not to say that my entire life is grim because it isn't. But I think there is ahmm, constant stress level which is what maintains my condition where it is.

70) T. So if we follow this logic.

71) C. Hmm.

72) T. Being when you were eleven you said.

73) C. Yes.

74) T. A certain stressor appeared.

75) C. Yes.

76) T. And was the trigger to your condition.

77) C. Yes so, so that's how it was explained to me, yeah.

78) T. Do you believe that personally?

79) C. Ehh yes, yes I think I do.

- 80) T. So, and that stresses since then have been maintaining
- 81) C. Yes.
- 82) T. So in that say that before you were eleven you did not have stresses in your life?
- 83) C. I think ehmm, no before I was eleven I did have stresses ehmm, but I think there is a combination of stresses of that time. That have done it I think.
- 84) T. Almost like a threshold.
- 85) C. Yes, yes, that have been pushed.
- 86) T. Ahhm.
- 87) C. Pushed on ().
- 88) T. OK, without going into details.
- 89) C. ().
- 90) T. Of those stresses psychological, physiological.
- 91) C. They were, they were all of them which is why I think it was probably right. It was moving from a small village school to a large comprehensive secondary school. To leaving a small community to enter a large one and to do along because as an eleven year old you go to school alone on the bus, mum doesn't take you, you know then you're alone. Coupled with what would have been the onset of, the very onset of puberty for me physically at that time, plus family upheavals at home, and I think the whole (). But I haven't, haven't thought too deeply about it, that the stresses that would have happened before that year, that there were others, I think possibly that was ehh combination.
- 92) T. Going back to the therapy you had.

93) C. Ahhm.

94) T. At the time, was all of that covered in those six weeks, all these aspects of.

95) C. Not in, not in a lot of depth. No, no the initials of that strangely, the initial fashion to ask me is this, you know, please go back in memory to when this occurred and the visualisation was of the school, of my first day at that school.

96) T. () it is of course ().

(client laughs)

97) T. And then he realised there where no ().

98) C. OK, but it is recording.

99) T. It is recording so.

100) C. That's right, you better take my number in case you need to call me again.

101) T. It's quite all right. I will check in a moment that, but.

102) C. (laughs) OK.

103) T. I had to make sure that's not.

104) C. That's, ehmm.

105) T. I'm not going to do () professional one.

106) C. Not technical.

107) T. Therapist.

108) C. Yeah.

109) T. Rather than a research end of it. But you were saying, and sorry for having interrupted.

110) C. That's OK, that the stress ahmm, that were brought to light weren't addressed individually.

- 111) T. Ahmm.
- 112) C. The therapy seemed to be, to try and engender a feeling of well being and a relaxation and that was it. It wasn't aimed at dealing with the stress of it.
- 113) T. So it was finding what was the trigger?
- 114) C. Yeah.
- 115) T. And trying to ehmm, take over the results by being able to relax.
- 116) C. That's right yeah, yeah.
- 117) T. You mentioned something about twenty years down the line being a better time, were you would have being able to ().
- 118) C. I think so yes, yeah.
- 119) T. Did anything, have you though about that period?
- 120) C. No I haven't.
- 121) T. () at home.
- 122) C. No I haven't. Ehm, I have had to come to terms with my condition and provide it doesn't progress beyond a certain point, I think I have come to terms with it and haven't really thought of doing any more, as long as it doesn't get any worse then that's it really, I think.
- 123) T. So ehh, any way, in a way you mentioned acceptance, and you said the therapy it served some purpose at the time and that it helped you halt the advance of the.
- 124) C. Yes.
- 125) T. So we have not, you have not tested this belief.
- 126) C. Yes.

- 127) T. And ehh, that it also taught you about what were the triggers.
- 128) C. Hmm.
- 129) T. Compared to other things in your life, other experiences, how important was the role of the therapy in helping you cope with psoriasis? More physically and.
- 130) C. Hmm.
- 131) T. Psychologically as you know, a disorder that has certain difficulties related to.
- 132) C. Hmm.
- 133) T. More psychological and physiological.
- 134) C. I don't think it had emm, effected much at all, except that I will be aware if there are stresses that I'm going to have an exacerbation of my () it felt really silly, put it before I'll make sure that I have extra creams in to deal with the problems. I, I don't ahh, I don't have any particular method of dealing with the psychological side of it. I just make sure that I can cope, if there is going to be a sever result.
- 135) T. Ahhm.
- 136) C. With ahmm, the exacerbation, and that's it really.
- 137) T. So, you're saying, if I understand you correctly and please correct me if.
- 138) C. Hmm.
- 139) T. Just learn cope with the day to day details.
- 140) C. Hmm.
- 141) T. Hmm the psoriasis plays a more important part in your cope strategy today, than the understanding you gained during that ehmm, therapy?

- 142) C. I think so, yes, yes.
- 143) T. Another point that () psoriasis most often effects is eh, socially.
- 144) C. Yeah.
- 145) T. It's eh, I've () to be, put bluntly it is and considered unsightly.
- 146) C. No it is.
- 147) T. And eh, a lot of people with psoriasis either hide.
- 148) C. Hmm.
- 149) T. Their lesions, for instance it has been found that taking off clothes, in a socially accepted manner such as at the beach or at the pool.
- 150) C. Yeah.
- 151) T. Is eh, an activity that eh, that with psoriasis are far less likely to.
- 152) C. Yes.
- 153) T. Do then people without psoriasis.
- 154) C. Yeah.
- 155) T. Self conscious, being negative evaluation of their own bodies are in due process here. There is also the experiences of.
- 156) C. Hmm.
- 157) T. Other people, of experiencing difference.
- 158) C. Hmm.
- 159) T. Would you say that you, had a problem in that sense?
- 160) C. Still do.
- 161) T. Ahmm.
- 162) C. Still do. I don't wear short sleeves if I can avoid it because it's eh, here.

163) T. Ahmm.

164) C. I don't ahmm, care much for swimming or ehh I, I don't, I prefer not to go swimming or to go to a pool. I don't take holidays, I don't usually take holidays where I'd be required to take my clothes off or to sun bathe. But when I do, I'm conscious if people look, and people do look and at work, I have to wear short sleeves and ahmm, an, an alarming number of people, including the medical profession, professional people, don't know what it is and don't, aren't aware of what it's, contagious which is a ridiculous thing to think, because they're not going to let me work in that situation and I, I'm constantly aware of it.

165) T. I see. Ehh so would you say, this has been a contributing factor in sense of being a stressor?

166) C. I think it must be, yeah, I think it must be. Ehmm I'm not sure how, it would manifest itself, but I think it must have an effect.

167) T. If we go back to the period when you first experienced the, psoriasis

168) C. Hmm.

169) T. It was eleven and you went to see the therapist, when you were fourteen fifteen.

170) C. Yeah.

171) T. During those three years, as a growing young woman, how do you remember how it felt having psoriasis?

172) C. I remember that as long as I had, ehh sleeves and I wore jeans all the time and it didn't show. I didn't have any on my face or hands at the time, so I could be, I was all right as long as I had sleeves on and its (). It's only as I got older they

come on my hands, that it's been a constant, I can't hide it. So ahhm, what ever reaction it's going to be, that's going, it's going to be there, I can't hide it now as I used to.

173) T. Was this aspect explored in your therapy?

174) C. No.

175) T. The social.

176) C. No, not at all. No. I think the therapy, at a time must have been quite primitive, by today's standards, so there was no attempt to ahmm, give me any coping mechanisms or ahh, any thing other than basic relaxation. Which is why I didn't really benefited much at that age.

177) T. So ehh, would you consider going for therapy today? I know I asked that before.

178) C. (laughs) Ahmm, I, I think, I might benefit now, yeah, I got, I would ahmm, be interested to see any ahmm, research or any evidence that it actually helps and if it did, then I might consider it.

179) T. Ehh, if you were to engage in therapy again.

180) C. Hmm.

181) T. Psychological therapy, any particular thoughts or any particular expectations what would you with hindsight say you'd like to have today during therapy?

182) C. Ehmm I don't know, I think there's an awful, it's an awfully big area to try and explore. I think, I would like to ahmm, I would like to cope better with stress,

I'm frequently aware now ehmm, of stresses and I would like to cope better than I do.

183) T. So improving your stress coping.

184) C. Yes.

185) T. Ability?

186) C. Yeah, I think that would be an enhancement, whether it did any thing for my skin or not and an improvement in confidence like ehmm, have both benefits and I might not be so worried about people looking at me. It's a bit of a () when you think people are going to look at you and your.

187) T. Yes.

188) C. Maybe breaking up with people, you know.

189) T. There is some evidence that, there is evidence and that's as far as it can get from psychotherapy.

190) C. Hmm.

191) T. Although those who say, no argue () psychotherapy ehmm, were as far as it causing psychological stress.

192) C. Hmm.

193) T. And therefore, can be alleviating to start with () or some people say no, it starts with the physiological ().

194) C. Hmm.

195) T. But then it causes particularly social stresses and that stress causes you to become.

196) C. ().

- 197) T. Exacerbated so it can alleviate, but not cure just by.
- 198) C. Yes.
- 190) T. if you become immune to social stresses, then you have less stress.
- 191) C. Yes, hmmm.
- 192) T. So this argument is open, but ahmm, but if you recall your therapist at the time, I mean, did you feel or do you remember was he concerned? Was he helpful? was he, anything about the relationship you had?
- 193) C. He was, he wore a white coat. He was very pragmatic, I mean ahmm, ahmm, dignified and methodical and it was not, I wouldn't call it a relationship, it was ahmm, like a consultation with a doctor but it didn't go beyond that particularly condition. You couldn't call it a therapeutical relationship, he ehmm, had an agenda that he was pursuing for the hour and that was it. He never said 'how was it for you', to me.
- 194) T. So your saying he was following a, () in your case being a doctor.
- 195) C. Yeah.
- 196) T. Giving you a treatment.
- 197) C. It was a consultation, he gave me that treatment.
- 198) T. Ahmm.
- 199) C. And that was it.
- 200) T. () there was little interpersonal relation?
- 201) C. No interpersonal relation, I would say.
- 202) T. Would that have made any difference?

203) C. I don't know, I think it may well have done. I think hmm, at the time, if this would have been 1971, and in a village in South Wales it wasn't, it wasn't the usual thing to even think of, psychology or ahmm, a mental aspect to anything. it's physical, you go into the doctor you were treated and that's it, and if the doctor can't do any thing there isn't anything to be done. I think that was the main attitude, to that condition at the time.

204) T. So I didn't ask then why were you taken to see a hypnotherapist at the.

205) C. (laughs).

206) T. It sounds like it was a bit unusual.

207) C. Oh it was.

208) T. ().

209) C. It was, it was. But I think my father was very, very old fashioned and looks were more important then brain to a woman and he felt that ahmm, this was ahmm, something he had to try and overcome for me to make a good marriage, to have a good future. He felt that ahmm, looks were that important and I think, he (), he (), he had some interest ehmm, whether or not it would work.

210) T. In his view, did it work?

211) C. No.

212) T. In his view.

213) C. No, in his view, it didn't work.

214) T. And in yours?

215) C. No, I didn't think it did work, I didn't think at the time it had any effect at all, apart from, as I said earlier, enabling me to connect my psychological state with

the physical, but that didn't have any great effect on the (), experience () it was just a sort of fact in the corner.

216) T. OK. If you had a possibility of any therapy.

217) C. Hmm.

218) T. Psychologically speaking, psychotherapy, psychologically speaking.

219) C. Yeah.

220) T. What would you expect it to be and can have one or two () for instance it could () to help you psychologically alleviate.

221) C. Hmm.

222) T. () psoriasis or would ehmm, psychological contentment that is being able to accept it and to live with it, with having () or less difficult to live with?

223) C. Yeah.

224) T. Would that be a sufficient goal or any other expectations that you might have?

225) C. Now I would like to think, if I underwent therapy, that it would help me ahm, cope better. That I would (loud noise on tape). It's very hard to say, I would like not to be bothered by it, I would like to have enough coping mechanism or understanding. I don't think it will ever go away and I don't really expect it to ever go away, but I would like to cope with it, I would like to not be bothered (silence) And ehm, think is it, going back a few years to my training to remember () cognitive therapy helps you recognise most states and alter, to control most states and and a ().

226) T. Some claim that it does and some claim.

- 227) C. (laughs).
- 228) T. Otherwise.
- 229) C. Well you always have that don't you?
- 230) T. Yes.
- 231) C. That's, that's, I think would be the most ahmm, beneficial.
- 232) T. So would you say that therapy today, you would envisage, would be more of ahh, a goal oriented specific type?
- 233) C. Hmm.
- 234) T. Reducing stress, identifying modes conducive to.
- 235) C. Yeah.
- 236) T. Stresses and changing or working on them before they affect you rather than exploring oriented.
- 237) C. Yes.
- 238) T. Psychoanalytic, if you wanted those who look at you as a (), sorry I'm trying to be at the same time both very short very and very.
- 239) C. Hmm.
- 240) T. Does, sorry.
- 241) C. Yes, no I understand what you're saying, I'm not sure that the psychoanalytic.
- 242) T. Ahhm.
- 243) C. Except is ahmm, I mean in practical use I mean that's awful to expect because I don't know so much about it. But from my point of view then I would be wondering, I can identify that I was angry with my father over something, well

that's fine but what do I do about it now. Do your know, do you see what I'm trying to explain?

244) T. Ahamm.

245) C. So analyzing is, is fine, but I would like to know what application it would have.

246) T. Ahmm.

247) C. For practical purposes.

248) T. I don't have much else to ask so I.

249) C. Fine.

250) T. Just you know, it's not going to be one of those interminable discussions.

251) C. (laughs).

252) T. But what the therapist and the relationship with the therapist would be of importance to you or would you ex, happy if it were any, would any kind of relation be good or do you expect any particular one?

253) C. I would expect ahmm, (silence) I, I think, I would expect the therapist to be reactive so that ahmm, I didn't feel that it was a formula that you go through and perhaps you would react to therapy itself, would be reacting to what came from me. Does that make sense?

254) T. Certainly that's fine. Your passed experience () almost like going to a doctor.

255) C. That's right.

256) T. A consultant.

257) C. It was.

258) T. Things were done to you.

259) C. That's right. I would expect that to have any benefit.

260) T. Ahmm.

261) C. Now, I expect it to be a two way process ().

262) T. I would expect or accept.

(change side of cassette)

263) T. We were, part two, and we were speaking of acceptance.

264) C. Ahmm.

265) T. And how would exactly recognise or acceptance. I mean () then the eyes flick from the lesions that.

266) C. Ahmm, well, no a bit of () curiosity is allowed and people do ask me some times what they are and I tell them what they are and if their interested enough I tell what causes, causes the appearance. But ahmm, I've been told in public, for example, I shouldn't be handling a child with hands so diseased. The fact it's my child and I want to know who would handle it if I didn't, but that and people who try not to touch you, because I have the lesions on my hands. Sometimes people avoid shaking hands or a very brief shaking hands and make it, it's very obvious that they don't want to come into contact. So that's what I mean, when I say that its not accepted, that people don't accept that sort of obvious thing that I'm in.

267) T. I'm interested in the therapy you would seek, or would you prefer it's qualities relatively focused on () or on practical solutions or ().

268) C. To yes.

269) T. Acceptance.

270) C. Yeah, yes the practical solutions to my coping abilities, the practical solutions to my dealing with the stresses not necessarily ahmm, () how to ignore.

271) T. I see. Well I don't have any more questions at this stage. But if you anything you would like to add, any thing that I should have asked.

272) C. I don't think so, I don't think so. I think ahmm, I think you've got everything. I don't think there's very much more ahmm, unless its so well hidden that I don't know its there.

273) T. I see. Perhaps one thing that did come to my mind is ehh, and which I didn't ask in this way. Compare to the help you've got from other sources and I'm making an assumption that.

274) C. Hmm.

275) T. Other people other sources have helped you, how would you rate the help you received from the therapy?

276) C. Ahmm, very little really, I don't think its ehmm, interestingly at one time during my life I was given tranquilisers for a very bad depression so I () after my father died and I was prescribed a very mild tranquiliser which actually had more effect than any other treatment, cream otherwise I had since. So that sort of indicates to you () OK there must be a psychological, mental aspect of it, but it's never been suggested to me and that is, I never had an NHS doctor or dermatologist or anybody suggest psychotherapy or any other form of coping () treatment.

277) T. () did you have any psychological help from non-professionals? Talking with a good friend?

278) C. Oh we all do I think.

279) T. Yeah.

280) C. ().

281) T. Do you think you also use it to a degree to () psoriasis or use it ().

282) C. No. No. not specifically to that ahh.

283) T. Do you have any questions for me?

284) C. No I don't, no.

285) T. OK.

286) C. Curiosity aroused, but ahmm, no I don't think so.

287) T. OK, thanks very much.

288) C. You're welcome.

289) T. All the best.

290) C. You didn't eat your salad.

291) T. No I didn't want any of it ().

Tape finished.

MATERIAL REDACTED AT REQUEST OF UNIVERSITY