A PORTFOLIO OF STUDY,
PRACTICE AND RESEARCH
WORK

Submitted for the Doctorate of Psychology
(PsychD) in Clinical Psychology

University of Surrey

Volume One

EXPLANATIONS FOR VARIATIONS IN MALE PARTNER
VIOLENCE DURING PREGNANCY: AN EXPLORATORY
STUDY

Robert Hill

2000
ACKNOWLEDGEMENTS

I would like to thank Dr. Linda Dowdney and Dr. Adrian Coyle for their supervision and incisive comments on earlier drafts of the thesis. I would also like to thank John Dowsett who kindly acted as field supervisor for my large-scale research project. I would also like to thank Paul Davis and Emma Dunmore for their supervision of my critical literature review and small-scale research respectively.

Thanks are also due to all of my placement supervisors: Margaret Hemming; Dr. Jeanne Males; Ann Kimber; Sara Turner; John Doswett; and Shamil Wanigaratne, all of whom made my clinical placements both educational and enjoyable.

Thanks once again to Ann McD.
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Introduction to the Portfolio

This portfolio contains a selection of work completed over the course of the three year Psych.D, Clinical Psychology course. The academic dossier comprises five essays which cover both core and specialist topics. The clinical dossier contains summaries of all core and specialist placements undertaken and five summaries of formal clinical case reports. A separate confidential appendix to the clinical dossier containing the five formal clinical case reports in full and all placement evaluation forms will be kept at the University of Surrey. The research dossier comprises a literature review completed in Year 1, a service-related research project (i.e. research completed on placement) completed in Year 1 and a major research project completed in Year 3.

The work presented in each section of this document reflects the variety of client groups, referral problems, approaches and contexts covered during the course. In each section, work is presented in the order in which it was completed in order to reflect how my academic, clinical and research skills and interests have developed.
ACADEMIC DOSSIER
Summary of the Academic Dossier

This section comprises five essays, intended to reflect the depth and breadth of work covered over the three year course. The essays are presented in the order in which they were completed, in order to demonstrate how my academic skills and interests have developed during training. There are four essays chosen from the four core client groups studied during the first and second years of training, and one essay on a specialist topic from the third year. These essays critically examine the theory and practice of clinical psychology with reference to wider social, cultural, ethical and epistemological issues.
What is the role of clinical psychology in psychiatric rehabilitation?

LONG TERM DISABILITIES ESSAY

February 1998

Year 1
Introduction

Clinical psychologists have an important part to play in psychiatric rehabilitation through their work with individual clients, staff, organizations and wider service structures. However, it is noteworthy that psychiatric rehabilitation is an area where there has been much cross fertilization of ideas between psychologists and psychiatrists (who tended to pioneer such services) and where there has been a great deal of genuinely effective inter-disciplinary working. Part of the reason for this lies in the range of social, psychological and medical factors that are deemed important in an area as broad as optimum psycho/social functioning, which is what rehabilitation is essentially about. Understandably, therefore, psychiatric rehabilitation is an area inextricably linked to wider health and social policies, so that the focus of rehabilitation work never remains static (Chadwick, 1995, p.34, calls rehabilitation a 'kinetic concept').

Understanding rehabilitation work in this way one can see that it has at various times had different foci - the institutional setting, alternatives to hospital admission, hospital closure, as well as work with both resettled patients and those with more severe and intractable social and psychological difficulties. Thus, both the current state of rehabilitation work and its history indicate the extent to which wider health and social policy initiatives effect practice: as Pilling (1991, p.34) states, 'our understanding of the process of rehabilitation varies not only with the tasks presented to a service but also in response to prevailing economic and social conditions of the society in which the service operates.' Today the scope of rehabilitation work is broad and occurs both inside and outside the hospital setting, although the main focus is on providing services to those with severe and enduring mental health problems in the community through community mental health teams (CMHT's).

Definitions of Rehabilitation

Optimum psycho/social functioning is only one way of defining 'rehabilitation' and no definition is entirely satisfactory, often seeming either too restricted or too broad. Thus Anthony, Pierce, Cohen and Cannon (1981, p.5) see rehabilitation as directed at
increasing the strengths of clients so that they can achieve their maximum potential for 'independent living' and 'meaningful careers' (my italics) whilst Shepherd (1983) goes for a broader approach by identifying rehabilitation with 'the whole of an individuals life and functioning' (my italics). Nor is the replacement of definitions by synonyms much use, for as Kowalski (1991, p.vi) notes 'The thesaurus gives "cure", "therapy", "treatment", as alternatives to the word "rehabilitation". None of them quite fits, so we are left with a rather ugly word to describe a rather serious and complex issue: the system of care that we have, want to have, want to develop, for long-term mentally ill people.' Another way of looking at rehabilitation is by distinguishing between the end point of rehabilitation and the process of rehabilitation (Watts & Bennett, 1987). If the end point is the objective of the rehabilitation process, the process can be thought of as the means of attaining this. Often the end-point will be dependent upon the location or type of clients being worked with. Thus rehabilitation in the context of working with mentally disordered offenders may well have different goals to the rehabilitation of the new-long stay, or to those who are seeking very specific rehabilitation goals such as finding meaningful day time employment. This underlines the fact that to be optimally effective rehabilitation must reflect the needs and goals of the individual and to some extent society-at-large.

**Scope of the Essay**

In terms of psychiatric rehabilitation it is common to make a distinction between work with individuals with long term mental health problems, sometimes referred to as continuing care clients (Lavender & Holloway, 1988) and rehabilitation work with those recovering from neuro-psychological problems. Generally, psychiatric rehabilitation refers to work with continuing care clients and this will be the focus of this paper.
The Role of Clinical Psychology

Definitions give some idea as to the broad area of work activity and aspirations involved in rehabilitation for continuing care clients and generally these tend not to be constructed in terms of professional roles and responsibilities. Thus, one has to be explicit about roles. Within clinical psychology it is possible to isolate three main roles which clinical psychologists currently employed in the NHS have in relation to the rehabilitation process. These can be conveniently divided into: (i) individual client work; (ii) working with staff and (iii) working with the organization. One could add to this the establishing and developing of services, although most clinical psychologists have little opportunity or influence to make a dramatic impact in this area. Such a clear-cut separation between these areas is of course rarely undertaken in practice and interventions to be optimally effective should always recognize the interplay between these three areas and their dependence upon wider social structures. Thus, many well thought out intervention strategies fail because they treat individuals, staff groups or organizations as independent entities and ignore the interplay between them and the wider service/policy context. One relatively recent means of overcoming any such single focus is through quality assurance (QA) strategies, which at their best attempt to resolve some of these issues (Clifford, Leiper, Lavender & Pilling, 1989). Due to the increasing importance of QA, I will discuss this specifically at the close of this paper.

(i) Individual Client Work

Rehabilitation work with individual clients can be thought of in terms of assessment, treatment and management sequences. Rehabilitation also focuses on 'capacities and tendencies and not fixed behaviour' (Watts & Bennett, 1987, p.1). The starting point of any rehabilitation process with individuals is a thorough assessment which is both reliable and valid, or as Shepherd (1987, p.37.) puts it 'that is they should measure adequately whatever it is that we are interested in and they should do this in a reproducible way.' To do this Shepherd suggests using a problem checklist covering
such areas as (i) engagement with services; (ii) physical and psychiatric symptoms; (iii) attitude towards illness; (iv) current resources and skills; (v) work history and (vi) family situation and social support. By focusing on these areas, a baseline measure of current difficulties and indeed strengths can be ascertained and an individually tailored course of treatment structured. This list does not explicitly focus on the aspirations and goals of the client, which when linked to motivation to change is one of the most important determinants of any successful change strategy. However, it is also important that clients do not overestimate their capacities, and that goals and objectives are realistic. In the past rehabilitation tended to be employed more along the lines of blanket programmes, now this would be seen as both unacceptable and psychologically naive. One also needs to be clear not simply about which area of functioning one is going to focus on, but what level of functioning one is attempting to achieve. Having a goal of being employed may well be legitimate, but until the level of employment is defined, little progress can be made. The difference for instance between working in a Clubhouse with their focus on entry level part-time employment is very different to the goal of attaining a full-time job from the competitive market place (Hill & Shepherd, 1997). The latter may well be a long-term objective and the Clubhouse the first, but such things need to be clearly delineated and thought through.

Given that clients and psychologists can agree on the goals of rehabilitation, what role does the clinical psychologist have? Clearly, the answer is dependent upon the nature of the difficulties and aspirations uncovered. Thus, they may be involved with social skills training (Liberman, Wallace, Blackwell, Eckman & Kuehnel, 1994), prodromal signs monitoring (Birchwood, Macmillan & Smith, 1994), teaching coping strategy enhancement methods (Tarrier, 1994), utilizing already existing specialist services or disciplines (particularly the case in terms of employment and work related opportunities), constructing an intervention programme for a ward team, or tapping into an already existing programme or course of activity. Whatever it is, there is some
expectation that the assessment, particularly where it has used psychometrically credible instruments, will allow some means of assessing whether any change has occurred as a result of the intervention. The psychologist thus has a continued overseeing role in terms of the evaluation of rehabilitation process and outcome and this can best be seen in terms of overall management responsibility of programme intervention. It is also possible that clinical psychologists may have a case management role, either in terms of direct client management (Onyett, 1992) or in terms of ongoing case monitoring and evaluation (Gournay, 1995). This is increasingly likely where CMHT's are fully integrated.

Of course measured outcome is not the only valid measure of effectiveness. Satisfaction with the process of rehabilitation is equally important and may well be more important from the client's perspective (Reed, 1997). Thus while psychologists may focus on the manifest goals of the rehabilitation process, they should also attend to the latent and therefore unstated functions of rehabilitation. For instance Wendy Lindsay (1996, p.88) highlights the benefits she derived from attending an occupational therapy woodwork class for a number of years, as she stated 'What I gained from woodwork was not what I made but what I shared, what I saw, what I felt and what I grew to admire.' What this was, she goes on to state, was 'a man who saw and acknowledged our pain, and did something about it.' Clearly, this important element relates to the process of rehabilitation and not to any obviously identifiable goal.

A final point that needs to be made about individual treatment relates to Illich's (1978) views on the iatrogneic nature of some medical interventions and the suggestion that rehabilitation is not a benign process of recovery from illness. The view is put most strongly in relation to psychiatric rehabilitation by Lucy Johnstone (1995, p.27) when she states that 'most people need rehabilitation not mainly from their "illnesses" but from their "treatment."' Although a rather dogmatic and over inclusive statement,
Johnstone does make us reflect on the fact that treatment goals are not the same as outcomes and that like Barton (1959) individual illnesses can be compounded by external factors or interventions.

(ii) Working with Staff
When working with staff, the clinical psychologist has a number of roles: these include staff teaching, staff training, and a more general consultancy role. It is important to note that, depending upon the local structure, the psychologist may or may not be a full member of a team such as a CMHT while undertaking such activities. When they are team members, a whole host of professional issues concerning the interplay between effective team membership and professional identity may emerge (Pilling, 1995).

Conning (1991, p.89) notes that ‘most rehabilitation psychologists will be involved in teaching, either basic psychological principles or principles or theories of rehabilitation.’ It is often suggested that the reason why clinical psychologists are in a position to offer such teaching arises from the skills levels associated with clinical psychology, namely their level III skills of being able to draw on a 'multiple theoretical base,' and their flexibility to 'adapt and combine approaches' (DCP, Date Unknown, p.2). These skills may be even more important in the area of psychiatric rehabilitation because of the wide range of factors that contribute to a successful rehabilitation strategy.

In terms of staff training for rehabilitation, Lavender & Sperlinger (1988, p.115) note that 'training should be designed to reflect the philosophy, goals and types of staff recruited to, or found within, a particular service or project. They go onto distinguish three different groups of staff: (i) staff within new services; (ii) staff within existing services (hospital-and community based); (iii) staff involved in the process of service planning and development, who will benefit from separate but related strategies of
staff training. Lavender's own research, which will be discussed below shows how a
duly thought out piece of research can impact on all three areas.

In terms of consultancy, the Clinical Psychology Manpower Advisory Group has
advocated a position where knowledge and skills are at the disposal of other mental
health professionals on request. In a briefing paper written by members of the
Division of Clinical Psychology, entitled 'Using Clinical Psychology' (DCP, p.6 date
not given) clinical consultancy is defined as 'indirect work providing advice and
guidance without having the patient referred.' Examples given range from a 'help-line'
for referrers, a consultancy session with a GP. practice or group of nurses, to working
directly with the carers of a patient. This last area, which is probably more usefully
classified as psychological consultancy, is particularly important in terms of
rehabilitation where so often the carer is central to any community based
rehabilitation process. Moreover, the need for carers to be familiar with the ideas of
expressed emotion in families is an area of immediate practical relevance and one that
has been well developed and increasingly promoted by clinical psychologists.

(iii) Working with the Organization

One way that clinical psychologists work with organizations is in examining current
practice and looking at ways of improving this. A good example is Tony Lavender's
(1985) development of four Model Standards Questionnaires to assess key aspects of
care offered in psychiatric rehabilitation settings. Importantly this was also subject to
a careful evaluation of outcome (Lavender, 1987). Lavender used a controlled design
to evaluate the effects of providing feedback and recommendations, based on the
information gathered from these questionnaires to 12 wards in a large hospital: for
each of the four questionnaires, feedback was given to half and withheld from half, so
that all wards received feedback from two. Results indicated that there was significant
improvement for the experimental group for the Individual Programmes of Care area.
Secondly, a quasi-experimental design was used to compare pre- and post-
intervention scores for all 12 wards to assess whether there had been generalized change in practice. This indicated that there was significant changes for all wards, showing improvements regardless of whether they had received feedback on that particular questionnaire. These changes could not be accounted for by changes in other variables, including nurse/patient ratio, physical environment or the number or dependency of patients. It thus appeared that the introduction of feedback led to a generalized improvement in practice.

Other psychologists have developed questionnaires for use in rehabilitation settings. Clifford has developed a questionnaire to assess the needs of long-stay patients, the Community Placement Questionnaire (Clifford, 1987) as well as a questionnaire to assess the care environment, the Functional Assessment of Care Environments (Clifford & Wolfson, 1989).

Clinical Psychology and Quality Assurance
One way that clinical psychologists can work with staff is through quality assurance strategies. A good example of a system developed by four clinical psychologists is the QUARTZ (Clifford, Leiper, Lavender and Pilling, 1989) system of quality assurance that was developed at a relatively early stage in relation to QA in this country.

The QUARTZ system is based upon a detailed theoretical rationale derived from a review of the literature concerning different approaches to quality assurance, provided in Clifford et al. (1989). The system draws on the work already mentioned by Lavender (1987) on Model Standards for care environments. Central to the approach of QUARTZ is finding a balance between internal and external approaches to QA. Thus, the system attempts to maintain the engagement and motivation of clinical care staff typical of internal approaches, whilst introducing the objectivity found in the external review.
These principles are implemented through the role of a quality reviewer who acts as the consultant or facilitator to a group of care staff within an individual service setting, enabling them to review critically elements of the service which they provide. Reviewers tend to be senior professionals from within the service organization of which the setting is a part, but are external to the setting itself. Reviewers are themselves typically organized into a Quality Review Team to monitor that overall service. Each setting review is guided by a set of schedules, which point to key issues of quality in mental health care. Schedules cover a range of quality related issues and are intended to be tools which guide the identification of strengths and weaknesses within a service in order that significant problem areas will emerge for which action plans can be agreed. The QUARTZ schedule set currently comprises 15 schedules grouped in four main domains: (i) Environment and Resources; (ii) External Links; (iii) Management Practices and (iv) Client Review.

The main findings, conclusions and directions for future development are reported in a Quality Report at the conclusion of a period of review. The system is intended to be cyclical, with further reviews taking place which monitor the outcome of previously agreed action plans and consider further areas of the service. The system has also been subjected to a three-year evaluation programme (Leiper & Hill, 1992).

Of course, most clinical psychologists will not be constructing their own systems of quality assurance, but they still have an important role to play in the implementation, facilitation and evaluation of such programmes. The reason that clinical psychologists may be particularly well suited to such work lies in their scientist/practitioner training programme. Good quality assurance programmes are patient centred and fully evaluated.
Conclusion

Clinical psychologists have played a major part in the area of rehabilitation and there are signs that its importance as a specialty area is increasingly being recognized (Gentry, 1986). There are also indications that rehabilitation is being focused on as an area of wider interest. Thus, the All-Party Parliamentary Mental Health Group produced a Report in November 1996 calling for 'a rehabilitation strategy and package, a co-ordinated approach covering health, social security, education and training, and employment' and called for a specific Rehabilitation allowance (cited in Bray, 1997, p.29).

What about the future role of clinical psychologists in rehabilitation? Although rehabilitation is increasingly being recognized as an important area, numbers of clinical psychologists remain low and the development of a further specialty may weaken professional identity. The Sainsbury Centre for Mental Health (1997) in their major review of the roles and training needs of mental health staff, saw the future of clinical psychologists when they worked with people with severe mental illness as being very much within the CMHT. Whilst the challenge of retaining a professional identity and yet optimizing the use of specialized psychological skills is clear, it is not the only challenge for clinical psychology in the future. Given the focus of the recent White Paper on a primary care led NHS and the Government's recent decision to increase the numbers of secure places in the community for the most severely disabled clients, clinical psychologists may well end up performing the St Vitus dance between the relatively impermeable boundaries of the community secure unit and the more open CMHT.
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What were some of the driving forces behind the move towards community care for people with a learning disability and what is the role of the clinical psychologist in resettlement?

PEOPLE WITH LEARNING DISABILITIES ESSAY

June 1998

Year 1
Introduction
Living in the community is now a reality for many people with a learning difficulty and although this process has been going on for a number of years, the pace of development has in the last few years increased dramatically. To give some idea of numbers, in 1969 there were some 60,000 places in hospitals and NHS facilities, 20 years later this had been reduced to 20,000 places. Simultaneously, Social Service day provision increased from 23,000 in 1969 to about 50,000 in 1986 (cited in Williams, 1996). Moreover, in just thirteen years (between 1980 and 1993) the capacity of UK mental hospitals was reduced by 26,000. This process is not yet over and it is estimated that 70% of the remaining hospitals are due for closure, while the remainder will reduce their numbers (Emerson & Hatton, 1994). This dramatic reduction in the availability of hospital beds, and the corresponding shift to care in the community, has come about as a result of a number of forces, amongst them: changing perceptions of educability; the beginning of work on residential alternatives to hospital admission; a recognition of abuse in hospitals and lastly a change in the philosophy of care and perception of the person with learning difficulties. Thus in the last one hundred years there has been a radical shift in how we perceive those with learning difficulties, a shift that has done much to open doors and bring opportunities to a group of vulnerable and undervalued people. This essay will examine this shift into community care and focus on the way clinical psychologists have helped (and continue to help) in the process of resettlement.

What is Resettlement?
Resettlement refers to the move from institutional to community living. Such community living can involve: (i) living with one's family; (ii) living with a foster family; (iii) living independently; (iv) living in partially supported accommodation and (v) fully supported living.
Segregation and Learning Disabilities

Before examining some of the forces that led to individuals with learning difficulties being resettled in the community, it may be worth while to ask what led to the process of segregation in the first place. Prior to the industrial revolution, the community presence of individuals with learning difficulties was not seen as a problem. As Race (1995, p.46) notes 'Most villages were able to cope with the "idiots" in their midst, sometimes at the expense of ridicule and exploitation, sometimes with an almost reverent regard for their simplicity.' However, with the advent of industrialization there came about not only a need for improved levels of educational functioning but also a nascent form of measurement through which people could be categorized as fit for particular functions. Individuals with learning difficulties were not at this stage viewed negatively, as indicated by Itard's famous case of the wild boy of Aveyron (1932). By the turn of the century however, perceptions of those with learning difficulties were beginning to change.

One reason for this change was the science of genetics developed by Galton and continued by Pearson (Rust & Golombok, 1989). A second reason was scepticism regarding the notion of educability as a result of the introduction of intelligence testing. These forces led to a view concerning the inateness of dispositions and a fear that left to circulate freely there would a massive growth in the propagation of the 'feeble-minded' with a result that the stock of the nation would be greatly diminished. Needless to say this notion of a high birth rate amongst individuals with learning disabilities was more theory than fact, but other factors also encroached as summarised by Tregold (1909, p.97) when talking about the need for segregation:

In the first place the chief evil we have to prevent is undoubtedly that of propagation. Next, society must be protected against such of these persons as either have definite criminal tendencies, or are of so facile a disposition that they readily commit crimes at the instigation of others. Lastly, even where these poor creatures are relatively harmless, we have to protect society from the burden due to their non-production. Such views were held to a greater or lesser degree for the next forty years or so.
Perceptions of Educability

The IQ score still remains the main conceptual index for classifying people with learning difficulties and whilst the nomenclature of those who score below 80 has changed, the global intelligence quotient statistic remains as dominant as ever. However, what has changed over the years are notions of educability. Although Binet introduced the IQ test precisely in order to offer remedial help to those most in need, a low-test score quickly became equated not simply with low intelligence but with poor educability. This supposition went unchallenged until about the nineteen fifties.

Around this time psychologists actually began to measure hospitalised patients' IQ's. What researchers like Tizard (1964), the Clarks (1953, 1954) and Claridge and O'Connor (1957) found was that IQ scores were higher than they had originally been led to believe. For instance, Castell and Mittler (1965) in a survey of twenty hospitals assessed all those patients classified as either "subnormal" or "severely subnormal." They found that 26.3% had an IQ over 80 and 6.8% over 90. Studies such as these indicated that not only had levels of intelligence been underestimated, but also that IQ was not determinately fixed at birth. This led directly on to the recognition that environmental factors could play as much of a role for people with learning difficulties as they did for others.

The second major force was a recognition, built up by careful research that low IQ and poor social performance were not automatically correlated. For instance, Kingsley and Hyde (1945) had shown that the majority of those rejected for military service on the basis of being "mentally deficient" were both socially and economically self-supporting. Clarke and Clarke (1953, 1954) examined the effect of incentives and work on those who had previously been thought of as ineducable. Results from these and other related studies indicated that there was definite potential for incentive induced learning of industrial tasks.
It was in this context that perceptions of where people with learning difficulties should live changed. As Race (1995, p.54) notes 'The psychologists' ideal environment at that time was described by Gunzberg (1957) who saw the hospital primarily as a rehabilitation centre, preparing people with handicaps for community living.'

**Alternatives to Hospital Admission**

Given that people with learning difficulties could perform social functions at a higher level than previously thought and given the evidence that stimulating environments were more likely to enhance such skills, it is not surprising that researchers began to think up alternatives to the large institutions.

At the beginning of the nineteen sixties the idea of small residential units, 'hostels' was being mooted. Tizard (1964, p.32) made the case for 'an approach to the problem of organising residential care...based upon small residential units, closely associated with the day care services of a particular area.' Other researchers (e.g. Galloway & Garratt, 1964) followed a similar model but divided the client group into streams, each stream associated with a particular type of residential provision. However despite these advances, there were in reality few alternatives to hospital and much of the work that did occur continued to focus on educability and critiques of existing institutions (e.g. Morris, 1969). It should also be noted that legislative changes (The Mental Health Act, 1959) and Government Policy most notably outlined in a speech by Enoch Powell in 1961 focused on the need for most care to be provided outside the hospital setting. It was to be the next decade however, that saw such rhetoric being transformed into practical policies. The Education Act (1971) removed the notion of ineducability and the White Paper (1971) 'Better Services for the Mentally Handicapped' focused not only on deficiencies in current services, but on the need for reprovision in the community.
Thus, by the beginning of the nineteen seventies there was data which questioned the assumption that all people with learning difficulties had a very low and fixed IQ and that this was necessarily correlated with poor social performance. However, such optimism did not 'transmit itself to most of those directly involved with caring for people with learning disabilities, or for those with power over admission and discharge from hospital' (Race, 1995, p.54). It was to take another factor, namely a series of hospital scandals to change this dominant view.

Scandals and Abuse in the Hospital Setting

Concern both about the conditions and the sorts of institutions individuals were being detained in and the fact that individuals were being permanently detained had begun to emerge in the nineteen fifties. Whilst the 1959 Mental Health Act regulated compulsory detention, little was done about the services in which people with learning difficulties received their care and one can only wonder at the level of personal distress that occurred behind closed doors. However, there was no public outcry until around the 1970s, when a number of inquiries were held into abuse in hospitals e.g. The Mary Dendy Hospital Inquiry (1977); the Normansfield Hospital Inquiry (1978) and the Church Hill House Hospital Inquiry (1979). Also of particular importance in terms of raising public awareness about conditions inside mental handicap hospitals was the film *Silent Minority* (1981) by Nigel Evans focusing on St Lawrence's Hospital in Caterham. Such scandals and media images provided some impetus for change and resulted in the creation of models for monitoring and introducing change into long stay institutions. Subsequently as Wistow (1991) notes there has arisen a concern about more deep-seated weaknesses in service delivery systems. Thus whilst the well publicised scandals may have acted in a catalytic manner, it is the further recognition both of the iatrogenic nature of some medical interventions (Illich 1975) and of the de-individualising nature of many social institutions that have fuelled the flames of change. Wistow (1991, p.9) puts it as follows 'Just as it has been recognised that medicine can harm as well as heal, so it
has become clear that social care services can disable as well as enable, can create
dependence rather than independence and can disempower as well as empower.'

More recently as a result of the policy of closing many of the old mental health
hospitals and institutions and the dispersal of the clients into the community, there has
emerged an increased need for effective monitoring. Whilst undoubtedly things have
changed for the better, it is important to note that abuse of process and abuse of
person often seemed to occur not through malice but as a result of viewing people
with disability in a certain way (Martin, 1984). Thus whilst small community based
units may have enhanced environmental characteristics, it is the level of restrictive
staff practices that generally determine an individual's quality of life. In such a
context the case for mechanisms for ensuring a 'quality' service has increased: as
Clifford, Leiper, Lavender and Pilling. (1989, p.17) state, 'greater attention to quality
is necessary if some of the worst excesses are not to be reproduced in mini-institutions
that are as invisible to the public eye as the remote hospitals were twenty-five years
ago.'

Changes in the Philosophy of Care
During the late nineteen sixties the idea of normalization was being developed in
Scandinavia, before being taken up by Wolfensberger in the USA. The central
proposition of this approach was equality of opportunity for people with learning
difficulties. This was reflected in the Jay Committee Report and 'An Ordinary Life'
published by the King's Fund. There was also an increasing movement for advocacy
as in mental health services, an increasing toleration of difference in society and
general interest in questions of medical ethics and quality of life. These factors
collectively came together so that individuals with learning difficulties were perceived
to be in need of greater support and opportunity. In this sense the wheel has come full
circle, as the primary motivation behind Binet's work was to evaluate a persons
intelligence so that remedial aide could then be given.
The Role of the Clinical Psychologist

One way of looking at the role of the clinical psychologist in resettlement is to focus on those elements of the quality of care, as described by Donabedian (1966), namely outcome, process and structure variables.

'Outcomes, by and large, remain the ultimate validation of the effectiveness and quality of medical care.' (Donabedian, 1966, p. 169). Clinical psychologists due to their research based training are in a strong position to carry out applied research in community settings, with both staff and clients. Examples of research work related to resettlement is the impact of ordinary living (Evans, Todd, Blunde, Porterfield & Ager, 1987), the transfer to community care (Mansell & Beasley, 1990) and the effect of individual and environmental characteristics on outcomes in residential services (Joyce, 1993). Thus, clinical psychologists have a role in the evaluation of different types of service structures and intervention, in order that care practices can be based on valid research.

The second approach Donabedian suggests is the examination of the process of care, in other words whether 'what is known to be "good" medical care has been applied' (p.169). A great deal of work by psychologists has been undertaken around the area of behavioural functioning and a number of longitudinal studies have looked at the impact of different institutions on behaviour (e.g. Tizard, 1964). Other work relates to staff/client interactions and the effects of milieu, particularly in relation to challenging behaviour (Hill-Tout, 1992). Such work has enabled psychologists to develop specific staff and client based educational packages.

The third approach to the assessment of care Donabedian identifies is the study of the settings in which care takes place and the instrumentalities of which it is the product. 'This may be roughly designated as the assessment of structure., the assumption is made that given the proper settings and instrumentalities, good medical care will
follow' (p.170). A great deal of this work focuses on environmental characteristics and resident care practices, a well-known scale being that by King, Raynes and Tizard (1971). Other work has focused on the size of community living facilities e.g. Gagnan and Drewitt (1994). Important in respect to structure is the acknowledgment of the reality of sexuality for clients with learning difficulties and the need for structures to accommodate and in some instances promote this. Many resettled clients will have found means of expressing their sexual needs (not always appropriately) within a hospital setting. Expressing sexual need becomes more difficult within small community based settings and psychologists have a role as much in educating staff as with the client, in exploring means and methods for the appropriate expression of sexuality. Brown (1994) for instance provides an overview of the principle of normalisation as it applies to sexual options for people with learning difficulties.

A final role for clinical psychologists is in quality assurance activities themselves, activities which provide some means of ensuring that the quality of residential and community care is being assured. Of particular importance in terms of a structural approach to quality are the PASS 3 'Programme Analysis of Service Systems' (Wolfensberger & Glen, 1975) and PASSING 'Programme Analysis of Service Systems' (Wolfensberger & Thomas, 1983). PASS was originally developed in order to monitor the quality of community services for individuals with learning difficulties. Since that time it has been used and developed into a tool that can be used more widely for all groups of disabled individuals. PASSING is a more recent development of PASS, although one which excludes management and administration of a service. Both systems consists of a number of ratings of specific aspects, undertaken by a team of raters, in PASS 3 these are structured in terms of: integration; appropriate interpretations and structures; model coherency; developmental growth orientation and quality of setting.

PASSING makes a stronger separation between aspects of a service that impact upon
public perceptions or image 'and those that have a primary influence on direct help to people to overcome difficulties' (William's, 1995, p16.) Both PASS 3 and PASSING are based on the principles of 'normalisation' now termed 'social role valorisation' (SRV) and attempt to evaluate both service deficiencies as well as service successes. There is an extensive literature on SRV, and the concept itself has been the subject of much heated discussion (Jones & Withers, 1991). Both PASS and PASSING have been extensively evaluated and have had a great influence on the way services for disabled people are constructed. It is also important to note that whilst I have situated PASS and PASSING as structure measures they could be viewed causally as outcome measures as Wolfsen (1995, p.78) states 'The environment is a measure of outcome or an intervening variable in many studies involving mental health.'

A development from PASS was ACE ('Assessment of Care Environment') that has been used in order to evaluate the closure of a large London mental health hospital (Pilling & Midgley, 1995). Whilst the system has been subject to a reasonable amount of developmental work, it does not seem to have taken on a wider role outside of this one evaluation setting. However, ACE did seem to have some benefits over PASS in that it focused more on individuals' everyday experiences.

**Conclusion**

This essay has looked at some of the main driving forces behind the move towards community care and examined the role of the clinical psychologist in resettlement. It has been suggested that the shift to care in the community came about as a result of a number of forces, amongst them: changing perceptions of educability; the beginning of work on residential alternatives to hospital admission; a recognition of abuse in hospitals and a change in the philosophy of care and perception of the person with learning difficulties.

The role of the clinical psychologist has by no means been peripheral to such a
process, with much of the research emerging from practitioners in this area. In examining the current role of the clinical psychologist I have suggested that Donabedian's focus on process, structure and outcome variables provides one means of conceptualization. I have also suggested that the clinical psychologist has an extremely important part to play in quality assurance activities themselves. Given that much resettlement has already occurred and the nature of residential provision has changed for individuals with learning disabilities, it remains to be seen to what extent the specific skills that clinical psychologists have developed in the area of resettlement can be transferred to other salient aspects of care as they emerge in the next decade.
References


Clinical depression is an adult phenomenon and is of little relevance for children and adolescents? Discuss.
Introduction

The exact nature of clinical depression in children and adolescents has been discussed for a number of years and is still a matter of 'considerable controversy' (Harrington, 1993, p.1). Sceptics claim that clinical depression is an adult only phenomenon and that children and adolescents do not experience clinical depression themselves. Thus Rie writing in 1966 (p.654) states that 'the familiar manifestations of adult, non-psychotic depression are virtually non-existent in childhood. There is remarkable consensus about this finding.' This can be contrasted with the current view that the controversy surrounding the existence of childhood depression has now been resolved into 'a generally accepted view that it does exist, even in young school-children' (Almqvist, Piha, Moilanen, Tamminen, Kumpulainen, Rasanen & Koivisto, 1998, p.577). It is the aim of this paper to examine the divergence between these two points of view by examining the arguments for and against viewing depression as a non-age specific phenomenon.

The paper is split into three parts. The first part offers a definition of childhood and adolescence, before examining the range and scope of depressive disorders. The second part examines the arguments for seeing clinical depression as applicable to an adult only population. The third part reviews evidence for the contrary point of view, namely that clinical depression is as relevant to children and adolescents as it is to adults. The paper concludes by reviewing the arguments both for and against the existence of clinical depression in this age group.

Definitions of Childhood and Adolescence

Childhood is as much a social construction as a clear and undifferentiated developmental stage (Aries, 1973) and if in contradistinction to the medieval period we can articulate a period of childhood, the parameters of infancy, childhood and adolescence are by no means clear-cut. This is particularly true for the separation between them. Thus, adolescence often appears to be defined as much by the onset of puberty as chronologically and this may be the more salient factor in the onset of depression (Rutter, 1979). However, for the purposes of this essay the cut off between childhood and adolescence will be taken as occurring at around eleven years old (when senior school is started) and seventeen as the end of adolescence (based on the
current age for entering adult mental health services). No separation will be made between infancy and childhood, instead a distinction will be made between pre-school children (assuming normal developmental progress has been achieved) and school-age children. Such a distinction is important given the still unanswered question of whether depression both exists and can be diagnosed in preschoolers (Cytrin & McKnew, 1996; Kashani & Sherman, 1988).

The Nature of Depressive Disorder

Depression in adults is both an emotional state and a disorder amenable to diagnosis. However, depressive disorders are not a unitary clinical phenomenon and as Rutter (1988, p.8) notes 'there has been an unfortunate tendency in the literature to discuss childhood depression as if it were a homogeneous clinical entity.' Thus, it is important to identify the different forms of depression as well as the different ways of classifying them. Clinical depression as a term can thus include bipolar affective disorder, including types 1, 2 and 3 (Klerman, 1981); depressive episodes; recurrent depressive disorders, including severe psychotic depression as well as such affective states such as dysthymia (melancholia). Moreover, depression can be seen as endogenous or exogenous. Clinical depression can thus encompass an extremely wide territory and as Snaith (1991, p. 42) notes 'more confusion has surrounded the term "depression" than any other concept in psychiatry.' One means of establishing some form of classification for depression is to differentiate unipolar from bipolar disorders and acute conditions of psychotic intensity from mild chronic dysthymic conditions (Rutter, 1988). Such a classification essentially involves viewing bipolar and psychotic depression as severe forms of affective disorders and an absence of such psychotic features as less severe forms. The extent to which these less severe forms of depression can become diagnosed as severe depression depends to a large extent on intensity, duration and frequency of symptoms. In this paper, clinical depression will refer to non-psychotic depression unless otherwise specified. The rationale for this follows on from the scope of the studies reported, which in the main take non-psychotic depression as the focus of their concern.
Clinical Depression: An adult only phenomenon?

Those who question the reality of clinical depression in children and adolescence have advanced three different arguments. The first acknowledges the reality of depression for adults but not for children. Theoretical justifications for this thesis focus on issues of self-representation and ego/superego conflicts, both of which are thought to be lacking in children although not necessarily adolescents. The second position focuses on the role that social factors play in the onset of some forms of depression and suggests that children and adolescents are either relatively immune to such stressors or rarely experience them. The third position simply suggests that clinical depression is extremely rare in children and adolescents and thereby questions the heuristic value of diagnosing clinical depression in this age group.

(i) Self representation and ego/superego conflicts

Children it is argued do not experience depression because they lack a fully developed sense of self-representation and/or superego. Such theories suggest that the adult’s mind is qualitatively different to the child’s.

The first and longest standing theory of mind model is psychoanalytic and implicitly explains both exogenous and endogenous depression by focusing on the development of primary and secondary narcissistic impulses and ego-superego conflicts.

The classic statement of depression in psychoanalytic terms is to be found in Freud’s 1917 paper ‘Mourning and Melancholia’ (1984a). In this paper, Freud contrasts the experience of melancholia with that of mourning. Melancholia as outlined is seen as a pathological form of mourning in which what is lost is not a real person but an ‘internal object’, which is actually part of the ego, or more exactly conscience. Freud notes that although the original object-choice was a person to which the libido was attached (object-cathexis), when this object-relationship is undermined the libido is withdrawn into the ego. This loss of the object becomes ‘transformed into a loss in the ego and the conflict between the ego and the loved person transformed into a cleavage between the criticizing faculty of the ego and the ego as altered by the identification’ (Freud, 1984a, p.258). Thus, the individual feels both hostility and dependence towards the object and in melancholia feels dependence upon an object that is
believed to have been destroyed. Although often cited as the classic psychoanalytic statement on why depression is an adult only phenomenon, Freud does not actually state that children are incapable of such a process. He does however imply this (for infants at least), by stating that melancholia requires two necessary pre-conditions: (i) a strong fixation on the love object; (ii) low power of resistance in the object-cathexis due to narcissistic impulses. Given that Freud is clear on the ability of children to develop strong fixations on love objects, the narcissistic role of the child must be a central factor in preventing children from developing depression.

Classical theory distinguishes between primary narcissism and secondary narcissism. The former is a type of self-love, while the latter is love of one's self as a result of introjecting and identifying with an object. It is suggested that because infants are born at the level of primary narcissism they do not initially establish any object-cathexis. Only when they are capable of secondary narcissism is melancholia or depression possible. This it has been suggested occurs around the age of 3-4 months with awareness of the mother's breast, face and hands and has been formulated in terms of a transient external ego. Thus by the age of 6 months primary narcissism has already been modified, but the world of objects has not necessarily taken on greater shape (Hoffer, 1950). Thus for Freud the structure of the infant's mind precludes the possibility of melancholia.

An extension of the psychoanalytic theory focuses on the role of the superego (the ego ideal and conscience) which essentially originates from the introjection of objects. It is suggested that superego development is not possible in children until they have reached a certain level of development. This occurs after ego development usually between the ages of 5 and puberty (Dare, 1985). Rochlin (1959, p.300) notes that because the superego of the child is not fully developed it lacks the aggressive guilt inducing element found in adults. He states 'clinical depression, a superego phenomenon, as we psychoanalytically understand the disorder, does not occur in childhood. The child accepts substitute objects willingly and thus his ego makes restitution more quickly than the adults.' At some stage this narcissism appears to be displaced on to a new ideal ego to which 'is now directed all the self-love which the real ego enjoyed in childhood' (Freud, 1984b, p.88). As Freud (1984b, p.88) notes 'that which he projects ahead of him as his ideal is merely his substitute for the lost
narcissism of his childhood, the time when he was his own ideal.’

Thus, for some psychoanalysts the possibility of childhood depression based upon secondary narcissism and object introjection is possible only after the age of about six months. However, for others childhood depression is only possible where there is conflict between ego and superego, something which occurs at a later age. Such theories are as much about causal networks as types of depression, although it is possible that the depression of secondary narcissism will take a different form to the guilt inducing superego type. Given Freud’s limited writings on depression and the fact that he did not claim generality for his findings in ‘Mourning and Melancholia’ one has to be cautious about making any categorical judgements concerning the potential for children to experience depression. Moreover, as Rie (1966, p.661) notes ‘there is a lingering doubt not only whether this “classical” formulation characterizes a childhood disorder but indeed whether all adult depressions fit the mold.’

There is little empirical evidence for the emergence of the superego, due in part to the lack of specificity of the construct (e.g. the difference between ego, ego ideal and conscience is not always clear) and partly because of the powerful role that the ego and/or superego plays in the reporting of conscious experience. Thus, a second group of theorists have focused on notions of self-representation and self-expression. Rie (1966) in a review paper has suggested that it is the lack of intrapsychic maturity in children which prevents depression from occurring, however ‘intrapsychic maturity’ is not properly defined and appears to be little more than the superego renamed. Rie does however review a number of studies that have focused on the role of hopelessness in adult depression, something which is linked to the perception of time. Such future time orientation Rie suggests is lacking in children. The evidence for this assertion is not given.

Other theoretical work has been undertaken by Selman, Jaquette and Redman (1977) who have proposed a five stage developmental sequence of awareness of interpersonal issues. They suggest that earliest awareness is of being a physical entity only, through to being an intentional subject, an introspective self, stable personality and finally complex self-system. Although an interesting typology it is supported by minimal empirical evidence and lacks any explanation as to how the changes occur
between one level and the next. There is however some empirical work on the emergence of events and actions that can be regarded as normative in infants aged 17-20 months (Kagan, 1982). Kagan argues that the development of normative standards within the second year of life implies the development of self-awareness and that this is tied up with an evolutionary need to control aggression, particularly towards siblings. Although Kagan does not set out to discuss childhood depression the implication of his work (if correct) appears clear. Essentially infants within the first one and a half years of life have not developed a sense of self by which Kagan (1982, p.374) means 'the emergence of awareness of one's actions, intentions, states, and competencies.' Given that depression is at root an attack on the integrity of the self or perception of one's future self (Rie, 1966), there seems good reason to suppose that depression, certainly as adults know it, cannot therefore occur before around age 20 months. Although Kagan does not use self-awareness as an 'explanatory construct' it is possible to construct an argument as to why such infants are not capable of exogenous depression. In essence, if the infant lacks a sense of self then it logically knows no boundaries. It would then not be possible for depression or anything else to enter the child's world exogenously since only endogenous experiences are possible and even these internal experiences it could be suggested remain undifferentiated and conceptually indistinct.

Thus, the route to depression for at least one group of theorists can be seen to lie in the attainment of certain developmental milestones. Yet, such ideas have, as Gnomon and Garfinkel (1992) point out seemingly illogical implications for the existence of depression in other groups such as those who have learning disabilities. While the Freudian stress on secondary narcissistic impulses and superego development would appear to rule out depression in the very young infant it clearly does not rule out depression in the older child or adolescent. Furthermore, other psychoanalytically oriented clinicians do not regard depression in children as problematic at all. Spitz (1946) was one of the first clinicians to propose childhood depression and noted a form of depression based on hospital observations which infants fall into when separated from their mothers, the so called anaclitic depression because of the child's real dependency needs. Klein (1948) similarly talked of the 'depressive position' as an event of infancy occurring within the first six months.
(ii) **Social factors as protection**

The second area that needs to be briefly discussed concerns the role of social factors in depression. According to this view, children and adolescents are protected from depression not by the structure of their cognition or self, but by the fact that much depression is related to social events which children and adolescents are either protected from or which have less emotional impact. Thus romantic relationships, employment stress and primary financial worries may all well be outside the remit of the pre-adolescent. However focusing on the child’s structural relationship to the world appears both unwarranted and over simplistic, ignoring as it does the powerful role of systems in the child’s life. Moreover, it appears entirely unsustainable to suggest that children are protected from all of life’s stressors since some events such as parental separation and bereavement cannot be avoided by children. Van Eerdewegh, Bieri, Parrilla and Clayton (1982) found in their study of bereaved children, aged 2 to 17 years, that there was a significant increase in dysphoria (although not severe depression) following the death of a parent. The authors conclude that their results are in agreement with the psychoanalytic literature ‘indicating that the immediate reaction of a child to the death of one of its parents is usually mild and shortlived.’ (p.28). Although this finding is not adequately explained in the paper, the implication may be that life-events per se have less affective salience for children whenever they do occur. A more recent study by Weller, Weller, Fristad and Bowes (1991) would appear to back this up. In this study only 37% of children who lost a parent met the diagnostic criteria for depression. As Kovacs (1997, p.288) notes ‘if the aggregate of symptoms and signs that constitute major depression was to be a “normal” response to major loss one would expect much higher rates than about 30%.’ Similarly, one could note the extreme rarity of suicide in the under 12 age group (Hawton, 1982) as indicative of either children being protected from certain social experiences or the lower emotional salience of life events. One would also have to note the powerful role of alcohol, illness and romantic attachment as causal features of suicide: factors which most children do not experience first-hand.

(iii) **The rarity of clinical depression in children and adolescents**

A third argument does not deny that depressive moods can exist in children, but rather focuses on questions of utility. The issue appears to be whether diagnosis is possible in the same way it is for adults. Thus, the rarity of depression in children may result in
a lack of heuristic value to the concept. Thus, because Anthony and Scott (1960) reported a low prevalence of manic-depressive psychosis in children, one could question the utility of diagnosing such children. This is a rather weak argument and one that confuses the utility of a term with its precision. Thus, if one can effectively diagnose clinical depression, it appears irrelevant whether this occurs once or ten thousand times providing the diagnosis is reliable and valid. A more refined concern with diagnosis focuses on issues of (i) temporal stability and (ii) measurement validity (Lefkowitz & Burton, 1978). In terms of temporal stability, the concern is in the ever-changing developmental path of children and adolescents and the difficulty of using fixed diagnostic criteria for developmental states that are not always age based, e.g. the onset of puberty. The second concern is with the validity of the diagnosis itself, as Lefkowitz and Burton (1978, p.720) note ‘the disorder is inferred from the symptom and then it is claimed that the symptom is produced by the disorder.’ Obviously, such issues are as valid for those who accept the reality of childhood depression as those who negate it and thus could be seen as part of the current debate regarding how best to assess childhood depression.

In summary, there are a number of arguments that have been put forward to question the view that clinical depression can occur in children. The strongest of these the psychoanalytic and self-representation models suggest that it is simply not possible for very young children (infants) to experience depression. Other theorists have suggested albeit tentatively that social factors somehow protect children from experiencing stress in the first place. This argument however would seem to apply to only some very specialized areas such as work related depression and financial responsibility. There has also been some debate about the utility of diagnosing children, albeit accepting that depression can and does occur. Only one argument has proposed that adolescents are incapable of clinical depression and this only indirectly through the later development of the superego. However even here the age range at which this is thought to develop (5-14) precludes only the earliest adolescent experiences.
Clinical Depression in Childhood and Adolescence

Those who argue that clinical depression can occur in children and adolescents have adopted two positions, the one following on from the other. The first was a response to the argument that children did not experience depression and focused on the idea of 'depression equivalents' and 'masked depression.' There then followed what may be regarded as the current position, that clinical depression in childhood and adolescence is more or less equivalent in presentation to depression in adults, albeit with a number of difficulties.

(i) Depressive equivalents and 'masked depression'

The idea that depression may be occurring in childhood and adolescence, but that symptom presentation was always "masked" was a view that held particular appeal in the nineteen sixties (Glaser, 1967). It is by no means clear why the concept emerged when it did, although the fact that clinicians were seeing children whom they thought were depressed and who responded to treatment with anti-depressants provided a clue to the existence of the disorder. Added to this was a theoretical explanation that suggested that depression appeared in diverse manifestations due to the developmental age of the child (Conners, 1976). Importantly the essential feature of depression that was being noted was an absence of depressed mood even though treatment with tricyclic anti-depressants seemed to work. Thus, disorders such as phobias, delinquency and somatic symptoms were all being categorized as masked depression and social withdrawal, aggression, fear about death and enuresis as depressive equivalents (Harrington, 1993). Although establishing construct validity of depression for this age group appears to have been initially neglected, it soon became clear that there were a number of problems associated with the concept. The three most notable being: (i) how to differentiate between 'masked depression' and those disorders in which the presenting symptom was really the disorder e.g. a child's phobia really was a phobic response; (ii) the fact that 'masked depression' knew no boundaries and 'became extended to the point where almost any form of childhood and adolescent disorder could be considered as a "masked depression"' (Bailly, Beuscart, Collinet, Alexandre & Parquet, 1992, p.135); and (iii) the fact that most other diagnostic systems relied on description and not aetiology (Harrington, 1993). Such criticisms and the absence of a focus on mood led to a situation in which the
concept of 'masked depression' was doing both too much and too little. Too much because as Lefkowitz and Burton (1978, p.717) noted 'almost any behaviour that is disturbing enough to prod parents into referring a child for professional help may earn for a child the label of depressed. If the notions of masked depression and depressive equivalents are considered in the diagnosis, childhood depression reaches a state of omnipresence.' On the other hand 'masked depression' could be seen to be doing too little because the concept ostensibly ignored the main features of depression—mood incongruity.

(ii) Clinical depression as non-age specific

As a result of the interest in masked depression a research agenda developed which in the last twenty years has established clinical depression in children and adolescents as a reality. In order to make some sense of what is now an extremely large literature the arguments presented in four recent review papers (Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, Perel & Nelson, 1996; Birmaher, Ryan, Williamson, Brent & Kaufman & 1996; Harrington, Rutter & Fombonne, 1996; Harington, Whittaker & Shoebridge, 1998) will be explored.

The two papers by Birmaher and colleagues published in 1996 review the literature on childhood and adolescent depression (major depressive disorder and dysthymic disorder) over the last decade, examining a wide range of variables including epidemiology, clinical characteristics, natural course, biology, assessment, treatment and prevention. There is no mention of the 'disputed nature' of the illness in this group, rather that 'several lines of evidence provide support for the validity of childhood major depressive disorder and dysthymic disorder and their continuity with the adult depressive disorders' (Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, Perel & Nelson, 1996; p.1435) This is also the case with the papers by Harrington et al. 1996; 1998). What then is the evidence presented to substantiate such a position?

The review of work conducted at the Institute of psychiatry over the past thirty years by Harrington et al. (1996) is instructive in this regard. They suggest that originally the use of symptom-oriented interviews with children corroborated the existence of depression, albeit with some disparity between the rates of self reported depression and observable sadness. This raised the issue of whether inappropriate reporting as
opposed to underreporting was one possible reason for previously low-recorded rates of depression. The position now appears to have changed somewhat, for instance in a recent study of 5682 pre-pubertal children it was shown that children and adults report similar depressive features, but that, worryingly, this does not always lead on to assistance being given to those thought to be showing such symptoms (Almqvist, et al. 1998). However underreporting remains an issue particularly with younger children since it has been hypothesized that it is children’s ability to report and not simply experience depression that is problematic (Rutter, 1988).

Harrington et al. (1996) suggest the next important step was taken when work was undertaken connecting depression as a feature of mood to depression as a diagnostic category. Rutter’s work on the Isle of Wight indicated that there were also age and sex trends associated with the development of depression and that this would have an important bearing on diagnosis. Harrington reports that a study undertaken by Pearce (1978) indicated a degree of discriminative validity for a depressive diagnosis. Pearce found that depression related symptoms clustered together when examined in a routine clinical assessment and that these constituted 12% of all child and adolescent referrals. Pearce also showed that such symptoms become more frequent and are more likely to occur in girls with the transition from childhood into adolescence. The increased probability of adult depressive disorder for children who experienced severe depression also increased the construct validity of the diagnosis of depression. Similarly, Zeitlin (1986) looking at depression across the age continuum found a high preponderance of depressive symptoms in children that carried over to later life. Both of these studies added a measure of validity to the idea of childhood depression and its diagnosis.

A more recent paper by Harrington et al. (1998) focused on what is known about effective treatment, utilizing randomized controlled trials (RCT) for both children and adolescents. Examining CBT, interpersonal therapy and family therapy, the evidence indicated that CBT provided the most promising treatment approach, and that interpersonal therapy while promising remains untested in this age group. This was also true with family therapy with only four RCT’s being conducted to date. The importance of the review lies in the fact that the effectiveness of treatment provides some evidence for the validity of the underlying disorder. What is not clear from the
review however is how well such treatments discriminate between illnesses that may be co-morbid with depression or are in its place altogether.

Thus, there is evidence from a number of studies over the last twenty years that appears to have established the validity of depression in both childhood and adolescence. However, there remains some debate about whether pre-school children experience depression in the same way that adults do. At issue are two questions: (i) the ability of very young children to report on and conceptualize their internal concerns in language amenable to adults and (ii) the extent to which children experience depression as a state or trait. Notwithstanding the acceptance of depression as a reality both in terms of mood and diagnostic category for children and adolescents there remain a number of unanswered questions. In particular: (i) the relationship between biology and psycho-social factors remains to be specified; (ii) a greater understanding of protective factors as well as risk factors needs to be explored; (iii) the issue of co-morbidity and causality networks remains to be specified and (iv) the long-term efficacy of different treatment approaches needs further study.

Conclusion
This essay has examined the question of whether clinical depression is meaningful for children and adolescents. Evidence for depression as an adult only phenomenon is not compelling. Children are clearly vulnerable both to social stresses and life events and while the evidence suggests that their reactions to such events are milder than adults, adverse reactions clearly occur. The evidence put forward by both psychoanalytic theories and researchers interested in theories of self-representation would suggest that the very young infant is structurally incapable of depression. However other work, particularly Spitz’s observational study of mother-infant separation would appear to argue against this position. Theoretically, the arguments based on the development of secondary narcissistic impulses and superego development are convincing, although such ideas remain to be empirically demonstrated. Thus there are arguments as to why young infants at least are not in a position to experience depression. This is not the case with adolescents and there is little convincing argument as to why clinical depression is irrelevant to adolescents aside from the
development of the superego. Moreover, even this development would only appear to rule out depression in all but the very youngest adolescent. Thus, the current situation in which the reality of depression is accepted both as a mood state and as a legitimate diagnosis is hard not to accept.
References


What is the potential for psychotherapeutic work with people with dementia?

OLDER ADULTS ESSAY

December 1999

Year 2
Introduction.

This paper examines the potential for psychotherapeutic work with people with dementia, focusing specifically on older adults. The first part of the paper outlines the types, severity and duration of dementia before examining some general issues associated with working psychologically with the elderly. The second part examines the term 'psychotherapeutic work' and suggests that 'psychotherapeutic' can be defined both globally and specifically. The third part of the paper reviews what is known about behavioural, cognitive and psychodynamic work with individuals with dementia both individually and in terms of group work. The final part of the paper looks at more systemic approaches to working with the elderly and the role that indirect work plays in the lives of people with dementia. Among the issues discussed are the role of environmental and social factors, technical procedures such as dementia care mapping and the therapeutic role of relatives and informal carers. The paper concludes by summing up what is known about the extent to which psychotherapeutic work with individuals with dementia is effective.

Dementia and Issues of Working with the Elderly.

Dementia, of which there are a number of different types is a gradual and general deteriorating non-reversible condition effecting a person’s behaviour, cognitive abilities and emotions over an extended period of time. Hanley (1988) notes that the term applies to a diffuse deterioration in the mental functions resulting in most cases from an organic disease of the brain and manifesting itself primarily in thought and memory and secondarily in feeling and conduct. Behaviour changes may include wandering/restlessness, aggression, incontinence and loss of previously learnt skills. Cognitive changes can include memory difficulties, difficulties with orientation, loss of intellectual functioning and language/communication difficulties. Emotional changes can include changes to both mood and to personality. Early signs of dementia may included such things as increased forgetfulness, word finding difficulties and getting lost in unfamiliar surroundings. New learning tasks may also be impaired. Moderate dementia may involve poor memory for recent events, personality changes, loss of skills related to activities of daily living (ADL) and disorientation in terms of time and place. Severe dementia tends to result in a lack of awareness of surroundings, impaired self care and personality changes. Some of the
symptoms of mild dementia may be misinterpreted as signs of 'normal' ageing. There are also a number of illnesses, the so called 'pseudo-dementias', that may be misdiagnosed as dementia.

There are, however, clinicians who would question the deficit model of dementia. Best know is Kitwood's work in relation to Alzheimer's disease. Kitwood (1996) claims that the standard paradigm of dementia which he models as X ➔ neuropathic change ➔ dementia while explanatory in terms of dementias such as multi-infarct, remains unproven in Alzheimer's disease. In particular Kitwood suggests that the nature of X remains unclear and that there are only weak correlations between measures of dementia and the extent of neuropathology.

Squire (1982) in a review of the experimental literature on brain damage also suggests that there are some preserved abilities in dementia. Squire suggests that although declarative learning tends not to be preserved, procedural learning is. This clearly has implications for non-behavioural psychological approaches to dementia where cognitions and language take precedence over learning by action.

Irrespective of whether dementia is present or not, a number of clinicians have identified a number of general issues that need to be considered when working with the elderly. Bradbury (1991) identifies three factors: (i) the fact that elderly people are subject to the same range of psychological problems as adults of any age and that these may be neglected; (ii) the increased probability of loss and bereavement the older one becomes and (iii) the fact that older people are more likely to have chronic health problems which may interfere or act as distractors in therapy. One can add to this list the important role that the environment plays in the lives of those who suffer from physical frailty, the relative slow down of the rate of new learning and less familiarity and possibly acceptance of psychological explanations among older people. Such factors obviously will impact to a greater or lesser degree depending upon the client, but generally are more likely to be important in an older population that a younger one.
Defining ‘Psychotherapeutic’.

The term ‘psychotherapeutic’ can be seen to have both a specific and a global meaning. Thus the term can be used specifically to denote intervention that focuses on behaviour, cognitions and the role of the unconscious, while a more global use of the term would include anything that improves an individual’s quality of life such as ability to bathe, improved continence and mobility. Moreover such non-psychological factors can act as intervening variables by impacting upon an individual’s well-being, independence and levels of depression (Woods, 1999). Some writers such as Cheston (1998, p.221) deal exclusively with the former area, focusing on interventions which derive from ‘established psychotherapeutic principles.’ Sadly Cheston fails to state what these established principles are. In this paper consideration will be given to both the specific and global aspects of the term ‘psychotherapeutic.’

Behavioural Approaches to Dementia.

If Squire (1982) is correct about the preserved abilities of procedural learning in dementia then there are good theoretical grounds for viewing behavioural work as particularly suited to clients with dementia. This does indeed appear to be the case, although Woods and Roth (1996, p.335) note that ‘there are still relatively few reports of the successful application of behavior modification to patients clearly identifiable as having dementia.’

Behavioural modification programmes can be crudely divided into those that focus on the reduction of problem behaviours and those that attempt to increase or in some cases instil positive behaviour. In the former case work has focused on problems such as incontinence, agitation and shouting (Stokes, 1990), and a reduction in wandering (Mayer & Darby, 1995). The latter approach has focused on increasing mobility (Burgio, Burgio, Engel & Tice, 1986), increasing participation in nursing home activities and improving levels of social contact (Carstensen & Erikson, 1986). Given the wide range of studies that could be reported, a limited number of empirical studies will be examined in order to provide an overview of behavioural modification work.

One of the earliest forms of successful behaviour change, in which there was an attempt to instil more positive behaviour, occurred as a result of work on environmental modification in hospital wards. Sommer and Ross (1958) found that a
simple rearrangement of hospital day room seating could almost double the level of
social interaction. They found that when chairs were placed against the walls of the
room, the effect was similar to that of a waiting room, with the patients acting as
observers and in their memorable phrase “waiting for a train that never comes.”
Although this work and the work of Peterson, Knapp, Rosen and Pither (1977) has
shown that moving chairs into small groups has measurable effects on levels of
interaction, both studies found that it was difficult to maintain the chairs in their
rearranged place. A number of suggestions are put forward for this. In particular
pragmatic considerations concerning ward routine and management, so called
‘institutional maintenance’ are seen to be more important than concern with patient
care. However, as Lindesay, Briggs, Lawes, Macdonald and Herzberg (1995) have
suggested in their work on ‘the domus philosophy’, acknowledging the needs of staff
as well as patients is often overlooked.

Another and more recent example of the effect that environmental modification can
have, this time in reducing negative behaviour, is a study undertaken by Mayer and
Darby (1995). They wanted to know whether a full sized mirror placed near to an exit
door (but not blocking it) on a hospital ward could reduce attempts to exit the ward.
The underlying theory being that attraction to mirrors in dementia results either from
an attempt to reclaim a lost personal identity or to communicate with the
unrecognized image in the mirror. Nine patients with dementia and habitual
wandering were identified on a ward and observed over a two-week period. Three
conditions were implemented, daily use of the full-length mirror, daily use of the
reversed mirror and neither. Baseline data was collected on number of exit attempts
prior to the placing of the mirror. Results indicated that without the mirror in place
76.2% of approaches resulted in exit door contact, when the reversed mirror was used
contact fell to 51% and when the non-reversed mirror was used contacts fell to 35.7%.
Thus use of the mirror reduced exit door contact by half. The authors are aware of the
limitations of the study both in terms of sample size and limited observation period.
However, it is unclear from the data presented whether attempts to exit were reduced
between baseline and the condition in which the mirror was not in use. The
Hawthorne effect would have to be considered if this was indeed the case. That stated,
this research does indicate the possible benefits of simple environmental modification
and although in this case attempts at exit did not stop entirely, gross attempts dropped dramatically.

Larger scale attempts to modify patients' behaviour on the basis of a change in the structure of care environments for people with dementia are to be found in the work of Lindesay et al., (1995). The so called 'Domus Philosophy' is based on four assumptions: (i) that the domus is the resident's home for life; (ii) that the needs of the staff are as important as those of the residents; (iii) that the domus should aim to correct the avoidable consequences of dementia, and accommodate those that are unavoidable and (iv) that the residents' individual psychological and emotional needs may take precedence over the physical aspects of their care. The authors have empirically evaluated this philosophy using an uncontrolled cross-sectional comparison of two psychogeriatric long stay wards. The authors while acknowledging the limitations of the study conclude that 'a philosophy of care directed at preventing institutional maintenance is associated with improvements in the residential care for the demented elderly.'

Robbins (1998) has recently undertaken a study that has intervened directly with patients using a group format. She used a number of structured assessment tools on a pre-test/post-test basis to measure the impact of a time limited activity group on members level of functioning, level of depression and level of group participation. Although no control group was used and numbers were small (7 men with a diagnosis of dementia), Robbins found that cognitive and behavioural abilities were maintained over a two month period and that post group depressions scores were significantly lower.

Behavioural approaches to dementia would appear then to be an important form of intervention for people with dementia, particularly in terms of reducing problem behaviours, and there are a number of studies, particularly single case studies, that claim to have met with a high degree of success (Woods, 1999). However the situation does not appear to have changed markedly from 1982 when Holden and Woods talked about behaviour modification as an extremely promising approach, but one in which there was a lack of convincing evidence for its effectiveness. There
remains a need for more experimental interventions in which control group methodologies are used.

Cognitive Approaches to Dementia.

One is struck by the fact that the diagnosis of dementia is itself based on a cognitive model of functioning and that cognitive assessment is pivotal to this. At one level then the assessment of cognitive functioning can be regarded as the starting point for any psychotherapeutic work in this area, and for some people clear knowledge of current skills and deficits may in and of itself provide some psychological benefit.

However, it is in the area of practical work that cognitive approaches would seem to be of most benefit. Perhaps there is no more important area than that of memory for, as Williams (1996) notes, the healing of memory is central to cognitive work. Thus work that focuses on improving or strengthening memory in dementia may be viewed as an important core of cognitive work. Clearly, viewing memory in cognitive terms does not ignore the fact that there are many behavioural dimensions to memory work such as the use of external aids like diaries, notebooks and so forth.

Memory clinics have been a feature of British psychological approaches to dementia since the early nineteen eighties. The first being established at St Pancras Hospital in 1983, followed a year later by the Maudsley Hospital Memory Clinic. The clinics generally operate on the basis of a multidisciplinary team based in a hospital and often linked to ongoing research projects. Empirical studies of memory retraining however do not appear that often and while clinical psychologists have been active in intellectual assessment they have tended not to follow this up with memory rehabilitation approaches (Emmerson & Frampton, 1996). Zarit, Zarit and Reever (1982) reported only mild and fleeting improvements in patients with dementia as a result of memory training but some negative results, in the form of greater distress on care givers. This indicates the importance both of adequate screening for inclusion into such studies and the need to explore participant’s expectations beforehand. Emmerson and Frampton (1996) report on their memory management approach at the Bristol Memory Clinic. Using a case study approach they note that there were immediate positive outcomes as a result of such retraining; however, they also acknowledge the need to investigate whether these gains held over time.
Another form of intervention that may be construed as primarily cognitive is reminiscence therapy (Norris, 1986), although primarily a verbal form of activity, outcome measures in this form of therapy are usually focused around levels of participation outside the session. McKieman and Yardley (1991) examined the impact of reminiscence therapy on elderly people with dementia and found that levels of engagement (both verbal and non-verbal) increased as a result of participation in a reminiscence group as compared to a ward based control group. However, a controlled cross over study found improvements in only one of two groups as measured by improvements to behavioural orientation (Baines, Saxby & Ehlert, 1987). Similarly disappointing results were found by Head, Portnoy and Woods (1990). Given that both of these studies used controlled methodologies, the mixed pattern of results makes it difficult to establish that reminiscence therapy itself is effective, rather it may be some element of the group dynamics that is exerting the influence for change.

Isolating psychotherapeutic approaches to dementia that are primarily cognitive and have been evaluated is surprisingly difficult. Given the important role of memory retraining and its use in clinicians work, few evaluative studies seem to have made their way into the general psychological literature on dementia. It is also noteworthy that approaches that are labeled as cognitive actually rely mainly on behavioural outcome measures. This of course may be saying something about the ecological validity of much cognitive assessment work, but it also raises questions about cognitive therapy in general. Thus, whether this form of intervention is the most suitable for individuals with declining cognitive functioning must remain an open question.

**Cognitive Behavioural Approaches to Dementia.**

Written accounts of the application of CBT to clients with dementia seem to be extremely limited. This is undoubtedly because the logical and collaborative nature of CBT becomes increasingly problematic when cognitive ability declines past a certain point. Thus, Grant and Casey (1995, p.561) suggest that severe cognitive impairment is a contraindication because impairment ‘renders new learning impossible’ with the result that patients are unable to participate meaningfully in therapy. While such a claim may be relatively uncontentious there eems little reason why CBT could not be
employed in the earliest stages of dementia, either to examine questions of loss and meaning or as a means of dealing with any depression that may arise as an adjunct to the diagnosis. This is what Terri and Gallagher-Thompson (1991) have done, focusing on the balance between positive and negative experiences and activities. Central to this process, which took place over a 16-20 week period was the challenging of cognitive distortions.

Grant and Casey (1995) in a paper examining the utility of CBT in mild dementia suggest that it can be particularly useful as a supportive medium and that the emphasis on the resolution of practical concerns and behavioural change is particularly useful for an older age group. They do however suggest a number of adaptations to the generally accepted CBT structure, including brief, informal and frequent sessions, the use of simple language and a minimization of professional jargon. They note that homework is often ‘based on the patient’s participation in a social activity or on carrying out self-care activities through a “try it and see” approach’ (p.561). They also note that the therapist is obliged to furnish much of the energy for the therapeutic process.

Grant and Casey (1995) also acknowledge the utility of CBT in terms of patients coming to terms with the meaning of their life, consequent to diagnosis, something they term “existential CBT.” The aim of such an approach is specifically to help patients to develop a less negative life appraisal. This is undoubtedly a challenge in dementia where the concerns about future functioning are realistic. However as Moorey (1996) has clearly argued there is a role for CBT in exploring ‘realistic’ negative thoughts. Although Moorey does not deal with dementia directly it would seem that CBT may be of benefit when patients learn of their diagnosis and where ‘depressive realism’ may be particularly salient. Indeed his work with patients with cancer would appear to be relevant up to a point. The primary difference being that CBT relies so heavily on the mechanism of the mind in order that a form of cumulative self-understanding can occur, that disruption of the ability to learn and remember, would appear to make the process of self-understanding uniquely problematic.
Husband (1999) reviews the use of a CBT approach to the learning of a diagnosis of dementia on three patients with mild cognitive impairment who were part of a larger study. Like Grant and Casey, Husband modified the CBT approach. In particular she emphasized the use of a more solution focused approach, slow pace, more frequent summarizing and feedback and an absence of formal ‘homework.’ Interestingly the patients in the study were reported to be preoccupied and anxious about the diagnosis, but not to have depression. Although no standardized outcome measures were used Husband reports that the patients benefited from the intervention. In particular self-stigmatisation, catastrophization and social withdrawal were all challenged. Husband concludes that the greatest impact was not on areas previously hypothesized to be important such as putting ones affairs in order (Meyers, 1997) but on self-esteem and ‘personhood.’ Although a suggestive study, the lack of any standardized outcome measures and small sample size make the results unclear.

There are a number of other techniques not readily classified as cognitive behavioural that do to some extent focus on both cognitions and behaviours. Reality Orientation (RO), developed in the USA in the 1960’s (Holden & Woods, 1982) is a good example of this in which there is an attempt to reduce both patients’ confusion as well as their behaviour. Rands (1999) has divided RO into a 24hr or informal approach and a classroom or group format. Spector, Orrell and Davies (1999) in a meta-analysis of 6 randomised controlled trials of RO with patients with dementia found that RO improves cognitive functioning. Behavioural outcome measures although not reaching statistical significance indicated a positive trend for RO over control groups.

In summary CBT does appear to be useful in the early stages of dementia and there are good theoretical reasons for this with its focus on distorted cognitions. Moreover both Grant and Casey (1995) and Moorey (1996) provide a clear rationale for using CBT in adverse life circumstances and both sets of authors suggest ways in which CBT can be adapted to take such circumstances into account. Neither paper is empirically based, although Grant and Casey do state that their exposition is based on clinical experience. This is indicative of the current research base in which the number of published studies is currently extremely limited. Clearly if clinicians are to be informed by the evidence, more single case design studies and larger experimental samples using standardized measures are required. Reality Orientation which has been
subject to far more research would appear to be of some benefit to individuals with dementia and has the added advantage of being applicable beyond the stage of early onset.

Psychodynamically Informed Approaches to Dementia.

Accounts of psychoanalytically derived work with people with dementia have begun to increase in the last ten years or so. However there remains a lack of published evaluative studies and as Cheston (1998, p.219) notes ‘those that do exist are often anecdotal in nature.’ A good example is the work of Hunter (1989) who reports her work with ageing people with dementia over a period of about ten years with the aim of reducing emotional isolation. Reflecting on her experience of running 17 psychotherapy groups with 121 participants aged between 68 and 100 she suggests that group cohesion and the ability of group members to ‘resist excessive demands [of the individual] without rejection’ play a central part in the utility of group approaches over individual approaches. Although not scientifically assessed, as Hunter acknowledges, the paper does point to advantages of group over individual therapy.

On an individual basis Sinason (1992) describes her work with a man suffering from early onset dementia and the work that she undertook with him over a period of some months focusing on his adaptation to the news of his illness and the reality of his limitations. At one level this followed a relatively traditional psychoanalytic form. At another there was some recognition that the generally accepted notion of consent was problematic and could not be deemed to have been given simply on a one off basis. This was particularly salient for Sinason as unusually she was undertaking the therapy sessions at the patient’s home.

Validation therapy developed by Feil (1993) and based on the developmental theories of Erikson (1963) and Roger’s (1965) person centred approach, can be viewed as a form of psychoanalytically derived therapy. Feil uses Erikson’s developmental framework by formulating current difficulties in terms of unresolved developmental tasks from the past and Roger’s approach in terms of restoring self-worth. Unlike RO, validation therapy concentrates not on the actual content of a person’s speech but on the emotional content that lies behind it.
Evaluations of validation therapy remain on the whole the exception rather than the rule. Barker (1997) does report a small scale study (six members) using a subjective rating scale derived from Kitwood and Bredin (1994). Barker argues that the group exemplified the four subjective states identified by Kitwood and Bredin namely personal worth, agency, social confidence and basic trust. However the use of a subjective scale only along with the author’s own observations tend to result in the study being of limited generalizability.

Cheston (1998) has published a paper reviewing some of the evidence for ‘psychotherapuetic work,’ (by which he seems to mean psychodynamically informed work) with people with dementia along with some suggested adaptations. These are summarized under four headings: (i) adaptations to the treatment programme to accommodate cognitive deficits; (ii) adaptations to the therapeutic context; (iii) containment and (iv) transference and counter-transference. At an individual level Cheston suggests that therapeutic interventions can focus on support for the grieving process, resolving conflicts from the past and identity work.

Approaches to dementia based on psychodynamic principles appear to be at a very early stage and the evidence for their utility remains weak. Theoretically the process of resolving past conflicts would not on the face of it appear the most pressing need for those with dementia. Indeed given that this form of therapy would probably be confined to the early stages of dementia, as Sinason’s account shows, coming to terms with the diagnosis would appear of more help. That stated, more ‘humanistic’ approaches which focus on meaning could be hypothesized to be important, although Grant and Casey’s (1995) use of existential CBT may in fact already cover this.

**Systemic and Indirect Approaches to Dementia.**

There are a number of approaches to the care and treatment of people with dementia that can be construed as systems based and which often aim to improve the quality of an individual’s life through indirect means. The Domus philosophy discussed under behavioural approaches would be an example of an indirect environmental approach, another would be Kitwood and Bredin’s (1992) work on dementia care mapping (DCM).
Dementia care mapping is essentially an attempt by Kitwood and Bredin to apply person centred theories of dementia to service provision using an ethological approach. They argue that it is possible to differentiate those care practices which support personhood from those that do not. At the core of DCM is an assumption that relative well-being equals good quality care (Kitwood & Bredin, 1992). DCM is essentially an observational method that records both activity/inactivity, type of behaviour and any personal detractions (essentially negative interventions/situations). At the end of the recording process one is able to see which types of behaviour are encouraged in any particular setting. The environment is also rated through a Dementia Care Quotient which is 'a rather gross index of the overall efficiency of a scheme in delivering care, taking into account the ratio of staff to dementia sufferers.' (Kitwood & Bredin, p.55). Inter-observer reliability estimates are reported to be around 0.7 by the authors. Criticisms of the model noted by the authors include its reliance on the observation of public events and the potential for observers to create bias through their observation. It has also been suggested that the method does not take into account levels of severity and therefore is a rather crude means of assessing individual care. Kitwood (1997) has gone on to highlight two types of care environment which he believes are common, Type A (hierarchical and based on power structures) and Type B (egalitarian and based on common goals). Although Kitwood’s work lacks much empirical support and can be criticized on the grounds that it seems to include a little bit of everything (neuropsychology, social psychology, personality theory, ethology) his work is clearly of value in highlighting the effects of poor care environments and the more general aspects of malignant social psychology in dementia care.

The role of both professional and informal carers is obviously of some importance in dementia care, particularly in the later stages of the illness. Work looking at the role of carers has often focused on their own needs and stresses (e.g. Matson, 1994; McKee, Whittick, Ballinger, Gilhooly, Gordon, Mutch & Phelp, 1997) and rather less work has been undertaken on elements of good quality care. Kitwood’s person centred approach is one obvious exception to this whereby he highlights 12 positive types of interaction that carers can use, three of which he suggests are of particularly therapeutic value (validation, holding and facilitation).
One recent paper has examined what is known about the effect of training families in care giving to people with dementia (Terri, 1999). Terri notes that there are now a number of case controlled trials, particularly of behavioural interventions that have been successful in reducing patient’s problems and that routine work and training in this area would be beneficial.

Conclusion.

This essay has reviewed some of the main psychotherapeutic approaches to dementia. In arriving at an overall conclusion to the question of whether such approaches have potential for people with dementia two things need to be borne in mind. Firstly, that dementia by its very nature remains a very personal disease and one in which general accounts of progression and treatment probably obscure as much as they elucidate. Secondly, there does appear to be a sense in which there are potentially two dementias for every individual, one in which there is awareness of the disease and one where such awareness can no longer be presumed.

Reviewing the psychological literature the utility of approaches to early stage dementia would appear to be strong. The work on CBT while in its infancy with regard to this condition would appear to offer a productive way forward. Similarly cognitive approaches focusing on memory retraining would appear to be of some practical as well as theoretical importance. However, the empirically demonstrated benefit of such approaches remains to be determined. Behavioural modification work, particularly environmental modification would appear to be particularly useful in the second stage of dementia. Psychodynamic approaches in dementia remain relatively unproven and theoretically the arguments for implementing this particular approach seem weak. At a more systemic level, Kitwood’s work has been of undoubted benefit, particularly the way it has shifted the agenda of dementia care, a shift which makes psychological approaches to dementia probably more acceptable to professional staff and informal carers alike. Thus the conclusion would be that a number of psychotherapeutic approaches are of potential benefit and a few of actual benefit. In a sense what is required to enhance the validity of this conclusion are the views of individuals with dementia. Sadly as Stalker, Gilliard and Downs (1999) note this remains a neglected area of research.
References


Assess the Adequacy of Psychological Explanations for Munchausen by Proxy Syndrome.

SPECIALIST ESSAY

June 1999

Year 3
Introduction
On the face of it, intentionally presenting one's child to a hospital or doctor for unneeded investigations or intentionally harming it to secure such investigations must be one of the strangest acts a parent can commit. Munchausen by Proxy Syndrome (MbPS) or factitious disorder by proxy (FDP) as it is known in the DSM-IV research criteria (American Psychiatric Association, 1994) are the technical terms for this pattern of behaviour. The term MbPS will be used in preference to factitious disorder by proxy throughout this essay since this is currently the more widely used term.

Although there are now several hundred articles that describe MbPS, there has been no attempt to draw this material together and explain what motivates the perpetrators from a psychological perspective. The largest body of psychologically relevant material focuses on psychotherapeutic treatment of the disorder without making explicit whether the focus is on cause, predisposition or sustaining factors. Thus, Levin and Sheridan (1995, p.x) note: ‘there is still much to be learned about MbPS. Some of the most basic questions: how frequently it occurs, what dynamics underlie it, how it might be prevented, are still unanswered.’ One of the reasons for this lack of knowledge may be a cynicism concerning what can be achieved by talking to perpetrators. Thus even one of the most incisive writers in the field can state:

> From a pediatric point of view, the intent of the perpetrator is diagnostically immaterial. Realistically, the pediatrician has no way to measure intent, either quantitatively or qualitatively. The perpetrator, who would be the only reliable source of information concerning intent is, by definition, unreliable. She generally lacks insight, is severely psychologically disturbed, and has a vested interest in clouding, rather than clarifying, matters (Rosenberg, 1995, p.95)

This essay is an attempt to review the material relating to these ‘underlying dynamics’ through a review of the published psychological and paediatric literature. In order to do this the essay is split into four parts. Part one introduces the concepts of Munchausen Disorder, Factitious Disorder, Factitious Disorder by Proxy and Munchausen by Proxy Syndrome. Part two looks at what is known about the perpetrators of MbPS in terms of social and demographic factors such as occupation, marital status and gender. Part three reviews the material relating to psychological

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1 Where cited authors use slightly different terms such as Munchausen Syndrome by Proxy (MSBP) these will be noted in the text.
explanations of the disorder and focuses on psychoanalytic explanations, systemic explanations and explanations in terms of personality disorder. The concluding part of the essay briefly raises some concerns about the extent to which MbPS can be seen as a distinct and separate form of abuse.

Conceptual Distinctions

(i) Munchausen and factitious disorder.
Munchausen syndrome was identified in 1951 by Dr. Richard Asher and so named because of the similarities between reports given to him by his patients and the flights of fancy in the fictional tales of Baron Von Munchausen. The central features of Munchausen syndrome were described by Asher (1951, p.339) as follows:

Here is described a common syndrome which most doctors have seen, but about which little has been written. Like the famous Baron von Munchausen [sic], the persons affected have always travelled widely; and their stories, like those attributed to him, are both dramatic and untruthful. Accordingly the syndrome is respectfully dedicated to the baron, and named after him.

In DSM-IV the term Factitious Disorder is used instead of Munchausen Syndrome. However, there is unanimity within the literature that the underlying disorder remains the same. The diagnostic criteria for factitious disorder are given in Table 1.

Table 1 DSM-IV Diagnostic Criteria for Factitious Disorder.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>300.16</td>
<td>With Predominantly Psychological Signs and Symptoms: if psychological signs and symptoms predominate in the clinical presentation.</td>
</tr>
<tr>
<td>300.17</td>
<td>With Predominantly Physical Signs and Symptoms: if physical signs and symptoms predominate in the clinical presentation.</td>
</tr>
<tr>
<td>300.19</td>
<td>With Combined Psychological and Physical Signs and Symptoms: if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation.</td>
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As one can see from this table, Factitious disorder is not a disease as such, but a syndrome defined as ‘a cluster of symptoms and/or signs which are circumstantially
related’ and which ‘in contrast to a disease may have multiple or different etiologies, this may prove to be the case with Munchausen Syndrome by Proxy.’ (Rosenberg, 1987, p.58.)

(ii) Factitious disorder by proxy

Just as Munchausen disorder is the favoured term in the scholarly and medical community for self presenting symptoms of illness, factitious disorder by proxy (FDbP) is the term that is currently included in DSM-IV for symptoms or signs presented or induced by someone else. Currently, FDP occurs only in the research section of DSM-IV and not in the main diagnostic criteria section (See Table 2). One can interpret this in one of two ways. Either the psychiatric community is beginning to acknowledge FDbP as a formal diagnostic entity (Parnell, 1998), or there is some diffidence in differentiating FDbP as a separate diagnostic grouping at all, particularly in relation to child abuse.

Table 2 Research Criteria for Factitious Disorder by Proxy in DSM-IV (APA, 1994).

<table>
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<tr>
<th>Criteria</th>
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<tr>
<td>A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care.</td>
</tr>
<tr>
<td>B. The motivation for the perpetrator’s behaviour is to assume the sick role by proxy.</td>
</tr>
<tr>
<td>C. External; incentives for the behaviour (such as economic gain) are absent.</td>
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<tr>
<td>D. The behaviour is not better accounted for by another mental disorder.</td>
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Epilepsy, smothering, poisoning, the fabrication of allergies, breathing problems and the induction of bleeding have been reported as the most common manifestations of FDbP (Bools, 1996).

(iii) Munchausen by proxy syndrome

There is no reason to believe that MbPS is a new phenomenon. Roy Meadow (1995) who is credited with first noting the similarities with Munchausen disorder, notes that that which is claimed to be new either has been unrecognized, unreported or described in another way in other times. Although the term MbPS is used almost exclusively in relation to an act that occurs between an adult (usually the mother) and a child, Meadow did not restrict the definition to this dyad himself. Sigal and Altmark (1995) note that while typically MbPS occurs between mother and child, it can develop in
other kinds of human interaction models in which both the victim and the perpetrator are adults. Although there are very few reported cases of adult-to-adult MbPS its existence highlights the role that dependency and not just chronological age may play in the instigation of the abusive activity.

However, to date the main focus has been on the mother and MbPS has been defined as a triad of abuse, self-abuse and deception in which ‘the crux of the triad is the manipulating mother’ (Sigal, Gelkopf & Meadow, 1989, p.531). This triad highlights the abuse of the child, deception of medical authorities and ‘self abuse or passivity of the child.’ While this differentiation may have some heuristic value, the last category seems to confuse two separate phenomena and to unhelpfully suggest a level of control on the part of children which is probably absent. Sigal et al. (1989) report that the youngest child presented with a case of factitious disease by proxy was 8 weeks; the oldest being 11 years. Passivity in children of such ages may be normal, particularly in pre-verbal children and should not be regarded as implying an abnormal response. Passivity in the psychological and psychodynamic literature is often assumed to imply some form of unwillingness to initiate action (Rycroft, 1985) a factor that is clearly not relevant for infants and young children whose dependency is based upon real physiological, emotional and psychological needs. Secondly the inclusion of self-abuse within the triad conflates the majority of cases with a smaller subset. Rosenberg (1987, p.557) in her review paper notes that

Although the mothers were directly responsible for only 75% of the morbidity in children with MBSP, they actually precipitated 100% of the morbidity, using medical professionals as unwitting agents in the execution of the maternal psychopathology. Medical professionals were not the only agents; there was a strong trend seen for children to adopt mythic symptoms as genuine and begin to express them “as their own.” This trend increased as children grew older.

Thus it may be important to distinguish between the majority of MbPS cases where perpetrators act on incapable infants and unwilling children and those rarer cases where older children actively participate or collude in their own ‘symptoms.’
A different way of describing what is occurring in MbPS that retains a focus on the perpetrator was put forward three years earlier by Libow and Schreier (1986). They differentiate three forms of MBPS: (i) 'help seekers;' (ii) 'doctor addicts' and (iii) 'active inducers' and suggest that each of the three groups have differing motivations for the behaviour.

For Libow and Schreier (1986) 'help seekers' are described as those individuals who present someone in their care to medical authorities as the result of either factitious or induced symptoms. Both symptom frequency and motivation of the perpetrator are seen as different from other forms of MbPS. In particular, children will be seen either on a single occasion or only occasionally. Bluglass (1997, p.90) notes that 'unlike more typical MbPS parents, when help seeking parents were offered psychotherapeutic services... the interventions were usually met with co-operation.' Bluglass provides no evidence for this assertion and her statement that help seeking parents co-operated appears something of a tautology. However, other writers such as Fisher, Mitchell and Murdoch (1993, p.702.) lend support to this view and note that 'confrontation helps these mothers communicate their “anxieties, exhaustion and depression.” Unlike 'active inducers', who resist intervention, they more readily accept psychotherapy and support, indeed they are often relieved.' Libow and Schreier (1986, p.605) however are clear that 'help seekers' are not characteristic of the 'true MbPS patient' and that they are as mothers often seeking 'critical relief' from their own problems.

'Active inducers' are probably the most commonly described group within the MbPS literature, although not necessarily the most prevalent or the most frequently uncovered (Fisher, Mitchell and Murdoch, 1993). They are also the group in which the potential for serious or fatal damage to the child is highest. For this reason some authors have suggested that this should be classified as the “true” form of MbPS (Eminson & Postlethwaite, 1992). Libow and Schreier (1986, p.606) note that the maternal style is often ‘above suspicion’, but when uncovered mothers ‘resist therapeutic intervention and flee from contact.’

'Doctor addicts' represent something slightly different from both ‘active inducers’ and ‘help seekers.’ Fisher, Mitchell and Murdoch (1993) note that ‘doctor addicts’ do
not actively fabricate illnesses in their children but rather will seek out treatment for non-existent illnesses often allergies. Fisher, Mitchell and Murdoch (1993, p.702) also note that whereas mothers who are ‘active inducers’ are ‘helpful and pleasant’ ‘doctor addicts are more ‘suspicious, antagonistic and paranoid.’ Whereas children whose mothers are active inducers are likely to be pre-school children, children of doctor addicts tend to be school age. Interestingly the question of whether this is a ‘developmental’ pathway for MbPS perpetrators to take does not seem to have been addressed.

Libow and Schreier (1986, p.609) also talk about ‘the extremes of MbPS’ and this has been followed by a number of other authors (e.g. Baldwin, 1994; Kinscherff & Famularo, 1991). However no agreed upon or satisfactory distinctions between the different profiles of MbPS perpetrators have been accepted.

**Prevalence, Demographics and Gender**

Quite a lot of data has been gathered about the perpetrators of MbPS and Howarth and Lawson (1997) provide a useful overview of this data. Table 3 summarizes this data which has been updated to include important work by Alexander (1995) and Schreier and Libow (1993). See Table 3.

**Table 3. Demographic Profile of MBPS Perpetrators**

- Usually the child’s birth mother.
- Previous paramedical training (most common in ‘doctor addicts’).
- May suffer from Munchausen syndrome (15-20%).
- Previous contact with a psychiatrist or DSMIV diagnosis.
- Physical, sexual or emotional abuse as a child.
- In local authority care during childhood (children’s homes or foster care).
- History of conduct disorder (faecal smearing, petty crime, running away from home, teenage prostitution, arson) or previous criminal record.
- Previous overdoses or episodes of harm.
- Eating/weight disorders
- The mother is more articulate, intelligent or dominant than the father and is the child’s exclusive carer.
- Generally occurs in two parent families, but with absent father (Alexander, 1995).
- Borderline to low average FSIQ (WAIS-R) in mother perpetrators (Schreier & Libow, 1993)
Given the preponderance of mothers as perpetrators, it is important to say something about the role of mothers in MbPS. Meadow (1995) estimates that the perpetrator is the child’s mother in 90% of the cases, another female caregiver in 5% of the cases and the child’s father in the remaining 5%. It is for this reason that some authors talk about MbPS as a form of ‘perverse motherhood’ (e.g. Welldon, 1988; Schreier, 1992). However, while such figures indicate a clear gender bias, they say only a very little about risk and nothing about causation. Clearly one problem is that the majority of primary care givers are women and it may be that gender is being confounded with ‘care giving’ in examining the risk of MbPS to infants and children. An examination of the frequency of MBP in primary male caregivers would clearly be of value in examining this question. Thus it is important to be open to the possibility of social conditions or what Libow and Schreier (1986, p.610) call the ‘larger social context’ which impact upon mothers not as women, but as care-givers. Alexander (1995, p.61) notes that ‘the observation that MBP occurs mostly with mothers is not well explained, but there is no particular reason to suspect a sex-linked genetic basis. Thus MBP must be a product of environmental factors primarily impacting upon women.’

**Psychological Explanations**

There are three main ways in which researchers and clinicians have attempted to explain MbPS. These can be broadly classified in terms of personality based explanations, psychoanalytic explanations and systemic explanations. These three ways of explaining MbPS can be seen as a movement from the manifest psychological pathology of the individual, through a focus on unconscious motivational factors to the pathology of the family and can be viewed as a potentially self-reinforcing system (See Figure 1). Space does not permit a consideration of a fourth possibility, namely that the perpetrator is not suffering from any recognized disorder either conscious or unconscious and is fully aware of the function of their actions.
(i) Individual and personality profiles
A number of researchers have attempted to categorize MbPS perpetrators in terms of their underlying personality structure or cognitive functioning. The main research carried out in this area has been undertaken by Schreier and Libow (1993), Bools, Neale and Meadow (1992, 1993, 1994) and Parnell (1998).

Schreier and Libow (1993) undertook psychological testing on 12 perpetrator mothers and gave them a battery of tests including the WAIS-R, the Minnesota Multiphasic Personality Inventory (MMPI), the Thematic Apperception test (TAT) and the Rorschach inkblot profiles. In terms of WAIS-R profiles collected from 7 subjects the FSIQ were in the borderline to low average range (range 71-92). Sub tests indicated poor general information strategies and poor ability to reason at an abstract level. However, commenting on these findings, Schreier and Libow note that low-level functioning may not be a reflection of perpetrators generally but of those caught or willing to submit to cognitive assessments.

In terms of the MMPI which was undertaken with 11 subjects, the only protocol which was raised was a negative F-K index, representing the validity score and correction score respectively. This raised profile score suggests an attempt at defensiveness or an attempt to 'fake good' (Anastasi, 1990) and throws into question the non-elevated scores on the other scales. However, despite this Libow and Schreier did find some pattern in the profile scores, representing superficiality, hostility, aggression, immaturity and narcissistic personality traits.

The two projective tests used, the TAT and the Rorschach which were used with 8 and 4 subjects respectively, indicated a group of mothers who had difficulty investing
in other people, a poor sense of causality and a bleak object world. Passive dependency and demanding behaviour were also noted. Although recognizing the limitations of their work both in terms of its small sample size and limited generalizability, Schreier and Libow conclude that:

While no single or simple psychological test profile yet emerges of the “classic” MBPS mother, we do feel an impressive consistency in the patterns of these mothers’ limited store of information (with the exception of medical knowledge), poor abstract conceptual abilities, superficial social skills, and outgoing behaviour. This is coupled with a rigid, denying defensive style masking an underlying rebelliousness, emotional immaturity, self-centredness, lack of social conformity, and intense passive resentment. (p. 185)

Parnell (1998) has also used the MMPI (version 2), to assess 15 cases of MbPS. Of these, 9 mother-perpetrators admitted to the abuse, while in the remaining 6 there was substantial evidence for MbPS. Although Parnell (p. 137) notes that ‘these protocols...reveal no particular pattern or profile concerning the mother-perpetrators as a group,’ she does draw some tentative conclusions ‘consistent with some of the conclusions drawn by Schreier and Libow (1993). In particular Parnell (p. 137) notes ‘subtly defensive profiles’ and ‘overt attempts on the part of mothers to present in a positive light.’ Perhaps not unsurprisingly Parnell notes that defensiveness reduces as therapy progress and there is an acknowledgment of the harm done to the child. Interestingly, most of these mothers were ‘active inducers’ the majority with co-existent DSM-IV diagnoses and just over 50% with a history of sexual, emotional or physical abuse.

Finally the work of Bools et al. (1992, 1993, 1994) has focused on the psychiatric profiles of 56 families where MbPS occurred and conducted follow-up interviews with 19 of these mothers. The researchers used developmental and psychiatric interviews as well as two standardized instruments, the Clinical Interview Schedule (CIS) to assess mental state and the Personality Assessment Schedule (PAS) to assess the perpetrator’s personality. Of particular note is the fact that 14 of the 19 mothers interviewed using the PAS were rated as meeting the criteria for personality disorder. Most common diagnoses were borderline and histrionic personality disorder. Interestingly half of the cases were rated as having four or more personality disorders.
Bools, Neale and Meadow also found a high preponderance of either sexual, physical or emotional neglect in their sample.

The work reported from the psychological profiling of mother perpetrators is extremely limited. While there is some agreement as to the initial defensive posture of mothers, there is little agreement as to any underlying personality disorder that may be behind MbPS. Thus Libow and Schreier (1986, p.603) note that the ‘adult Munchausen literature has described patients as character disordered, hysterical, psychopathic, borderline, psychotic, masochistic and exhibitionist.’ Generally however, antisocial or psychopathic personality disorder tends not to be diagnosed and a profile of borderline or histrionic personality disorder is more likely. This is a particularly important finding and does suggest a role for psychological therapies, a role that has to date been taken up using psychodynamic therapies.

(ii) Psychodynamic explanations

There are more psychodynamically informed interpretations of MbPS than any other. Such work does not start out with a solid theoretical explanation as to what is occurring with MbPS. Instead the dynamic workings of the unconscious, represented through the transference situation within therapy, is seen as the main way of accessing the problematic nature of the mother-child relationship. In contrast to the material discussed already, there is no a priori assumption as far as psychoanalytic interpretation goes that the individual who commits MbPS can have their behaviour explained by psychiatric illness or personality disorder per se. However there is a recognition that motherhood is not simply a biological fact but may be chosen for perverse unconscious reasons (Welldon, 1988).

It is sometimes difficult in accounts of analytic work to differentiate between symptomatic behaviour and causal explanations. This is clearly seen in discussions of projective identification, ‘the process by which a person imagines himself to be inside some object external to himself’ (Rycroft, 1985, p.67) which have occurred in a number of case studies of therapy with MbPS perpetrators (Coombe, 1995; Nicol & Eccles, 1985). Accounts of projective identification, particularly in a Kleinean framework are probably the closest one gets to a theoretical explanation of MbPS.
Coombe (1995) presents a case of inpatient psychoanalytic psychotherapy at the Cassel Family Unit of a mother and infant after she intentionally poisoned her 3 and 5 year-old children with high doses of salt. Over a period of two years Coombe and colleagues worked with the patient transforming her defensive and malignant projective identification into a more benign form. Four factors seem to have contributed to what Coombe (p.206) calls her ‘toxic concrete actions that parallel psychic projective identification’, these are: (i) the perpetrator’s own childhood sexual abuse; (ii) the perpetrator’s inability to bear frustration; (iii) feelings of jealousy and envy over her husband’s relationship with his mother contributing to a desire to destroy the objects of her husband’s love, namely the children and (iv) a persecutory superego resulting from her husband and mother-in-law criticizing her maternal abilities which she then projected into the children - ‘It seemed that she projected her self-critical agency into the children which she could only distance herself from by killing them’ (ibid. p.203) This seems a reasonable theoretical explanation if the attempt of the mother was to kill the children. However, although the children did almost die, there seems good reason to hypothesize that repeated presentations of induced illness to medical facilities do not have murder as the primary aim. Thus Sigal, Gelkopf and Meadow (1989, p.532) note that ‘in the case of MbPS the parent usually has no intention of killing or maiming the child since the motives for the mother’s behaviour lie not in inflicting damage. Paradoxically, death of the child may be contrary to the pathological interest of the mother, and the perpetrator may in some cases be truly sad if some mishap happens to the victim.’ Thus Coombe’s explanation does seem to fail at the crucial hurdle and may be better represented as a conflict between the patient’s superego which prevented her from killing her child and her feelings of murderous jealousy towards her children whom she saw as taking away her husband’s love.

A slightly different psychodynamic explanation has been provided by Hotchkiss (1997) who explores two different theoretical explanations of MbPS. The first focuses on the child ‘as a fetish in a compulsive relationship with the pediatrician and utilizes the much disputed idea of female ‘penis envy’ (p.315). An alternative theoretical model, which Hotchkiss proposes, focuses on the fixation of the mother’s ego at a pre-oedipal level. Thus Hotchkiss suggests that MbPS mothers are using illness in
their child to work through their own problems of separation-individuation through the introjection and projection of good and bad internal objects.

Psychodynamic therapy has been undertaken exclusively with mothers and has chiefly focused on the mothers internal object world. The behaviour and wishes of the mothers appear to be ego-syntonic, thereby strengthening the argument for viewing MbPS as a classifiable illness or personality defect. This of course accepts as basic that mothers are biologically and psychologically structured in order to provide maximally helpful and safe conditions for their child to thrive. Such a view can be held more or less strongly and tends to ignore the influences of other family members, particularly the father.

(iii) Systemic explanations
There is currently a considerable level of confusion surrounding the part played by the family in the causation and continuation of MbPS. This may be in part because ‘families often fail to cooperate (Mitchell, 1995, p.425). However, as early as 1986, Libow and Schreier (p.609) were noting how helpful it would be to adopt ‘a systems approach to pediatric care which evaluates the child’s symptoms in the context of maternal variables, the mother-child relationship, the marital dyad and the family-physician relationship.’

Some attention has been given to the role of the father and following interventions in families where child sexual abuse has occurred, questions have been raised about the intra-family circumstances that allow abuse to occur, go undetected and unreported to a non-abusing parent. Thus, Alexander (1995, p.59) talks about the important contribution of those who ‘catalyze or fail to prevent MBP behaviors.’

Sigal, Gelkopf and Meadow (1989) in their paper on the triad of abuse on MbPS talk about the father as the 'fourth variable' and Libow and Schreier (1986) note the peripheral role of the husband. Thus husbands have been reported as doing:

almost anything to avoid seeing what their wife was doing. Some have been geographically absent for too long and many have been uncaring and lackadaisical in thinking about their child’s welfare. Others have just become ground down and bored by their wife’s perpetual complaining about the
child's health and have left her to "get on with it" and go to different specialists, never volunteering or asking to actually see the specialist themselves. (Libow & Schreier, 1986, p.530).

Sigal, Gelkopf and Meadow (1989) view the husband as the biggest barrier to the wife confessing her actions, on the basis that if the wife did so the husband would leave. While this is probably true, it seems a very dubious form of attributing blame and manifests an unhelpful ideology of blame seeking. Such criticism aside, it would seem that Sigal, Gelkopf and Meadow (1989) are identifying paternal isolation as an important family dynamic. Another way of viewing this is to see the child victim and mother as isolated from the rest of the family (Chan, Salcedo & Atkins, 1986).

The peripheral role of the father may well lead one to see him as an unimportant figure within the dynamics of MbPS, but as Alexander, Smith and Stevenson (1990) have clearly shown MbPS nearly always occurs in two-parent households. This leads Alexander (1995, p.62) to state that ‘it is rare for MBP to occur when a father is entirely absent...this suggests that his presence may be part of the necessary psychosocial dynamic in many MBP cases.’ Alexander offers two main explanations for this. Firstly he notes that in a number of cases fathers are geographically distant because of their occupation e.g. serving in the armed forces and that MbPS may be an attempt to ‘elicit something from the father (e.g. his presence or attention)’ (p.63). Secondly Alexander suggests that MbPS may be an attempt by mothers to resolve a marital problem thereby acting as a form of ‘unification or repair.’ Both possibilities Alexander notes require further research. One could also add to Alexander’s list of areas that require further research, the issue of mother-child enmeshment which seems particularly salient in MbPS cases.

Sanders (1996) documents the narrative family treatment of MbPS in which falsification and exaggeration of illness occurred in two 10 year-old boys, using the narrative model of White and Epston (1990). The author and colleagues report successfully co-constructing ‘problem saturated stories’ into more desirable alternative co-constructed stories in one identified family. The steps in this model are shown in Figure 2.
Although recognizing the limitations of a single case study, the researchers did follow-up the family over a four-year period and recorded reduced instances of medical presentation. Sanders also helpfully discusses those family treatment and therapy characteristics that may have contributed to this successful outcome.

Given the important role that the family plays as the arena in which MbPS is played out it is surprising that ‘almost nothing is known about effective treatment of the family when MBSp is occurring (Rosenberg, 1987, p.558.) and no overall concepts of aetiology have developed (Mitchell, 1995). That stated, the work of Alexander (1995) appears to be particularly important and the distant father as opposed to the absent father may well be shown to be a central piece of the jigsaw of MbPS.

Conclusion
This essay has examined some of the psychological explanations being put forward for MbPS and has taken for granted that a perpetrator’s act can be meaningfully understood in this way. However a number of concerns can be raised about the identification of MbPS as a separate diagnostic and categorisable entity. Thus we need to ask whether researchers are running away with themselves and inventing a diagnosis of a more simple or basic piece of behaviour. Is it thus possible as Levin and Sheridan (1995) suggest that when seen in proper context, MbPS is but one form
of abuse, although in an unexpected form? Eight concerns can be raised in support of this claim: (i) that the range of behaviours identified as MbPS is extremely broad, which suggests that MbPS may have poor construct validity; (ii) the co-existence of psychiatric illness raises questions about causation of MbPS that have not been satisfactorily answered; (iii) limited and sometimes total exclusion of social factors; (iv) an absence of work on the belief systems of MbPS perpetrators; (v) an absence of cross cultural research; (vi) little discussion concerning the cross over between MbPS and infanticide; (vii) a lack of clear evidence that denials by perpetrators are psychological and not externally motivated and (viii) the research has failed to demonstrate that perpetrators are motivated to assume the sick role (see the definition of FDbP). This last criticism is probably the most trenchant and raises the question of whether MbPS is any different from other forms of child abuse in which psychological factors appear to be absent. While space does not permit a detailed discussion of this proposition, it is important to bear in mind that the giving of names does not demonstrate the existence of an object or entity *per se* and therefore as things currently stand the psychological research literature on MbPS fails to substantiate the research criteria used to define the syndrome.
References


CLINICAL DOSSIER
Summary of the Clinical Dossier

This section contains a brief overview of my three years clinical experience, including the name and nature of each placement and a description of the range of clinical experience gained. A selection of five formal clinical case reports have been submitted in full in a confidential clinical volume which also contains a full record of all clinical activity, placement contracts and supervisor evaluation forms for each placement undertaken. These case reports have been chosen to reflect the variety of clinical work, client groups, contexts and theoretical approaches covered during clinical placements. A summary of each case report is provided in this dossier. All client names and identifiers have been changed to preserve confidentiality.
An Overview of Clinical Experience During Training:

CORE ADULT MENTAL HEALTH, LEARNING DISABILITY, CHILD ADOLESCENT AND FAMILY, AND OLDER ADULT PLACEMENTS

&

SPECIALIST PSYCHODYNAMIC FORENSIC PLACEMENT AND ADDICTIONS PLACEMENT
ADULT MENTAL HEALTH CORE PLACEMENT

Location: Crawley/Horsham Trust
Supervisor: Ms. Margaret Hemming
(Consultant Psychologist)

Dates: October 1997 - March 1998

Client Demographics
- 27 clients, (14 male, 13 female)
- Age range 11-73

Presenting Problems/Issues
- Anxiety
- Thunder and lightening phobia
- Anger management
- Schizophrenia
- Alcohol related difficulties
- PTSD
- OCD
- Gender dysmorphia
- Depression

Assessment Procedures
- Assessment interviews within a cognitive behavioural and systemic framework
- Questionnaire assessments using: BDI (Beck), STAI (Spielbeger), BPRS (Gorman), Social Behaviour Scale (Wykes)
- Neuropsychological Assessment using: WAIS-R, WMS

Interventions
- Cognitive behavioural therapy
- Systemic/narrative therapy
- Consultancy model using existential formulation1

Other Work/Experience
- Attendance at Departmental meetings
- Weekly systemic supervision group
- Meetings with and observations of other professionals

LEARNING DISABILITIES CORE PLACEMENT

Location: Lifecare Trust (Croydon)
Supervisor: Dr. Jeanne Males (Head of Department)


Client Demographics
- 10 clients (7 male, 3 female)
- Age range 17-58

Presenting Problems/Issues
- Assessment for independent living
- Suitability for day care
- Anger management
- Suitability for toilet training
- Suitability for sexual health education
- Destructive/disturbed behaviour exhibited
- Assessment for future needs

Assessment Procedures
- Assessment interviews within a behavioural framework
- Functional analysis
- Neuropsychological Assessment using: WAIS-R, WMS, BPVS, Schonell, Leiter, Scale for assessing coping skills
- Functional performance record, Rorschach ink blot

Interventions
- Behavioural assessment
- Functional analysis
- Staff-based intervention/teaching

Other Work/Experience
- Attendance at Departmental meetings
- Case presentation
- Jointly ran two day teaching on ‘Managing Anger and Aggression’ with 13 staff.
CHILD AND FAMILY CORE PLACEMENT

Location: Chichester Trust
Supervisor: Ann Kimber (Head of Department)

Dates: October 1998 – April 1999

Client Demographics
- 15 clients (10 male, 5 female)
- Age range 18 months-15

Presenting Problems/Issues
- Bereavement issues and bullying
- Eating problems/language delay
- OCD
- Anger reduction
- ADHD and autism
- ADHD and Aspergers
- School refusal/hospital phobia
- Enuresis
- Sleeping difficulties

Assessment Procedures
- Assessment interviews within a systemic framework
- Cognitive behavioural interventions
- Behavioural interventions
- Neuropsychological Assessment using: WISC-R, BPVS, British Ability Scales, Stanford Binet
- Connors Questionnaire, Fear Survey Schedule (Wolpe), Griffiths Scale

Interventions
- Family therapy
- CBT
- Behavioural intervention

Other Work/Experience
- Attendance at Departmental meetings
- Attendance at ward rounds
- Attended teaching on solution focused therapy and interactive parenting skills.
- Day visits to primary and special schools
OLDER ADULTS CORE PLACEMENT

Location: Springfield Trust (London)
Supervisor: Sara Turner (Head of Department)

Dates: April 1999 –September 1999

Client Demographic
- 7 clients (4 male, 3 female)
- Group (5 clients, 1 male, 4 female)
- Age range 65-91

Presenting Problems/Issues
- Confusion/behavioural difficulties on ward
- Depression
- Early onset dementia
- Sexual disinhibition
- Depression/somatic problems

Assessment Procedures
- Cognitive behavioural interventions
- Behavioural management of staff behaviour
- Solution focused group work
- Neuropsychological Assessment using: WAIS-III, WMS-III, MEAMS
  BDI, BAI, FAS, Chrichton Royal Names Learning Test.

Interventions
- CBT
- Behavioural intervention

Other Work/Experience
- Attendance at Departmental meetings
- Attendance at ward rounds
- Ran six session group on solution focused therapy\(^1\) with psychology assistant
- Attended day workshops on dementia and hospital reprovision

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\(^1\) Submitted as Hill, R.G; Babbs. M & Turner, S. Using a Brief Solution Focused Therapy Group with Depressed Older Adults. *Journal of Systemic Therapy.*
FORENSIC SPECIALIST PLACEMENT.

Location: Maudsley Trust (London)
Supervisor: John Dowsett (Head of Department)
Dates: October 1999 –March 2000

Client Demographics
- 10 clients (6 male, 4 female)
- Group (4 clients, 4 male)
- Age range 18-43

Presenting Problems/Issues
- Compulsive shoplifting
- Anger control
- Assessment of social need for Court of Protection
- Sexual risk assessment
- Violence risk assessment
- Risk relating to custody of children
- Absconding risk
- Illness management in schizophrenia

Assessment Procedures
- Cognitive behavioural interventions
- Existential focused work
- BDI-II, BAI, FAS, SCID, HCR-20, Multiphasic Sex Inventory, Rorschach Ink Blot, Life Regards Index, Purpose in Life Questionnaire, Milon Personality Assessment, Novaco Provocation Inventory.

Interventions
- CBT
- Psycho-educational

Other Work/Experience
- Attendance at Departmental meetings
- Attendance at ward rounds
- Ran 6 session group on illness management for men with diagnosis of schizophrenia/substance abuse on secure unit
ADDICTIONS SPECIALIST PLACEMENT

Location: Maudsley Trust (London)
Supervisor: Dr. Shamil Wanigaratne (Head of Department)

Dates: April 2000 – September 2000

Client Demographics
- 10 (male 4, female 6)
- Age 29-50

Presenting Problems/Issues
- Anger control
- Alcohol addiction
- Drug addiction
- Cognitive impairment

Assessment Procedures
- Cognitive behavioural interventions
- Neuropsychological Assessment using: WAIS-R, WMS-R,
- BDI-II, BAI, FAS, SCID, Life Regards Index, Purpose in Life Questionnaire,
  Novaco Provocation Inventory.

Interventions
- CBT
- Psycho-educational
- Motivational interviewing

Other Work/Experience
- Attendance at Departmental meetings
- Attendance at ward rounds
- 6 session group on anger management planned
- Attended two day course on motivational interviewing
- Paper on Time, Self and Trauma: The Disruption of Phenomenological Time
  within Post Traumatic Stress Disorder presented at the BPS History and
  Philosophy of Psychology Conference, York, 18-20 April, 2000 with M. C.
  Chung.
Summaries of Clinical Case Reports Completed During Training:

CORE ADULT MENTAL HEALTH, LEARNING DISABILITY, CHILD ADOLESCENT AND FAMILY, AND OLDER ADULT PLACEMENTS

&

SPECIALIST FORENSIC AND ADDICTIONS PLACEMENTS
Adult Mental Health Case Report

Title: Using Graded Exposure to Treat a Case of Long Standing Thunder and Lightening Phobia

Date: March 1998 Year 1

Summary

This case report undertook a programme of graded exposure with a 39 year-old woman with a severe thunder and lightening phobia. She presented in the context of a complex family system in which she was requesting some specialist help for her daughters. A graded hierarchy of feared situations was developed and exposure to some of these situations took place. No in vivo exposure to thunder and lightening took place. By the end of treatment State anxiety as measured by the Speilberger State-Trait Anxiety Inventory had been reduced from the 100th percentile to the 2nd and Trait anxiety from the 71st percentile to the 40th percentile. Some of the implications of treating the client's specific problems and difficulties in the context of a complex family system are discussed.
Learning Disabilities Health Case Report

Title: 'Between a Miracle and a Hoax:' The psychological assessment of a young man using facilitated communication.

Date: December 1998 Year 1

Summary

This case report undertook a cognitive assessment of a twenty-one year old man who had developmental delay and associated physical abnormalities. Despite various genetic tests, a definitive diagnosis had not been produced. The client's cognitive ability was in dispute with a diagnosis of ‘mental retardation’ given by one consultant psychiatrist and as 'clearly not intellectually impaired' by a consultant neurologist. Neither of these conclusions appeared to have been based on any formal psychological testing. The client was attending a college for young people with special needs and was reported to be using facilitated communication (FC) both at college and home. The client’s mother reported extremely high functioning using FC which was discrepant with reports from the college. The assessment attempted to provide a valid estimate of the client’s abilities in order that his future needs could be appropriately catered for. Our experimental results could neither rule in nor rule out the possibility that FC was occurring, however we could conclude that the client was at times engaging in situation appropriate non-verbal communication.
Child Clinical Case Report

Title: The Assessment and Treatment of Eating Problems in an Infant whose Mother had an Obsessive-compulsive Disorder

Date: July 1999 Year 2

Summary

This case study outlines the work undertaken with a 19 month old boy whose height had dropped from the 50th to the 9th percentile and whose weight was below the 25th percentile. The child’s eating behaviour was erratic and his mother who had an obsessive-compulsive disorder was keen to employ some psychological interventions to assist with the eating difficulties. Meal time observation and two week baseline measures were recorded. A two-stage plan to tackle the eating difficulties was formulated. Firstly a strategy was formulated whereby food would be left around the house in order to maximise the child’s control over food. A second stage focused on mother and child sitting at the table together for regular meals. The intervention proved to be successful with the child’s weight going up to the 50th percentile and his height being age appropriate. Explanations for the success of the intervention were construed in terms of a reduction in maternal anxiety around feeding times, the extinction of an early association between food and danger/discomfort arising from an early aversive event, and the development of a more secure attachment between mother and child.
Title: The Neuropsychological Assessment of a Woman with Word-Finding, Arithmetic and Memory Difficulties

Date: September 1999 Year 2

Summary

This case reports the results of a neuro-psychological investigation of a 65 year old woman who was referred for an assessment of her current cognitive and memory functioning. The client reported that in the last three years she had become aware of a gradual onset of short-term memory loss, word finding difficulties and difficulties handling money. An assessment procedure was devised in order to: (i) get an accurate picture of current strengths and weaknesses and to note any discrepancies in ability both currently and pre-morbidly, (ii) to provide a detailed measure of current ability so that a reassessment could be made in order to pinpoint specific difficulties if current skills declined or new problems emerged; (iii) To provide information on current difficulties so that an appropriate intervention programme could be offered. The WAIS-III, Weschlser Memory Scale-III were used along with assessments of pre-morbid ability and mood. Results from the psychometric assessment showed a number of difficulties with memory functioning and some specific problems relating to arithmetic and speed of processing. Word finding difficulties were also apparent. There was some indication of pre-morbid decline.
Specialist Case Report

Title: The psychotherapeutic assessment and treatment of shoplifting and exploration of some of its underlying causes.

Date: March 2000 Year 3

Summary

This case report outlines work with a 33 year old French Algerian woman referred for an assessment for psychotherapy following a series of non economic shoplifting offences. The therapy focused on immediate relapse prevention strategies as well as an examination of some of the underlying motivations for the shoplifting behaviour. Use was made of Victor Frankl’s notion of an existential vacuum and the connection between levels of meaning, propensity to engage in problematic behaviours and relapse prevention. The connection between shoplifting and depression was also examined. In order to explore the relationship between shoplifting and meaninglessness, the therapist administered the Purpose in Life Test - Part A (Crumbaugh & Maholick, 1964) and the Life Regard Index (Battista & Almond, 1973). Psychodynamic supervision was provided for the case and some of the implications of the transference relationship discussed.
Summary of the Research Dossier

This section comprises three research components completed over three years. These are presented in the order in which they were conducted in order to show how my research skills have developed during training. The first component is a literature review from Year 1. This reviews the literature on non-romantic pathological jealousy and considers whether a term to denote non-sexual forms of jealousy is both meaningful and useful. The second component is a service-related research project that aimed to determine what the priorities were for a psychology service from the perspective of service users and psychologists. The final piece of research adopted a grounded theory strategy to explain and explore the reasons for male violence during pregnancy.
'Platonic Jealousy' - A Conceptualization and Review of the Literature on Non-Romantic Pathological Jealousy.¹

A Literature Review

November 1998

Year 1

Introduction

This literature review is concerned with pathological jealousy within non-romantic relationships or where sexual infidelity is not the concern. Good reviews of couple jealousy already exist (White & Mullen, 1989; De Silva, 1997), providing overviews of both theory and clinical practice. No such review exists for non-romantic pathological jealousy where 'sexual infidelity' is not the main presenting symptom. Sexual infidelity here means a person's belief that a sexual act has occurred or a relationship is being engendered so that such an act may be undertaken in the near future. The term 'pathological' is added to highlight the fact that such beliefs which can be delusions or over-valued ideas are held on inadequate grounds being based on unsound evidence and reasoning and are unaffected by rational argument (Gelder, Gath, Mayou & Cowen, 1996). Jealousy will be defined as a 'protective reaction to a perceived threat to a valued relationship or to its quality (Clanton & Kosins, 1991, p.40). However, there are two important provisos to such a definition. Firstly the extent to which the reaction is 'protective' will be held open to question. Secondly the threat must always result from the existence, perceived or real, of a third party who threatens one's current place in that relationship.

Cases of non-romantic jealousy have been reported in relation to childbirth (Smoller & Lewis, 1977; Waletzky, 1979; Brockington, 1996), siblings (Dunn & Kendrick, 1982), friendships (Friday, 1986; Orbach & Eichenbaum, 1994), work (Ankles, 1939; Wilkes & Kravitz, 1992) and the seeking of professional help for emotional problems (Myers, 1959). Parrott (1991, p.22.) notes that relationships may be hoped for, already existing, or those that are already over, and the relationship 'need not involve love, and the rival need not even be a person.' As Tov-Ruach (1980, p.466) notes 'the transfer is characteristically made to another person, but it can also be directed to a cause or an occupation.' Such instances remain clinically rare.

This paper also asks whether 'non-romantic pathological jealousy' is a useful concept to apply within the field of jealousy theory and research. Although non-romantic or what could be called 'Platonic jealousy' is not a term found in the literature, there may be good reasons for developing a term to denote those severe forms of jealousy that occur independently of either a belief in sexual infidelity or where envy is the main motivating force.
Scope of the Review
This paper is split into three parts. The first part examines reasons for the lack of a large research base in jealousy, the nature of pathological jealousy and how it can be distinguished from envy. The second part reviews the theoretical work and empirical data on non-romantic jealousy focusing on: (i) sibling jealousy; (ii) mother-child jealousy; (iii) father-child jealousy; (iv) child-parent jealousy and (v) friendship and co-worker jealousy. It should be stressed that 'non-romantic pathological jealousy' is used throughout the paper provisionally and the extent to which such forms of jealousy can be seen as a) pathological and b) non-romantic will be examined in the discussion. The paper concludes by assessing the extent to which 'non-romantic pathological jealousy' is a useful conceptual term for referring to severe forms of non-romantic jealousy.

Research into Jealousy
All societies appear to acknowledge the existence of jealousy at some level and it seems that all individuals experience jealous feelings to a greater or lesser extent (White & Mullen, 1989; Mullen & Martin, 1994). Authors such as the O'Neils (1972, p. 236) suggest that jealousy is primarily a learned response, determined by cultural attitudes. Thus they claim that 'in many societies around the world, including the Eskimo, the Marquesans, and Lobi of West Africa, the Siriono of Bolivia and others, jealousy is a minimum; and in still others, such as the Toda of India, it is almost completely absent.' Others such as Mathes and Deuger (1982) in their study of jealousy in cats and dogs found that jealousy was not simply an emotion taught by monogamous cultures to preserve monogamy, but rather an inevitable and universal emotion.

Given the ubiquitous nature of jealousy and its disrupting and sometimes devastating impact, it is surprising that a research agenda has only recently developed, as White and Mullen (1989, p.2) state 'we are still at the early stages of the expected debates concerning conceptualization, measurement and causes of jealousy.' Enoch, Trethowan and Barker (1967, p.26) writing some thirty years ago noted that 'the scant mention of this syndrome in textbooks suggests that it is rare, whereas in actual fact it is not uncommon in clinical practice, and is often encountered not only in the patients themselves but also in their relatives.' Moreover clinical interest in jealousy can by no
means be regarded as peripheral, for the catastrophic effects of morbid jealousy are well documented with infanticide, murder of spouse, self harm and suicide all being reported in the literature (Mowat, 1966; Mullen & Maack, 1985; Brockington, 1996). Even where such catastrophic outcomes do not occur, morbid jealousy is often implicated in physical assault, both towards women (Gayford, 1979) and by women (Stets & Pirog-Good, 1987). Family break-up and mental health problems also appear to be common for all those involved (Brockington, 1996). The role of alcohol in the exacerbation of jealousy is well documented, although the causal relationship between alcohol consumption and jealousy remains unclear (Michael, Mirza, Mirza, Babu & Vithayathil, 1995). While such negative behavioural outcomes are more common where the morbid jealousy is centered around the infidelity of spouse or partner they have also been reported where the jealousy does not focus on sexual infidelity (Brockington, 1996).

The lack of empirical exploration in clinical psychology is even more surprising given that jealousy is one of those areas where normality blends into pathology and therefore falls precisely within the expertise of clinical psychologists. To give some idea of the research base, White and Mullen (1989, p.2) could find 'no outcome studies on therapeutic treatments for jealousy, fewer than 10 research articles on sibling jealousy and fewer than 60 research articles on normal romantic jealousy spanning several decades of research.'

Although the situation has improved since then, empirical research remains limited. One explanation for this lack of research may lie in the fact that pathological romantic jealousy often comes to the attention of clinical and criminal justice systems 

\textit{ex post facto}. Sincerely held suspicions concerning fidelity are not on the face of it the province of the clinician. Another explanation may be that while jealousy does present as a symptom it may be seen as masking something else: in psychoanalytic terms it may be viewed as a defence against homosexual impulses (Freud, 1955) and for cognitive therapists as a non-specific cognitive error. Thus, in a cognitive model, jealousy begins with perceptions, leading to interpretations, which generate feelings that may or not be expressed behaviourally (Constantine, 1976). While there is empirical evidence to show that modification of cognitive schema does result in a reduction of jealousy disturbance in subjects with non-psychotic jealousy (Bishay,
Peterson & Tarrier, 1989; Dolan, & Bishay, 1996), Cobb and Marks (1979) found that changing jealous thoughts was more difficult than changing behaviour.

There is even less empirical research on non-romantic jealousy, with most work being undertaken on family networks and focusing on such matters as birth and sibling rivalry. Four possible reasons for this state of affairs can be suggested: (i) the fact that there is no discrete or diagnostic entity identifiable as non-romantic pathological jealousy; (ii) presentation occurs across a number of clinical areas; (iii) the question of whether such jealousies are 'pathological' is unclear, particularly as regards siblings and (iv) romantic relationships tend to be the dominant form of relationship in Western societies with perhaps the result that the research agenda focuses on such interactions.

The Continuum of Jealousy
Given that we all recognize something called jealousy which most people seem to be able to cope with and given that clinicians identify something called variously pathological jealousy (White & Mullen, 1989), morbid jealousy (Shepherd, 1961) and the 'Othello Syndrome' (Enoch, Trethowan & Barker, 1967) how is one to differentiate normal jealousy from pathological or morbid jealousy? Pathological jealousy is generally diagnosed as a special paranoid condition manifesting itself as a special symptom (Gelder et al., 1996). However, there is no separate category for pathological jealousy in either DSMIV or ICD10. White and Mullen (1989) suggest three types of jealousy: (i) normal reactive jealousy; (ii) pathological reactive jealousy; and (iii) symptomatic jealousy occurring as part of another mental disorder where delusional beliefs predominate. Thus clinical definitions of pathological jealousy accept both cases where there has been unprovoked irrational jealousy or provoked but excessive jealousy (Bers & Rodin, 1984). The vast majority of cases reported in the literature concerning non-romantic jealousy are non-delusional in character and generally reactive.

Jealousy, Envy and Social Comparison Jealousy
A great deal of anthropological work has been undertaken on envy and there seem to be clear conceptual grounds for distinguishing envy from jealousy. Schoeck (1969, p. 14) notes that jealousy is 'directed against a definite transfer of coveted assets or their
removal elsewhere.' With envy one's negative feelings can be directed at the asset as such, as Schoeck (p.14) states, 'crucial to this is the belief that someone is acquiring something which is really our due or which belongs to us.' This distinguishing feature results in Schoeck making two important but debatable points. First that a jealous person can never normally become a 'spontaneous, primary aggressor' (p.13) as jealousy requires the existence of a third party. ' As Schoeck (p.14) states 'the envious man, on the other hand, may have hostile feelings towards a person, who may actually be ignorant of their existence.' Second that in jealousy 'two or more persons must confront each other in a relationship that is avowedly reciprocal' (Schoeck, 1969, p14. As this review will indicate most non-romantic jealousy is avowedly non-reciprocal. Although it is not uncommon to hear people speak of jealousy and envy as if they were interchangeable terms, the distinction is by no means clear (Ankles, 1939; Bers & Rodin, 1984) leading some researchers to claim that there is no heuristic value in distinguishing between envy and jealousy (Salovey & Rodin, 1984). This has resulted in a focus on what has come to be called social-comparison jealousy (Bers & Rodin, 1984; Salovey & Rodin, 1984; Salovey & Rodin, 1986). This focuses on challenges to one's superiority or equality as compared to the more usually considered 'social-relations jealousy' which challenges one's exclusivity in a relationship (Bers & Rodin, 1984). Smith, Kim and Parrott (1988) looked at these distinctions in terms of envy and romantic jealousy and found that while jealousy could involve either romantic jealousy or envy, envy always involved social comparison. Moreover the authors found that jealousy had more affective salience and produced more intensive reactions than envy. It is interesting to note that none of the literature reviewed referred to 'morbid' or 'pathological' envy, although some researchers distinguish between malicious and non-malicious envy (Parrott, 1991).

Non-Romantic Jealousy
The main empirical data and theoretical material on non-romantic jealousy has been categorized under five headings: (i) sibling jealousy; (ii) child-parent jealousy; (iii) mother-child jealousy; (iv) father-child jealousy and (v) friendship and co-worker jealousies. 
(i) **Sibling jealousy**

'Hostile feelings towards brothers and sisters must be far more frequent in childhood than the unseeing eye of the adult observer can perceive.' (Freud, 1976, p.352)

Sibling jealousy has provided the richest source of empirical data, possibly because of the hypothesized connection between sibling rivalry and jealousy in adult life (Stearns, 1989), a connection increasingly disputed (Mullen & Martin, 1994).

It has been suggested that jealousy in infants begins in relation to the maternal breast (Gesell, 1906), however most research interest has focused on relationships between young siblings. Sibling jealousy has generally been regarded as a universal occurrence, although some researchers suggest that it is not inevitable and arises out of indirect suggestion in the family (Close, 1980). Developmental psychologists can be viewed as being split between those who view jealousy as an emergent property of the new born infant and those who view cognitive interpersonal awareness as a necessary condition for it’s emergence.

Early developmental psychologists tended to view the infant as capable of a time limited jealousy response in those situations where it is deprived of exclusivity (James, 1890; Piaget, 1932). It is suggested that all children up to about the age of two or three want the exclusive love and attention of their parents (Griffin & De La Torre, 1983). Sewall (1930) in her study of 70 children with siblings found that maladjustment in home (defined as an over-protective mother, a negative father, marital or relationship discord and inconsistent discipline) was correlated with jealousy. Jealousy was exhibited by either bodily attacks on younger siblings, ignoring, denial of a sibling’s existence or personality change. Dunn and Kendrick (1982) in their longitudinal study of 40 firstborn children in Cambridge similarly found that there was an association between the quality of the relationship between parents and the first born and subsequent quality of the relationship between siblings. Where mothers had particularly ‘close, sensitive and harmonious’ relationships with first-born daughters then sibling relationships were particularly difficult. Moreover same sex siblings were more likely to join mother and baby in a friendly fashion than different sex-siblings. Overt jealousy of the baby by the sibling was also more
apparent when the father as opposed to the mother interacted with the baby. One explanation for this later finding was suggested by mothers who felt that the father when interacting became insensitive to the first born. There are two major problems with Dunn and Kendrick’s study. Firstly they do not adequately define jealousy either theoretically or behaviourally, relying instead on terms such as ‘particularly difficult’ (p.172). Researchers such as Masciuch and Kienapple (1993) have empirically studied whether jealousy can be inferred in children aged 4 months to seven years and found that jealous behaviour can be identified from gaze, verbalization and action categories of behaviour. Secondly Dunn and Kendrick acknowledge the role that temperament plays in provoking jealousy, however this also remains inadequately defined. More recently Dunn (1994) has suggested that the development of jealousy and other emotions occurs during the course of the second and third year. This has been disputed by Draghi-Lorenz (1997) who found on the basis of observational and experimental studies that infants are capable of interpersonal jealousy at least from around 5 months of age. This research suggests that cognitive accounts of jealousy which depend on the development of internal representational skills are either not needed or occur earlier than thought. Russel and Parris (1994) in their study of the acquisition of complex concepts such as jealousy in children (aged 4-7) found that it was achieved through partial conceptualization rather than an all-or-nothing fashion. Clearly, due to the age of the subjects such research could support either Dunn’s or Dragi-Lorenz’z view.

Psychoanalytic reports of jealousy and envy within the young infant far exceeds the empirical work. Much of this relates to the Oedipal and Elektra complexes and will be discussed in the relevant sections below. In classical psychoanalytic theory it is possible to suggest that the basis of the parent-child relationship is sexual and thus the appearance of a new sibling in the family is a threat to the phantasized sexual relationship held by the already placed child. A revised version is held by writers such as Bowlby (1969) and Hadfield (1962) who argue that sexual attraction is secondary to a child’s need for security and dependence on their parents. Thus Hadfield (1962) situates jealousy in Darwinian terms focusing on the role of the survival instinct and talks of sibling jealousy as simple 'self-preservation.' He notes that 'since the first need of the child is for security in his mother’s love, if he sees that love passing to another, he is thrown into a state of panic and this gives rise to jealousy and anger' (Hadfield,
A great deal of contemporary research has followed this line of reasoning, most notably the work of Buss on sex differences in jealousy responses and its evolutionary function (Buss, Larsen, Westen & Semmelroth, 1992; Buss, 1995). A third reason for sibling jealousy, has been suggested by Winnicott (1971) who focuses on the desire for sibling incest. Thus he reports a case study of under-achievement in a nine-year old boy called Robert and his relationship with his sister. Winnicott (p.98) suggests that Robert is jealous of his sister 'for being a girl and she is jealous of you being a boy...and as you are not grown-up the nearest you can get to making love is to pester each other and fight.' Wisdom (1976) reporting on the case of jealousy in a one year old boy argues against this theory of sibling incest and proposes guilt, arising as the result of dreams of destroying the rival. Such psychoanalytic studies suffer from a number of weaknesses from the standpoint of experimental psychology, the most critical being a degree of circularity in which observations are based upon interpretations which in turn are immune from disconfirmation through observation.

Before turning to jealousy of parents by children, brief comment needs to be made on two special family situations which may increase sibling jealousy. Firstly adoption and fostering in which the child may feel excluded from the birth family. This can result in jealousy of a sibling's natural bonds leading the adopted child to seek out their natural parents (Scheehter & Bertocci, 1990). The second situation involves sibling illnesses. At the mundane level it is clear that illness within families changes the internal dynamics and shifts the focus of attention around (White, 1991). Peretti and Abderholden (1995) report that jealousy was one of five most reported responses by forty children (4-11 years) as a result of loss of attention due to a brain damaged sibling.

(ii) Child-parent jealousy
Given the reality of sibling jealousy is it to be expected that children will become jealous of their parents as well? Clearly both the Oedipal and Elektra complexes are of paramount importance in this regard, although the real existence of such complexes remains problematic. Melanie Klein (1952, p.78) has outlined a further theoretical position focusing on frustration because the 'father or mother enjoys the desired object of which s/he is deprived.' Thus the parents are seen as a combined parent-figure, 'the mother containing the penis of the father and the father containing the
mother' (Klein, 1957, p. 197). Klein (1957, p.197) further suggests that mitigation for this intense jealousy occurs through the gaining of new objects which can be loved 'the father and siblings and other compensations which the developing ego derives from the external world.' While Klein's insights are theoretically interesting, they are like much of psychoanalytic theory not susceptible to empirical confirmation or theoretical disconfirmation and proving or disproving such psychoanalytic insights is problematic when viewed from outside the psychoanalytic frame of reference. Suffice to say that such arguments do not readily meet the criteria of falsifiability either empirically on a case-by-case basis or in terms of the underlying model (Popper, 1963). Unfortunately empirical examinations of jealousy directed towards parents by children remains scant, with no studies being found in the psychological or medical literature.

(iii) Mother-child jealousy

When referring to mother-child jealousy we are essentially talking about a mother being jealous of her child, usually because of the perceived impact this has on the relationship with the partner. Thus Hadfield (1962, p.91) talks of 'exaggeration by thwarting.' A typical example he notes is 'that of a mother who is so anxious that her little girl should not be vain that she dresses her in shabby clothes and leaves her hair untidy. The real cause he suggests is often jealousy of her child, who is taking away some of the father's love.

Smoller and Lewis (1977, p.41) report on a case of fantasized child abuse resulting from the mother's jealousy of her husband's relationship with the child, 'the patient seemed to view herself in competition with her child for her husband's attention. She became jealous when she saw the two of them together.' The husband inadvertently fostered such feelings by articulating such statements as 'When you get visiting privileges, I won't know whom to be with, you or the baby' (p.41). Explanations for the behaviour focused on reenactment of the patient's own childhood in which she competed with her sister for her parents affection, with the result that 'her infantile needs were not met if her husband devoted time to the child' (p.41). Thus a pregnancy early in the marriage upset her. Smoller and Lewis also theorize in terms of 'role reversal' in which the child is 'parentified' by the mother. 'Perceiving the child as an
intruder in the relationship led to the realization that the husband would never provide the kind of mothering, protection and guidance that the mother desired' (p.42).

Not all jealousy that is held by mothers against their children exists solely because of the effect of that relationship on the partner. Ankles (1939, p.60) reports one case of a woman who reports never being jealous of her husband and whose jealousy was directed solely at her daughter. She states ‘I want to own my daughter and feel hurt at the slightest neglect.’ Ankles also reports the case of a woman who transferred her possessiveness from her husband on to her new born child, thus raising the possibility of the transferability of romantic jealousy into a non-romantic sphere given the right conditions e.g. the birth of a child. Unfortunately both cases are reported in extreme brevity.

(iv) Father-child jealousy
Given the presumed natural protective biological bond between mother and infant it could be assumed that father-child jealousy may occur more readily and with more intensity. The limited literature would appear to bear this out. Towne and Afterman (1955) talk about 'hatred of the competitive rival' (p.23) and that 'the father senses the child more as a rival for dependency than as a phallic competitor' (p.26). Waletzky (1979, p. 350) in an examination of husbands' problems with breast feeding notes that jealous feelings are usually not anticipated or even perceived consciously 'but are often reflected in behaviour that is negative, non-supportive, and non-involved through much of the postpartum period, especially the early months.' She notes that the most common negative reaction to breast-feeding is 'jealousy of the physical and emotional closeness of the nursing mother and child' (p.350). The degree of jealousy being determined by how happily and how often the wife breast feeds. This however seems to be more akin to non-malicious envy than any fear of displacement by a competitive rival. Jordan and Wall (1993) note that breast feeding perpetuates the exclusive mother/infant relationship formed during pregnancy resulting in feelings of exclusion and jealousy by the husband. An interesting and somewhat disturbing exploratory empirical study into the perceptions of women who were physically abused by their partners during pregnancy found that jealousy of the unborn child was one of four explanatory categories along with anger at the unborn child, pregnancy-specific violence (not child centred) and ‘business as usual’ (Campbell, Oliver &
Bullock, 1993). However, this study can be critiqued both for its sampling bias (subjects were self selected via newspaper and bulletin board advertisements) as well as its questionable validity (extrapolating from the women's perceptions of why they thought they were battered to the aforementioned explanatory categories of why men battered). Moreover such studies will almost always have to be retrospective due to the uncomfortable ethical questions which they would otherwise raise.

(v) Work jealousy

Outside of family relationships the main arena for non-romantic jealousy, appears to be the workplace. Although frequently referred to, it is an area with limited empirical research. Ankles (1939) reports a number of brief case studies in which professional jealousy was the main presenting symptom. These cases are particularly important in distinguishing envy from jealousy. Thus he reports the case of a man who when asked if it isn’t just envy of the extent of a rival’s business success, said “No,” recognising tender feelings towards those of whom he is jealous. The role of a third party and the fear of loss arising as a result is evident in another case, “They want the business from me that I want to retain - One day I might lose the business” (p.49) Another case, Mr. S is formulated in terms of a need for social approval and the fear that it will be lost. Mr. S states that “I feel myself humbled when a rival is chosen” (p.56) Another case is of a doctor who reports ‘wanting all the appreciation,’ ‘aggrandizement of self’ and a fear of loss when applying for jobs ‘inasmuch as the fear of not being the one appointed’ (p.47). Such comments differentiate feelings of jealousy from pure hate which often occur between rivals due to competition. Ankles makes the point that much professional jealousy is dependent upon the loss of social approval, emphasized by the apparent gain of a rival. Ankles postulates that all jealousy has its roots in sadomasochistic factors and therefore the concept of non-sexual jealousy is challenged, however he also suggests that social approval is a substitution for parental approval and quotes Darwin, who says that ‘the feeling of pleasure from society is very probably an extent of the parental and filial affections’ (p.97).

Wilkes and Kravitz (1992) in a more recent questionnaire survey of medical researchers’ relationships with the media found that while many reported positive experiences, one negative aspect was jealousy among colleagues. While the response rate was extremely high (92%), it is not entirely clear how much this study tells us
about work related jealousy since the negative responses appear more akin to envy or social comparison jealousy than to any threat to a relationship or its quality (Clanton & Kosins, 1991).

Discussion
This paper has examined the literature on non-romantic forms of jealousy. It is apparent that the literature is extremely varied in terms of its quality, theoretical precision and empirical basis. Two questions were uppermost in conducting this review. Was non-romantic jealousy as initially and superficially formulated, really non-romantic or non-sexual and secondly was it also pathological as opposed to normal? It has become clear during the process of the review that answers to these two questions depends to a large degree on the theoretical presuppositions of the underlying theory. Thus the extent to which something is perceived as a) non-romantic and b) pathological is determined by the theoretical model one adopts.

Firstly the question of whether the types of jealousy reported are of a non-romantic or sexual character needs to be addressed. Psychoanalytic theory suggests that all the forms of jealousy mentioned in this review have some sexual basis. Psychoanalytic theory would suggest that both envy and jealousy are determined by the in-built sexual instinct of the infant. Such an instinct can be directed towards one or other of the parents or siblings. Thus it is probably fair to say from a psychoanalytic position that sibling jealousy is neither non-romantic nor non-sexual, given the fact that we are born with polymorphous perversity. Even Ankles’ work on co-worker jealousy situates it within a schema of sado-masochistic impulses. While such ideas have been a rich source of theorizing, their empirical demonstration remains rare and a major concern must be that such case studies fit the already held theory and not vice versa.

From a cognitive or behavioural standpoint there is little empirical evidence to substantiate the claim that any of the jealousies discussed evidence an underlying sexual dimension. Indeed the lack of discussion of this highlights the important way in which theory generates hypotheses. Thus from a cognitive behavioural perspective jealousy is about faulty schemas which do not explicitly relate to the sexual sphere (although this is obviously possible) and there are no empirical reports to date. From a
behavioural standpoint jealousy remains at most an inference with researchers focusing on behavioural manifestations such as anger.

Jealousy understood from an evolutionary perspective can be seen as partially sexual in so far as any organism wants to survive in order to procreate. To explain co-worker jealousy from this perspective one would focus on the need for organisms to co-operate in order to survive. Any displacement of this, either actual or cognitively in terms of threats to self-esteem results in an increased threat. Adopting such a perspective one would expect higher rates of jealousy in those situations where the need for co-operation is less. The incidence of sibling rivalry as opposed to jealousy of parents would appear to lend some weight to this hypothesis.

What, though, about the pathological nature of non-romantic jealousy? This review has focused primarily on reactive jealousy. Given that jealousy is regarded as a continuum, it is useful to highlight the fact that an absence of jealousy in situations where it would usually be exhibited is itself abnormal. White and Mullen (1989, p.178) note that ‘distinctions between the normal and the pathological jealousy complex are difficult to draw’ so how is one to make such a judgement? From a psychoanalytic perspective the organism seems propelled to experience jealousy because of the existence of infantile sexuality. The emergent baby thus has no control over this due to the Oedipal and Elektra complexes being inbuilt phylogenetically, where even opposite sex siblings can be seen as potential love rivals. Moreover there is an issue as to whether, for children at a certain maturational level, the criteria of unsound evidence and reasoning noted by Gelder et al. (1996) can be applied at all. This raises a more general issue, since there are many religious, quasi-religious and other belief systems such as hero worship, that appear to be based on unsound reasoning and are unaffected by rational argument or empirical evidence (Festinger, Riecken & Schachter, 1956).

One argument for viewing such jealousy as normal may be its ubiquitous nature. This however is insufficient, in that even if every organism was born with pathogens, one cannot simply re-define abnormality into normality. Thus, one has to view pathology in terms of the structure of an organism. Given Freud’s views on the universal need
for analysis it may well be appropriate to view jealousy as pathological in the sense of needing to be treated, but normal in the purely statistical sense.

From a CBT perspective it is less the jealousy situation that is of importance and more what this means to the individual. Jealousy within a dependent, particularly non-verbal, infant may well be an adaptive mechanism resulting in behaviour that ensures increased protection and attention from carers. In an adult work situation jealousy may have less profound physical implications, although loss of income and employment through displacement may arouse strong feelings of dependency. From the evolutionary perspective, the jealous response in the young infant may similarly be seen as non-pathological in that it serves a functional purpose. Similarly from a developmental perspective sibling jealousy as manifested in Dunn’s empirical work would also have to be judged as non-pathological, given that it appears both as a normal developmental reaction to birth and an important milestone in identity formation or what Dunn (1988) calls ‘the beginnings of social understanding.’

Conclusion
The question posed at the outset as to the utility of Platonic or non-romantic pathological jealousy as a conceptual category needs to be addressed. What has emerged from the literature is very much a mixed picture. In some instances jealousy has indeed appeared as a functional ‘protective reaction’ (Clanton & Kosin, 1991), this is particularly the case in terms of sibling jealousy. In other situations, such protection appears unwarranted, particularly a child’s jealousy of the opposite sex parent. This gives some credence to psychoanalytic thought on the Oedipal conflict and the origins of early infantile sexuality. Thus there appear to be arguments both for and against viewing non-romantic jealousy in terms of pathology. There are also mixed arguments for seeing such jealousy as sexual in nature.

In answer to the question of whether it is important that we develop a term to denote those forms of jealousy that lie outside the area of sexual infidelity the implication of this review must be yes. Although one could argue that ‘non-romantic pathological jealousy’ is a simplification when viewed as an explanatory concept, its utility in differentiating a set of situations from romantic jealousy would appear useful. Clearly much conceptual work remains to be undertaken, particularly since jealousy as
researched remains very much a theory of blended emotion in which basic-level emotions such as anger, sadness and fear predominate (Sharpstein, 1991). This may or may not be the case within non-romantic jealousy. What is now required is a theoretical model to explain non-romantic jealousy irrespective of its site of presentation. This can then set the parameters for a research agenda into this powerful human emotion.
References


Service Related Research

Providing a Local Psychology Service: The views of psychologists and service users.

July 1999

Year 1

1. Addendum added March 2000
Introduction

Ever since the Griffith's report (1988) there has been a sustained effort to ensure that health services meet the needs of those who use them. Moreover, since the restructuring of the health service into purchaser and provider units, the remit of who should be consulted has widened considerably (Johnson, Thornicroft & Strathdee, 1996). The aim of this research was to discover what the priorities were in terms of the type of psychological services provided in one Trust from the perspective of service users and psychologists. The research question arose from proposed merger talks with neighbouring Trust's and the belief that any restructuring of psychological services could be best undertaken if the priorities of consumers and providers of psychological services were understood.

Method

(i) Participants

Members of the Psychology Department of one adult mental health Trust and mental health service users from two local non-statutory day centres were approached to participate in a piece of research examining priorities in terms of the provision of psychological services. The Psychology department contained 5 clinical psychologists (4 B grade and 1 A grade), two trainee clinical psychologists, one clinical psychologist from overseas gaining further clinical experience, four chartered counselling psychologists and three counselling psychology trainees. The day centres provide social and activity focused services for individuals with mental health needs (generally long-term) over the age of eighteen. Both centres receive core funding from social services.

(ii) Measures

Staff of the Psychology Department were asked via a questionnaire for audit priorities over the coming year (see Appendix 1), this formed the basis of a questionnaire focusing on the assessment of psychological services in the locality. As a result a draft questionnaire was constructed for use by mental health service purchasers, providers and service users and subsequently piloted on 6 individuals, including a mental health service manager, psychologist, direct care staff and the local user advocate. The questionnaire was revised in the light of comments received. The revised questionnaire asked respondents to rank the importance of a number of specialist
teams or areas, before rating a number of service areas (older adults, health psychology, children and adolescents, adults 16 to 65 years and services for people with learning disability) in terms of need (high, low, not needed, don’t know) and whether ‘treatment’ or ‘treatment and assessment’ was required. For three of the areas (older adults, children and adolescents and people with learning disability) a fixed choice format focusing on types of therapeutic approach was used. For services for adults 16-65 some fixed choices were given as well as an optional list. For ‘Health Psychology’ aside from the category of ‘general coping with chronic medical conditions’ an open format was used, it being felt that the area was governed more by presenting disability or illness than by therapeutic approach. Respondents were also asked to make a preference between two models of service delivery that had been devised by the author and Head of the Psychology Department (See Appendix 2 for the full questionnaire).

A semi-structured interview schedule was designed for use at the day centres. This included questions on experience of psychological services, views on what was provided and perspectives on what psychological services were needed. (See Appendix 3).

(iii) Procedure

Questionnaires were sent to all members of the Psychology Department and asked to be returned to the author. Both day centres were visited and the purpose of the research outlined. The questionnaires intended for completion by individual members (with help if necessary) were reported to be too detailed and complex by the user group participants. As a result a group discussion was facilitated using the semi-structured interview schedule only. As part of the group discussion the role of NHS psychologists was clarified prior to asking group members what they wanted from a psychology service. Meetings lasted approximately one hour. Participants were self-selected in that they chose to either attend or not attend the meeting. Two psychologists facilitated this meeting, enabling all responses to be recorded verbatim in writing. This data was subsequently content coded and reported in terms of major content areas (Krippendorff, 1980). A subsequent visit was made to one of the centres to talk to any members who could not be present at the first meeting.
Results
(i) Psychologist's views
Nine psychologists (6 clinical and 3 counselling) returned their completed forms (64% response rate), 8 were chartered psychologists and one was a clinical psychologist in training.

In terms of the broad service areas which psychologists thought they ought to be providing services to, CMHT's, primary care, adult specialist services child and adolescent services were ranked fairly high. Neuropsychology services and health psychology services were ranked very low (See Appendix 4 for full results).

Table 1 shows the results in those areas where a fixed choice format was given, namely services for older adults, children and adolescents and people with learning disabilities.
Table 1 Psychology Services for Older Adults, Children and Adolescents and People with Learning Disabilities (n=9)

<table>
<thead>
<tr>
<th>Services for Older Adults</th>
<th>Assessment and Treatment</th>
<th>Assessment Only</th>
<th>High Need</th>
<th>Low Need</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy</td>
<td>9 (100%)</td>
<td></td>
<td>2¹ (25%)</td>
<td>4¹ (50%)</td>
<td>2¹ (25%)</td>
</tr>
<tr>
<td>Systems and Family Approaches</td>
<td>8 (89%)</td>
<td>1² (11%)</td>
<td>4³ (67%)</td>
<td>2³ (33%)</td>
<td></td>
</tr>
<tr>
<td>Cognitive and Social Functioning</td>
<td>7 (78%)</td>
<td>2² (22%)</td>
<td>3¹ (37.5%)</td>
<td>3¹ (37.5%)</td>
<td>2¹ (30%)</td>
</tr>
<tr>
<td>Managing Role Transition and Change</td>
<td>9 (100%)</td>
<td></td>
<td>2¹ (25%)</td>
<td>4¹ (50%)</td>
<td>2¹ (25%)</td>
</tr>
<tr>
<td>Managing Loss and Bereavement</td>
<td>9 (100%)</td>
<td></td>
<td>4² (57%)</td>
<td>1² (14%)</td>
<td>2² (29%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child and Adolescent Services</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy</td>
<td>8¹ (100%)</td>
<td></td>
<td>5² (71%)</td>
<td>2² (29%)</td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td>9 (100%)</td>
<td></td>
<td>5² (71%)</td>
<td>2² (29%)</td>
<td></td>
</tr>
<tr>
<td>Cognitive and Developmental Levels</td>
<td>4² (57%)</td>
<td>3² (43%)</td>
<td>2³ (33.3%)</td>
<td>2³ (33.3%)</td>
<td>2³ (33.3%)</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>5¹ (62.5%)</td>
<td>3³ (37.5%)</td>
<td>2³ (29%)</td>
<td>2³ (29%)</td>
<td>3³ (42%)</td>
</tr>
<tr>
<td>Paediatric/Physical Health</td>
<td>5² (71%)</td>
<td>2² (29%)</td>
<td>2³ (29%)</td>
<td>4³ (71%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services for People with Learning Disabilities</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Development of Care Management Programmes</td>
<td>5¹ (62.5%)</td>
<td>3¹ (37.5%)</td>
<td>6² (86%)</td>
<td>1² (14%)</td>
<td></td>
</tr>
<tr>
<td>Relationship and Behavioural Difficulties</td>
<td>8¹ (100%)</td>
<td></td>
<td>7¹ (87.5%)</td>
<td></td>
<td>1¹ (12.5%)</td>
</tr>
<tr>
<td>Community and Environmental Management</td>
<td>7¹ (87.5%)</td>
<td>1¹ (12.5%)</td>
<td>7¹ (87.5%)</td>
<td>1¹ (12.5%)</td>
<td></td>
</tr>
</tbody>
</table>

Key ¹ n=8 ² n=7 ³ n=6
As can be seen, respondents predominantly wanted both assessment and treatment in all areas related to older adults. The highest need was felt to be for family and systems approaches (67%) and managing loss and bereavement (57%). In terms of psychology services for children and adolescents both family therapy and psychotherapy were rated as a high need by 71% of respondents. For all areas assessment and treatment was preferred over assessment only. In terms of services for people with learning disabilities assessment and treatment was rated as more important than assessment only and all three areas were rated as being of high need by over two-thirds of respondents.

In terms of health (medical) psychology aside from 'general coping with chronic medical conditions,' a number of other areas were noted by more than one respondent (oncology; pain management; paediatric health; diabetes care; neurological rehabilitation and coronary heart disease). General coping strategies, oncology services and pain management services were rated as the highest priorities. Almost all respondents required both assessment and treatment for each condition. See Appendix 5 for full details.

In terms of psychology services for adults 16 to 65 years there were a large range of areas felt to fall within the remit of an adult psychology department (See Appendix 6). Psychotherapy, family therapy and the provision of a personality disorder service were seen as the highest priority, with both assessment and treatment required.

In terms of models of service delivery, six psychologists (86% of respondents) wanted model 1 (See Appendix 1) which focused on psychologists working in both multidisciplinary teams and primary care based teams.

(ii) Users' views

Table 2 shows the number of respondents interviewed, the number who had seen a psychologist and gender distribution.
Table 2 Respondent Characteristics

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of Members Present</th>
<th>Number seen a Psychologist</th>
<th>Number of Female Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Centre 1</td>
<td>23</td>
<td>9 (39%)</td>
<td>13 (56%)</td>
</tr>
<tr>
<td>Day Centre 2</td>
<td>8</td>
<td>4 (50%)</td>
<td>3 (37%)</td>
</tr>
</tbody>
</table>

Responses in terms of the perceived work of a psychologist fell into 4 categories. Some respondents confused the role of psychologist with that of psychiatrist and thus spoke about the giving of medication and/or ECT. A second group saw psychology in terms of ‘behaviour matters’ and ‘behaviour problems.’ A third group identified the psychologist’s role in terms of ‘talking and analysing feelings.’ A fourth group identified the work of the psychologist in terms of ‘how you think.’ Three respondents mentioned a particular type of approach. One mentioned role playing, another the reflective role of the psychologist, while a third spoke of the non-judgemental nature of the work.

In terms of what psychological services respondents thought were being provided locally, family problems, behaviour problems and ‘talking to someone’ were identified as the services currently provided.

Those who had seen a psychologist spoke of their experiences as good, bad, indifferent and bewildering. One respondent noted: ‘Sometimes things can be very distressing, you’re allowed to get angry with things, can give you a greater understanding of things.’ Other respondents were less positive and one person spoke of the angry feelings he had and ‘that I talk, but don’t really resolve them.’ Another noted that ‘talking about problems just drained me.’ One respondent expressed anger at having to fill in a pre-therapy form, which he found personally distressing only to be asked exactly the same questions at his first appointment. There was however a recognition by some people of the high expectations that they placed upon their psychologist. As one person said ‘When you’re in a state and he’s not there, you think he doesn’t care, even though you know he’s busy.’ Others did not seem to hold particularly high expectations of what could be achieved themselves ‘I saw a young
psychologist once, don't know if he did any good, but he didn't do any harm either.'

Two respondents found the whole process perplexing 'I never really understood what it was about' while another noted that 'I didn't quite know what I was there to discuss.'

Respondents were also asked what they wanted from the psychology department, this was after the role of NHS psychologists had been explained by the Head of the Psychology Department. Responses were content coded into four main themes: (i) issues of access; (ii) places of delivery; (iii) concerns over consistency and communication and (iv) the question of changing psychologists.

In terms of access and place of delivery, respondents wanted to be able to contact someone outside the usual service structures. The importance of recontacting a psychologist, even if it wasn't the same person was considered important, as one person stated 'It makes me feel safe knowing I can contact someone.' Some respondents felt that it would be useful to establish such contact without having to go through the GP or psychiatrist; one person noting 'GPs can sometimes be a bit funny.' One proposed model for achieving this was for a psychologist to establish a weekly open access session in the day centres, an idea rated as favourable by the majority of respondents. Other suggestions included a 24hr crisis service with psychological input.

Individuals also prized consistency in who they saw. Although such consistency was directed more at CPN's and psychiatrists the message was clear, as one person stated: 'You get used to seeing one person.' Connected to this was the question of communication between professionals and a feeling that communication was not all it could be. One person spoke of a sense of 'being passed down the line.' Respondents wanted to be kept informed, particularly when they were on a waiting list.

The fourth area discussed by respondents (mainly those who had already seen a psychologist) concerned changing psychologists if they didn't get on with them. Particularly important was how people could change psychologists in a positive way both for themselves and the psychologist. Respondents felt that as things stood you needed to be reasonably assertive to ask to see someone else and the establishment of some non-stressful mechanism for seeing a different psychologist would be helpful.
One respondent stated that ‘They get funny if you want to swap,’ while another noted that ‘I don’t want to ask to change, feel it’s rude.’ One suggestion put forward was for the psychologist to be explicit about how this could be achieved at the beginning of therapy.

Discussion

There are a number of messages that emerged from the research from both psychologists and service users. Non statutory mental health service users were essentially asking for a more egalitarian service in which access to psychological services was more widely available and where it was easier to change psychologists within that service. Respondents wanted to know that it was OK to contact someone, for, as one person noted ‘because you have mental health problems you feel as if you are doing something wrong anyway.’ Another spoke about people with psychiatric problems not wanting to go for help because of pride. Open access sessions within services for people with long-term mental health problems, may be an effective method for achieving this. There is always a concern that such an open system couldn’t regulate itself, but as one person noted it ‘maybe just 10 minutes for advice.’ Moreover such a service could provide a useful and important gate-keeping function for referrals based on the assessment skills of psychologists as opposed to the current system based on GP’s varied level of psychological knowledge. Clearly providing such a service may entail structural changes to the way services are delivered and a major concern must be that individuals would not be penalized by default in terms of having to return to a waiting list were they to request a change to another psychologist.

Psychologists who responded endorsed a model of delivering psychological services in which psychologists would work as part of multidisciplinary teams alongside Primary Care based psychologists. This model was also reflected in the areas psychologists prioritized, with CMHT’s, GP’s and specialist adult teams being ranked most highly.

In terms of providing specific types of psychological intervention, three factors stood out. Firstly ‘systems and family approaches’ were considered a high priority not just
for child and adolescent services but across the entire age-span. Were such a focus to be achieved then it may be possible to construct a seamless non-age based psychology service, structured around this particular therapeutic approach.

Secondly there was some agreement but no consensus about those areas that should be covered by a health psychology service. Shortly after this research was completed the Department appointed a psychologist specializing in oncology and the Department Head moved to establish a pain management clinic in another Trust. Such factors lend some limited credence and validity to the views expressed in the questionnaire.

Thirdly within the area of psychological services for adults the importance of providing a service for individuals with personality disorders was marked. This is particularly noteworthy since personality disorders did not appear as one of the four categories given. Thus respondents had to intentionally write this area down and mark it accordingly. Their rating reflects wider concerns within health services and society generally as to how to best deal with such a problematic condition. By implication the fact that psychologists feel that they should be providing services to this group of individuals suggests that there are reasonable grounds for viewing psychological interventions as an important treatment goal in this area.

Although there were some clear messages to come out of the research there were also a number of weaknesses in terms of research design and method which need to be discussed. Firstly the questionnaire proved too complex for the client group. While some of this complexity was due to the structure of the questionnaire, some of it had to do with its detailed focus on the nature of psychological services provided. This highlights the importance of wider piloting of the questionnaire with a wider variety of stakeholders. Although the user advocate was consulted both about content and design this was clearly inadequate in terms of reflecting other users' knowledge. This means that the views of psychologists and service users cannot be directly compared as different methods of assessment were used which resulted in the focus for these two groups being different.

Secondly there is the question of the design of the research. The research was constructed by the author and Head of Psychology as part of a larger scale project to
be undertaken locally. The focus on wider user consultation was not possible in this part of the project. In particular it was not considered appropriate to undertake research with users currently using Trust facilities. While this was a political decision and not a methodological one, it clearly impacted on the scope of the research and has implications as to what can be said on the basis of the service users sampled.

Thirdly there are a number of measurement difficulties associated with the construction of reliable and valid surveys (Webb, 1993), both for service users (Holloway, 1993; Ovretveit, 1990) and for professionals and no explicit reliability or validity studies were undertaken as part of this study.

Finally there is the limited sample size and the question of generalization. Thus the number of users consulted was relatively small and no attempt was made to obtain a representative sample. For the purposes of this research non-statutory services were defined in terms of specific and identifiable mental health projects. Thus while there are many non-statutory forms of provision that are often of help to service users such as community and religious facilities (Copsey, 1997; Rose, 1996) and condition orientated support groups such as the National Schizophrenia Fellowship, these were not included in this part of the research. This decision was mainly to do with the feasibility of undertaking a wider consultation process in the limited time available. However, lack of ability to generalize does not mean that the views of those service users consulted can be ignored, particularly those who were commenting on their actual experiences of using psychological services. Thus the views expressed can be seen as pointers or indicators to needs in service provision, something which will be highlighted when the results of this research are fed back to the three groups of participants involved.

Conclusions
Soliciting the views of those who use and provide mental health services is an area of growing importance. There are not just ethical reasons for doing this but basic economic ones as well, particularly in an era in which quality, treatment effectiveness and treatment efficiency are seen as key to the effective provision and purchasing of services. This small-scale piece of research originally attempted to compare and contrast the views of mental health service users and psychologists as to which
services should be prioritized within the local psychology department. This did not prove possible. What did emerge was some agreement among psychologists as to what should be provided and suggestions as to what was wanted from service users. Central to this was the desire for a change in the ways psychological services are accessed. This has implications for the way services are delivered. While changing the ways in which psychological services are accessed would philosophically fit into the current focus on a primary based care service, practically it would not, especially while general practitioners remain at the heart of the primary care based system. Perhaps the question at the end of the day is whether primary care is determined by sites of access, such as the GP surgery, where many psychologists already play a full part or whether it is determined by open access to a range of services, in which currently there is limited opportunity to access a psychologist.
Addendum

This addendum answers some questions posed by the external examiner some months after the original submission of the work. In particular it includes clarification of the main research question, a more detailed literature review, clarification of the selection of participants and reflection on some of the underlying processes involved in the research.

Research Question

The original submission stated that 'The aim of this research was to discover what the priorities were in terms of the type of psychological services provided in one Trust from the perspective of service users and psychologists.' Clearly it would have been better to state this as a research question, namely 'What aspects of psychological service provision are prioritised by service users and psychologists?'

Literature Review

(i) Policy changes and user involvement

Up until the early eighties it was generally recognized as sufficient for health professionals to determine what services local populations and patients required. Professionals did this by: (i) assessing whether services met the professionally-assessed needs of its clients and (ii) whether the service correctly selected and carried out the techniques and procedures which professionals believed met those needs (Ovretviet, 1990).

In the last fifteen years or so things have changed. Consumers of mental health services have increasingly been approached for their views on the services that are 'provided' for them. One of the reasons for this shift has been the rise of a mental health consumer movement, where proactivity has taken the place of passivity. Groups such as MIND (National Association for Mental Health) have increasingly had an influence on local services, the way that mental health professionals thought about those services, and crucially, on the legislative framework associated with mental health law as in the case of the 1983 Mental Health Act. A more general reassessment occurred with 'patients' being re-designated as 'customers' or 'consumers' of services in the Griffiths report (1988) on community care in Britain.

More recently a number of important health policy initiatives have been introduced by
the Labour Government. Five initiatives stand out in particular, (i) the New NHS White Paper (DoH, 1997) (ii) ’A First Class Service’ which addresses quality in the new NHS (DoH, 1998a), (iii) a discussion paper, ‘Modernising Mental Health Services’ (DoH, 1998b); (iv) the consultation paper Partnerships in Action (DoH, 1999a) and (v) the National Service Framework (NSF) which aims to provide a framework for mental health services for the next ten years (DoH, 1999b). All of these initiatives are concerned with service users at some level and the implementation of the NSF in particular requires the involvement of users and carers at each stage of its implementation, evaluation and review. One of the major policy changes that will take place as a result of these initiatives is a shift from a competitive health market place to one based on joint planning and agency partnership. Practically, this should result in health and social services working far more closely together than has previously been the case and some joint solicitation of service user views.

(ii) Forms of user feedback
The most frequently used form of consumer feedback is the satisfaction survey, partly because of their ease of use and partly because of an emphasis in 'Caring for People' (DoH, 1989) which stressed the need for patients' views to be solicited, as one way of monitoring the quality of services. Such surveys range in form from the simple in-house construction to more detailed and psychometrically robust work and are frequently used in mental health services (Stallard, 1996). However there are a number of methodological problems associated with their use. Authors have increasingly come to question the seductive "face validity" of such direct expressions of consumer views and have criticized the poor reliability and validity of these instruments and the lack of attention to basic psychometric development in the numerous ad hoc instruments used (Lebow, 1982; Webb, 1993; Ruggeri, 1996). However as Ruggeri (1996) states:

Despite reservations made about their use as a means for evaluating interventions, various findings in the recent literature point to patients’ and relatives’ satisfaction with psychiatric services as a particularly salient and appropriate measure of outcome and quality (p.27)

However, and of equal concern is a doubt about the effective capacity of such surveys to create change within organisations, particularly when the structures to respond to such
feedback are lacking or where it is unwelcome (McIver, 1991). Related to this is a particular concern in mental health services where a significant strand of the criticism of their poor quality has been that they have tended to increase the passivity and dependency of their clients, rather than enabling them to maximise their capacity for independent functioning (Beeforth, Conlan, Field, Hoser, & Sayce 1990). The response has been a widespread movement for greater user involvement, which proposes a diversity of structures by which the interests of those receiving mental health services can be promoted and their effective power increased (Barker & Peck, 1985). The introduction of such systems as patients' councils, users' forums with representation on planning and management committees and advocacy support systems, is designed to empower "consumers" of the mental health services. It seems likely that in the future, evaluations will be seen as entirely inadequate if they do not explicitly take steps to incorporate the perspective of users and that formal clinical governance systems will be required not only to incorporate "feedback" but to create structures to enable users to be directly involved in the implementation of change.

Marion Beeforth (1993, p. 89) has outlined some of the tensions experienced in involving users in planning services and suggests that a fundamental attitude shift needs to take place on the part of professionals. She suggests that the traditional view of professionals entails a number of unhelpful assumptions:

- we are providers of mental health services;
- we know what is best
- we have to organize services
- we must have user participation
- let us set up a users' group
- do we know any user we can ask?

Beeforth (1993) suggests a better model would be one in which user organizations and service providers have to meet on middle ground. It is a model which recognizes that each party has their areas of expertise and organizational infrastructure, and as such aims to minimize the practice of 'tokenism.' Table 3 suggests some of the possible ways in which service users' or potential service users views might inform the planning and evaluation process.
Table 3. How service users’ or potential service users’ views might inform the planning and evaluation process

<table>
<thead>
<tr>
<th>Stage</th>
<th>How service users’ or potential service users’ views might inform the planning and evaluation process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identifying local needs</td>
<td>Users acting as researchers and consultants in research, as well as respondents e.g. Strategies for Living (Mental Health Foundation, 2000). Not just user consultation, but ongoing user representation. User monitoring of services (e.g. Rose, Ford, Lindley, Gawith &amp; Users Group, 1998)</td>
</tr>
<tr>
<td>Auditing local services</td>
<td></td>
</tr>
<tr>
<td>Setting local priorities</td>
<td></td>
</tr>
<tr>
<td>Deciding what services to commission</td>
<td></td>
</tr>
<tr>
<td>Monitoring delivery</td>
<td></td>
</tr>
<tr>
<td>2. Setting standards and terms for commissioning</td>
<td>User representatives are on all planning and review boards and are involved in all areas of policy (The Sainsbury Centre for Mental Health, 2000). Appreciation of the roles of advocacy and user involvement.</td>
</tr>
<tr>
<td>3. Assessing individual needs</td>
<td>The NHS White Paper recognizes that care should be built around individual need. Service users articulate their own needs through assessment tools such as the Avon Mental Health Measure.</td>
</tr>
<tr>
<td>4. Commissioning services for individuals</td>
<td>Users included in any commissioning decisions. Users in charge of their own commissioning decisions and budgets.</td>
</tr>
<tr>
<td>5. Care planning</td>
<td>Integrated CPA to include user’s views on crisis planning. User evaluation of case management/CPA to continue (Beeforth, Conlan &amp; Graley, 1994)</td>
</tr>
<tr>
<td>6. Reviewing and revising care plans</td>
<td>Use of client held records (Stafford &amp; Hannigan, 1997) and shared care booklets (Wolf &amp; Stafford 1997).</td>
</tr>
<tr>
<td>7. Education and Training</td>
<td>Continued user involvement in course curriculum, training and educational delivery. From Hill (In Press).</td>
</tr>
</tbody>
</table>

Clearly then, there are a number of ways of involving service users in strategic planning and evaluation. While the beginning of the nineteen nineties saw such suggestions being put forward almost exclusively by service users, sometimes with wider backing (e.g. Read & Wallcraft, 1992), governmental guidance now recognizes user involvement as a fundamental requirement. Some independent organizations such as the Sainsbury Centre for Mental Health have given a commitment to support service users experiences of monitoring the implementation of the National Service Framework (The Sainsbury Centre for Mental Health, 1999).
Selection of Participants

The two centre managers were approached concerning the best means of recruiting participants for the study. Both managers suggested attendance at the centre’s business meeting would be the most appropriate way of introducing the research. The research instrument designed to collect the views of both psychologists and service users was reported to be too complex by the service users present at the meeting and it was agreed to solicit opinions in a group format. Thirty-one members were consulted in this way. Given the revised format in which the information was collected it was not considered appropriate to ask individual members for their diagnosis or demographic information and no case notes (for which ethical permission would have been required) were in fact kept by the centre managers. This fitted into the service philosophy of both organisations. However, both centres had a remit to provide services for those with long-term and enduring mental health problems.

Reflections on the Research Process

The research design proved to be seriously flawed in practice and this raises a number of interesting questions. Firstly, although we undertook some limited piloting of the questionnaire this was clearly insufficient. Discussions with the local user representative who was a service user himself resulted in a number of changes to the questionnaire. However, it was still regarded as too complex by the service users we consulted. Looking back it is clear that both the user representative and ourselves seriously overestimated people’s knowledge of and ability to make distinctions between different levels and domains within mental health service structures. This raises some concerns about the issue of user representation (Crepaz-Keay, 1996) and the logistics of involving service users in strategic planning. In particular a clearer awareness of the complexity of health and social service systems should have been acknowledged and methods of facilitating user involvement at district level planning considered (Read & Wallcraft, 1992). Such a process is central to the philosophy of social inclusion and is an important way of overcoming discrimination and social exclusion (Sayce, 2000). Moreover the 1999 Health Act has placed significant emphasis on partnership and allows for the development of new models for achieving this. The involvement of users is also central to the National Service Framework (NSF) for Mental Health and as the Government’s paper on quality states (DoH, 1998a) ‘it is impossible to get the best from a change process without actively involving them.’
However, this research also raises issues about asking questions of the appropriate audiences. In retrospect it seems far too ambitious to expect those with little strategic knowledge, either as service user or psychologist, to be able to comment in such detail on the ways services ought to be prioritized.

More consideration should also have been directed at some of the dynamics underlying service user consultation. Consideration should have been given to the possibility that service users would feel afraid to criticize or complain about services for fear of the consequences. Promises of confidentiality and anonymity should be seen as only a minimum assurance in this regard. There should also have been some recognition that service users may feel that participation would involve further responsibilities and duties, something that they may not be willing or able to take on. It is also possible that the perceived benefit of the research was not perceived to be worth the time input. While these are only hypotheses they are clearly important points to consider when undertaking research work with long-term users of mental health services.

A final consideration concerns the extent to which one attempts to trade simplicity in research design against simplicity of research instruments. This small-scale piece of work aimed at simplicity of design in that it devised an instrument that could be used by two diverse populations with quite different levels of educational attainment and service knowledge. Such a design resulted in a questionnaire that clearly lacked simplicity and probably held poor face validity for both groups of participants. The design required adaptation and resulted in an instrument that was genuinely difficult to complete. Interestingly, despite these serious methodological limitations, the process of undertaking the work was reported to be of benefit to all of the organizations involved, when the research was fed back to them (See Appendix 7). The primary reason stated was a clearer awareness of the knowledge level of each group of participants and their respective organizations. Clearly this cannot make up for the difficulties encountered, but it does highlight the fact that reflections upon the process of research can be as illuminating as the results.
References


Beeforth, M., Conlan, E., & Graley, R. (1994). *Have We Got Views For You*. London. The Sainsbury Centre for Mental Health


Appendix 1 Psychology Audit Options

(Numbers for each block of text refer to individual respondents)

What areas do you think would be most useful for the department to audit?

1. CMHT clients increasingly seen in primary care - numbers and what happens. The use of clearly defined therapeutic goals and role of patient in defining these. Provision of appointment and discharge reports/letters. Number of contacts of primary care psychologists with other primary care staff.

2. Routine outcome
   Procedure following referral (different letters may elicit different levels of engagement)

3. Patient satisfaction as most useful aspect of contact with psychology services. Patient satisfaction

4. How many sessions are psychologists seeing people for?
   What percentage of clients benefit and to what extent?
   What percentage of clients DNA and CNA?

5. Outside of CMHT- referrals and whether there are clusters of a particular type, if so we can target areas of distress left out. Feedback from clients at the end of therapy. Investigation of CNA and DNA.

6. In global terms whether we are fulfilling a useful function/meeting the psychological needs in the community we are serving! Narrowed down, measures of client/referrer satisfaction (also possibly qualitative data on what they want).

7. Outcome e.g. at one month, 6 months, 12 months.- client assessment against their goals of therapy
   Effect of waiting time on clients and referrers.
   Following up reasons for DNA’s at first appointment.
   Seeking information from referrers on their expectations of service and any improvements they would like made. For GP’s this could be by written questionnaire to all GP’s and perhaps interviews with one from each practice.
   Use of questionnaire for assessment purposes. Psychologists within Dept. vary in how they use this. What can we learn from this variance and how do the different approaches come across to clients? Are there simpler or more effective questionnaires we could try out?

Numbers of sessions. I don’t think figures on averages or ranges are significant in themselves, but it might be interesting to survey how we each set limits. What expectations we give clients at outset and what expectations referrers give clients.
Appendix 1 Psychology Audit Options (cont)

Which of these areas do you see as the priority?

1. The use of clearly defined therapeutic goals and role of patient in defining these. Number of contacts of primary care psychologists with other primary care staff.

2. Routine outcome and procedure following referral (different letters may elicit different levels of engagement)

3. Patient views as most useful aspect of contact with psychology services.

4. How many sessions are psychologists seeing people for? What percentage of clients benefit and to what extent? What percentage of clients DNA and CNA?

5. GP referrals.

6. Referrer expectations of psychological input.

7. Outcome e.g. at one month, 6 months, 12 months.- client assessment against their goals of therapy and seeking information from referrers on their expectations of service and any improvements they would like made. For GP’s this could be written by written questionnaire to all GP’s and perhaps interviews with one from each practice.

Why is this?

1. Emphasis on client (patient and referrer) satisfaction.

2. It is perhaps psychologists responsibility even an ethical obligation to use scientific research skills to demonstrate the effectiveness of our interventions with a view to maximizing efficiency. Possibly clients are being ‘lost’ from the system due to inefficiency in the system which could be changed.

3. Implications for directing service and therapeutic interventions.


5. Our waiting list was so long for so many years that GP’s may be still thinking the ‘old’ way.

6. To know whether: a) their expectations are realistic, or whether informative input is needed; b) they feel their expectations are being met; c) any action needs to be taken in the department to improve the service (as perceived by referrers). Picked on referrers since they are our most direct purchasers and form a more unitary population than clients. Difficult to equate outcome or satisfaction results with e.g. psychotic vs. personality disorder vs. Phobias - too much diversity in client groups.
Appendix 1 Psychology Audit Options (cont)

What type and level of information would be most useful to you?

1. Specific therapeutic goals for clients and patient questionnaires for achieving this. Questionnaire to measure overall contact with psychologists and subsequent coping. Tally of reports sent and time from achievement to discharge.

2. General outcome measures (with some demographics to group for purposes of comparison)
Type of response letters and drop out rates.

3. In-depth representative sample and more superficial general audit.

4. Which clients feel they improved/not improved.
What did they find most/least useful.

5. Within primary care feedback from clients and CNA and DNA data.

6. Some quantitative, some qualitative.

7. Missing

What do you think would be the most useful method or process for this department to take in planning and collecting data for the audit?

1. Individual clinicians providing data or reason why this is not appropriate. Collect this for ten weeks and then provide immediate feedback to change practice.

2. Voluntary

3. Unsure at the moment—no time to think!

4. Talk about it a couple of meetings and then you go ahead and do it!

5. Missing

6. Semi-structured questionnaire, maybe backed up by interview especially if questionnaires are not returned by a high percentage.

7. I think first we need commonly agreed goals of audit within the Dept. And then guidance on what approaches have been used by others with recommendations.
This questionnaire gives you the opportunity to tell us which services you believe should be provided by the Crawley Horsham Psychology Department as part of the NHS.

ARE YOU? (please mark box)

A service provider □

What profession ........................................................................................................

What area of work (e.g. Primary Care, Hospital department, Social Services)
........................................................................................................

Service user □

Service purchaser □

Other □ Please specify ........................................................................

PLEASE INDICATE WHICH OF THE FOLLOWING AREAS YOU THINK WE SHOULD PROVIDE A PSYCHOLOGY SERVICE TO.

INDICATE THE ORDER OF IMPORTANCE BY PLACING A ONE NEXT TO YOUR FIRST CHOICE, TWO NEXT TO YOUR SECOND AND SO ON FOR AS MANY AS YOU CAN.

<table>
<thead>
<tr>
<th>SPECIALIST AREA OR TEAM</th>
<th>YOUR ORDER OF IMPORTANCE (FROM 1. ONWARDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care (G.P.) team</td>
<td></td>
</tr>
<tr>
<td>Community Mental Health team</td>
<td></td>
</tr>
<tr>
<td>Neuropsychology (brain damage)</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities team</td>
<td></td>
</tr>
<tr>
<td>Substance Misuse team</td>
<td></td>
</tr>
<tr>
<td>Specialist Health Psychology (see note 1 on last page)</td>
<td></td>
</tr>
<tr>
<td>Specialist Adult team (see note 2 on last page)</td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent team</td>
<td></td>
</tr>
<tr>
<td>Elderly Mentally Ill team</td>
<td></td>
</tr>
<tr>
<td>Other (please specify and rank order)</td>
<td></td>
</tr>
</tbody>
</table>
PLEASE GIVE YOUR OPINION ON EACH OF THE FOLLOWING SIX AREAS.

1. PSYCHOLOGY SERVICE FOR OLDER ADULTS

<table>
<thead>
<tr>
<th>CURRENT STAFF TIME ALLOCATED</th>
<th>tick one only</th>
<th>tick one only</th>
</tr>
</thead>
<tbody>
<tr>
<td>PER WEEK:</td>
<td>Ass. &amp; treat.</td>
<td>Ass. only</td>
</tr>
<tr>
<td>= NONE</td>
<td></td>
<td>Not at all</td>
</tr>
</tbody>
</table>

- Psychotherapy*
- Systems and family approaches
- Cognitive (thinking ability) and social functioning
- Managing role transition and change
- Managing loss and bereavement

*Psychotherapy* for the purposes of this questionnaire includes individual and group therapy and a range of different approaches.

2. HEALTH (MEDICAL) PSYCHOLOGY

<table>
<thead>
<tr>
<th>CURRENT STAFF TIME ALLOCATED</th>
<th>tick one only</th>
<th>tick one only</th>
</tr>
</thead>
<tbody>
<tr>
<td>PER WEEK:</td>
<td>Ass. &amp; treat.</td>
<td>Ass. only</td>
</tr>
<tr>
<td>= SIX DAYS</td>
<td></td>
<td>Not at all</td>
</tr>
</tbody>
</table>

- General coping with chronic medical conditions
- Specific hospital based services (see note 1. on last page for examples)
  1. ...................................................
  2. ...................................................
  3. ...................................................
  4. ...................................................

3. PSYCHOLOGY SERVICE FOR CHILDREN AND ADOLESCENTS

<table>
<thead>
<tr>
<th>CURRENT STAFF TIME ALLOCATED</th>
<th>tick one only</th>
<th>tick one only</th>
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</thead>
<tbody>
<tr>
<td>PER WEEK:</td>
<td>Ass. &amp; treat.</td>
<td>Ass. only</td>
</tr>
<tr>
<td>SUPPLIED BY MID SUSSEX TRUST</td>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>= TWO DAYS</td>
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</tbody>
</table>

- Psychotherapy*
- Family therapy
- Cognitive (thinking ability) and developmental levels
- Learning disabilities
- Paediatric/physical health

*Psychotherapy* for the purposes of this questionnaire includes individual and group therapy and a range of different approaches.
4. PSYCHOLOGY SERVICE FOR ADULTS 16 TO 65 YEARS

**CURRENT STAFF TIME ALLOCATED PER WEEK:**

1. **GENERAL SERVICE** = ONE HALF DAY TO EVERY 4 TO-5 GP'S.
2. **SPECIALIST** = ONE DAY EACH IN POST TRAUMATIC STRESS & EATING DISORDERS
3. **COMMUNITY MENTAL HEALTH TEAMS** = ELEVEN DAYS PER WEEK

<table>
<thead>
<tr>
<th>tick one only</th>
<th>Assessment only</th>
<th>Assessment &amp; treatment</th>
<th>Not at all</th>
<th>tick one only</th>
<th>High need</th>
<th>Low need</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy*</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Family and relationship therapy</td>
<td></td>
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<tr>
<td>Forensic (criminal)</td>
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<tr>
<td>Neuropsychology (brain functioning)</td>
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<tr>
<td>Specialist services relating to particular mental health problems (see note 2. last page for examples)</td>
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<tr>
<td>1. .........................</td>
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<tr>
<td>2. .........................</td>
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<tr>
<td>3. .........................</td>
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<tr>
<td>4. .........................</td>
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</tbody>
</table>

*Psyonotherapy’ for the purposes of this questionnaire includes individual and group therapy and a range of different approaches.

5. PSYCHOLOGY SERVICE FOR PEOPLE WITH LEARNING DISABILITY

**CURRENT STAFF TIME ALLOCATED PER WEEK:**

FOR CRAWLEY HORSHAM AND MID SUSSEX TRUST = FOUR DAYS PER WEEK

<table>
<thead>
<tr>
<th>Development of care management programmes</th>
<th>tick one only</th>
<th>Assessm ent only</th>
<th>Assessm ent &amp; treatment</th>
<th>Not at all</th>
<th>tick one only</th>
<th>High need</th>
<th>Low need</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural and relationship difficulties</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Community and environmental management</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
PLEASE MAKE COMMENTS, ADD TO, OR CROSS OUT PARTS OF THESE MODELS IF YOU WISH TO

MODEL ONE: Psychologists working as part of separate multidisciplinary teams and with Primary Care based Psychologists working directly with the Primary care teams and linking with the Psychologists in the separate teams

MODEL TWO: As for model one but without the Primary Care based Psychologists.

PLEASE INDICATE BELOW YOUR PREFERENCE FOR ONE OF THESE TWO OVERALL MODELS.

Model One ........................................... ☐
Model Two ......................................... ☐
I am unwilling or unable to choose .................. ☐
NOTE 1.  
Specific hospital based Health Psychology services

The use of a Psychologist in these areas has been shown to considerably improve the quality of patient care, it involves a specialist Psychologist being attached to specific hospital based medical services, providing among other services - patient counselling, staff support and training, treatment adherence programmes, managing side effects, relatives support, behavioural programmes for symptom reduction (e.g. sleep, nausea etc.), research.

Areas where this service is currently provided include:

<table>
<thead>
<tr>
<th><strong>PAIN MANAGEMENT</strong></th>
<th><strong>PAEDIATRICS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCER CARE</strong></td>
<td><strong>RENAL (KIDNEY) CARE</strong></td>
</tr>
<tr>
<td><strong>NEUROLOGICAL REHABILITATION</strong></td>
<td><strong>EAR NOSE &amp; THROAT AND AUDIOLOGY</strong></td>
</tr>
<tr>
<td><strong>GASTROLOGY SERVICES</strong></td>
<td><strong>RESPIRATORY MEDICINE</strong></td>
</tr>
<tr>
<td><strong>DIABETES CARE</strong></td>
<td><strong>CARDIOVASCULAR CARE</strong></td>
</tr>
</tbody>
</table>

NOTE 2.  
Specialist services relating to particular adult mental health problems

It is common for a Clinical Psychologist to specialise in one or more specific areas of adult mental health and where possible to work with members of other professions or other Psychologists to provide a range of treatment and management options in these specialisms.

Specialist mental health Psychology services offered frequently in the NHS include the following:

<table>
<thead>
<tr>
<th>EATING DISORDERS</th>
<th>ANXIETY DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST TRAUMATIC STRESS DISORDER</td>
<td>SEXUAL DISORDERS/DYSFUNCTION</td>
</tr>
<tr>
<td>DEPRESSIVE DISORDERS</td>
<td>SLEEP DISORDERS</td>
</tr>
<tr>
<td>PSYCHIATRIC REHABILITATION</td>
<td>PERSONALITY DISORDERS</td>
</tr>
<tr>
<td>SUBSTANCE MISUSE</td>
<td></td>
</tr>
</tbody>
</table>

Please write any comments on the back of this page.

Thanks for your time.

Please return to the Psychology Department, Horsham Hospital.
Appendix 3 Questions to Guide Group Discussion

What kind of work do you think of being carried out by a psychologist?

Is there anyone who has a different view or disagrees with what has been said?

What kind of services do you think the NHS psychology department in your area is currently providing?

Is there anyone who has a different view or disagrees with what has been said?

How many people have seen a psychologist here?

What were your experiences of this?

(At this point the group facilitator spoke about the role and function of NHS psychologists and of the local department)

What kind of services do you think the NHS psychology department in your area should be providing?

Is there anyone who has a different view or disagrees with what has been said?
Appendix 4. Areas Psychologists Thought they Ought to be Providing Services to (n=7).1

<table>
<thead>
<tr>
<th></th>
<th>Rank 1</th>
<th>Rank 2</th>
<th>Rank 3</th>
<th>Rank 4</th>
<th>Rank 5</th>
<th>Rank 6</th>
<th>Rank 7</th>
<th>Rank 8</th>
<th>Rank 9</th>
<th>Rank 10</th>
<th>Unranked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Team (CMHT)</td>
<td>43%</td>
<td>14%</td>
<td>29%</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Primary Care (GP) Team</td>
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<td></td>
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<tr>
<td>Neuro-psychology</td>
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<td></td>
<td></td>
<td></td>
<td>72%</td>
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<td></td>
<td></td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Learning Disabilities Team</td>
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<td></td>
<td>29%</td>
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<tr>
<td>Substance Misuse Team</td>
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<td></td>
<td>29%</td>
<td></td>
<td></td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Specialist Health Psychology</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>Specialist Adult Team</td>
<td>43%</td>
<td>14%</td>
<td>29%</td>
<td>14%</td>
<td></td>
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</tr>
<tr>
<td>Child and Adolescent Team</td>
<td>14%</td>
<td>43%</td>
<td>14%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Elderly Mentally Ill Team</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29%</td>
<td></td>
<td></td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>Other (Personality Disorder Service)</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>86%</td>
</tr>
</tbody>
</table>

1 Two respondents did not complete this part of the questionnaire.
### Appendix 5 Health (Medical) Psychology (n=8)

<table>
<thead>
<tr>
<th></th>
<th>Assessment and Treatment</th>
<th>Assessment Only</th>
<th>High Need</th>
<th>Low Need</th>
<th>No Need</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Coping with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Medical Conditions</td>
<td>5</td>
<td></td>
<td>4</td>
<td></td>
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162
Appendix 6 Psychology Services for Adults 16 to 65 Years

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<th>Service</th>
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<th>No Need</th>
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<td>Family and Relationship Therapy</td>
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<td>7(^2)</td>
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<tr>
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<td>2(^2) (29%)</td>
<td>4(44%)</td>
<td>2(23%)</td>
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</table>

n responses for fixed format questions

\(^1\) n=8

\(^2\) n=7

\(^3\) n=6
MH/as
25 May 1999

Dr Robert Hill
93A Streatham Vale
London
SW16 5SQ

Dear Robert

I am happy to confirm that you did, indeed, present your service related research to this Department, and in fact that your presentation was clear, well-structured and interesting.

Yours sincerely

MARGARET HENNING
Acting Head of Department
LARGE SCALE RESEARCH PROJECT

Explanations for Variations in Partner Violence During Pregnancy: An Exploratory Study

July 2000

ABSTRACT

While male partner violence during pregnancy is increasingly being recognized as a serious public health issue, little work has been undertaken on explanations for this. As a result there is little systematic theory as to the reasons for this potentially dangerous behaviour. Where suggestions have been put forward, these have been based entirely on women's accounts and explanations. To date no research could be found that included a male perspective on male violence during pregnancy. One possible reason for this appears to be a lack of screening and assessment for violence during pregnancy by forensic agencies. This hypothesis was tested in the first part of this project through a survey of medium secure facilities.

The second part of the project used a grounded theory approach to interview seventeen fathers about their experiences of fatherhood and their explanations for male violence during wanted pregnancy. To elicit their views, three vignettes were used which presented three different scenarios of violence during pregnancy – one in which violence occurred both before and during the pregnancy, one in which violence occurred before but not during the pregnancy and one in which violence emerged for the first time during pregnancy. The fathers who were interviewed included professionals, non-violent men and men with a history of violence. A tentative model is proposed in the final chapter along with methodological weaknesses of the current study and some of the clinical implications of the work.
1. Background to the Study

There is an increasing concern about male partner violence during pregnancy. Gazmararian, Lazorick, Spitz, Ballard, Saltzman and Marks (1996) in a review of all studies of violence during pregnancy between 1963-1995 report prevalence rates of between 0.9% and 20.1%. In this country a recent report found that 1 in 3 women were assaulted during this period (DoH, 1998), although the definition of assault used in this case was extremely wide incorporating both arguing and verbal abuse. Gillian Mezey’s ESRC funded work at St George’s Hospital, London is currently attempting to provide a more accurate assessment of the prevalence, suggesting a figure of around 6% (www.domesticviolencedata.org/database/fi...vrp/dvrp_gm.htm).

Yet there are a number of problems related to measuring violence during pregnancy including: (i) questions of definition; (ii) measurement of onset; and (iii) stability of partners (Ballard, Saltzman, Gazmararian, Spitz, Lazorick and Marks, 1998). Such issues have led Gazermararian et al. (1996, p.1919) to state that a basic research question is whether ‘patterns of violence change during pregnancy.’ Indications from the literature would suggest that there are different responses to pregnancy, with some men continuing or escalating their violence during pregnancy (Campbell, Poland, Waller & Ager, 1992; Campbell, Faan & Bullock, 1993; Campbell, Harris & Lee, 1995), others inhibiting it (Campbell, et al.,1993; Campbell, et al., 1995), and a third group of between 12-14% actually starting it, (Helton, McFarlane & Anderson, 1987; Stewart & Cecutti, 1993).

It is perhaps surprising given these reports, that there is little empirical work, or theoretical accounts of why, men batter their partners during pregnancy. Where such work has been reported the ‘male perspective’ has been constructed from accounts given by women (Campbell, et al., 1993). Given the powerful role of gender in battering during pregnancy, it would further our knowledge if we could increase our understanding of how men themselves explain such behaviour.
The principal aim of this project therefore was to increase our understanding of male violence towards pregnant partners, the reasons for this and whether there is anything unique to the situation of pregnancy that would appear to increase the risk of violence to women by their partners. The development of a model of violence during pregnancy was seen as a tangible outcome from which hypotheses could be developed in order that clinicians could provide treatment for men who exhibit such violence and their families.

The literature review that follows was undertaken through the period of research and attempts to present a reasonably comprehensive account of theories of male violence within intimate heterosexual relationships. As will become evident the empirical and theoretical literature on male to female violence during pregnancy remains scarce.

The review is split into three sections. Section (i) reviews the main explanations for intimate male to female partner violence outside of pregnancy including known risk factors. Section (ii) then examines some of the methodological issues surrounding domestic violence during pregnancy, including a discussion of definitions, prevalence and research difficulties. The final section of the review examines those empirical studies and theoretical accounts that have focused on violence during pregnancy as the main topic of enquiry. Papers relevant to the review were identified by computerized literature search and hand search.

1.1 Violence in the Context of Intimate Relationships

Domestic violence has long been an established arena for the investigation of psychological processes. In the last few years, the literature has focused on two emerging issues. The first has been the impact upon children of witnessing parental violence even where they have not been subject to direct violence themselves (Hilberman & Munson, 1978; Jaffe, Wolfe & Wilson, 1990; Moffitt & Caspi, 1998; Wolak & Finkelhor, 1998). Secondly there has occurred a recognition that partner violence can occur during pregnancy, jeopardizing the health of both the pregnant mother and her unborn baby (Grimstad, Schei, Backe & Jacobson, 1999; Mezey & Bewley, 1997; Peterson, Saltzman, Goodwin & Spitz, 1998). There has also been a recognition that some of the potential outcomes of violence during pregnancy such as
low-birth weight, handicap, retardation or developmental disability may increase the risk of subsequent child abuse by parents or caretakers (Bullock & McFarlane, 1989; Gelles, 1997, 1998; Kelly, 1994). Thus, violence during pregnancy may have long-term implications for the health of the entire family. Interestingly, while a research agenda has long been established to examine the impact of children witnessing parental violence (Wolak & Finkelhor, 1998) only a limited research programme has developed to examine violence during pregnancy. Much of this work has focused on the epidemiology and consequences of violence during pregnancy (Peterson et al., 1998). Where work has been undertaken on explanations for violence during pregnancy this has primarily focused on responses and attributions about the violence from the perspective of women (Campbell, et al., 1993). A literature search revealed no published studies on male explanations for violence during pregnancy. This is perhaps unsurprising, since there is only a very small literature on male responses to pregnancy and expectant fatherhood in general (Burgess, 1997; Clarke & Popay, 1998; Hearn, 1983; Jarvis, 1962; Lewis, 1986, Marsiglio, 1993; Towne & Afterman, 1955). Even the increasingly large literature on ‘masculinities’ tends to ignore the question of fatherhood and as Lupton and Barclay (1997, p.4) note “In its neglect of fatherhood this literature, particularly as written by men, tends to reproduce a limited notion of the problematics of masculinities.” As a result theories explaining male to female violence during pregnancy remain poorly developed, and are currently based entirely upon female accounts of such violence. This research project aims to begin to redress this imbalance.

1.2 Defining Partner Violence

There is no agreed definition of violence among researchers studying partner violence and this causes immense problems, particularly when trying to compare studies. Some researchers use a very broad definition of violence that includes both physical, emotional/psychological and sexual violence (Webster, Swett & Stolz, 1994), while others restrict their definition to one of these areas, usually physical violence (Helton, McFarlane & Anderson, 1987). Moreover there is little agreement as to what constitutes physical violence itself (Gazmararian et al., 1996), with some researches including attempts to hit (Hillard, 1985) and others actual injury (Gazmararian,
Adams & Saltman, 1995). This review focuses on violence defined as unwanted physical contact between two people, which may or may not result in injury. Where studies are cited that have used definitions of violence that are at clear variance with this broad definition, e.g. sexual violence, they have been highlighted.

1.3 The Epidemiology of Violence During Intimate Relationships

Epidemiological data on domestic violence can be derived from three sources: (i) local surveys (e.g. in specific localities or with specific groups of respondents); (ii) national surveys and (iii) international surveys. This section will review some of the more recent local surveys before looking at the most authoritative national survey, the British Crime Survey.

A number of local surveys have found rates of life-time domestic violence from a partner ranging from around 13% to 59% and experience of violence from a current partner of between 5% and 13%. The figure of 5% was reported by Carrado, George, Loxam, Jones and Templar (1996) in a quota sample of 1,978 adults aged 15 and over. Interestingly the authors found higher rates of female to male partner violence in both current relationships (11% to 5%) and previous relationships (18% to 13%). One suggested explanation for this higher female figure is the inclusion of a questionnaire item on slapping, behaviour which is more likely to be female dominated (Mirrlees-Black, 1999). The highest rates of domestic violence were found in a quota sample of 1,000 married women (Painter & Farrington, 1998). The authors found that 24% of married women and 59% of divorced/separated women had been hit at some time by a husband or ex husband.

The most authoritative estimates of domestic violence in England and Wales are provided by the Home Office’s British Crime Survey which is collected on adults aged 16-59. Figures on domestic violence have been collected since 1982. While figures for all violent incidents have increased between 1981 and 1995 by 88%, those for domestic violence have increased 242% (Mirrlees-Black, 1999). Figures from 1992 found that 8% of women reported that there had been some physical violence at some point in a relationship, but nothing that required treatment from a doctor or
nurse. Two per cent reported violence where such treatment was *occasionally* needed and 1% where it was *frequently* needed.

The latest findings from the 1995 British Crime Survey based on 16,000 responses are shown in Table 1.1.
### Table 1.1 Levels of Domestic Violence in England and Wales 1996

- 2% of women and 4.2% of men said they had been physically assaulted by a current or former partner in the last year.

- Women were twice as likely as men to have been injured by a partner in the last year. They were also more likely to have been assaulted three or more times.

- In total it is estimated that there were about 6.6 million incidents of domestic physical assault in 1995. 2.9 million of these involved injury.

- 23% of women and 15% of men said they had been physically assaulted by a current or former partner at some time.

- 12% of women and 5% of men had been assaulted three or more times (chronic victims).

- Women aged 18-24 reported the highest levels of domestic violence.

- Among women rates of physical assault were highest for those who were: aged 16 to 24; separated from their spouse; council tenants; in poor health; and/or in financial difficulties.

- Pushing, shoving and grabbing are the most common assaults. Kicking, slapping and hitting with fists took place in nearly half of all incidents.

- Women were more likely to be injured than men (47% v 31%). Injuries were usually restricted to bruising, although 9% resulted in cuts and 2% in broken bones.

- Of victims who had children in the house, about a third said that the children and been aware of the last assault.

- Chronic victims experienced more serious types of attack. They were more likely to be physically injured and were more emotionally affected by the experience. Three quarters of the chronic victims were women.

- 99% of all incidents against women were perpetrated by men. 95% of those against men were by women.

- The assailant was said to be under the influence of alcohol in 32% of cases and drugs in 5%.

- The majority of life-time victims were living with their assailant at the time of the most recent assault.

- Only 17% of victims considered their assaults to be crimes. Virtually no male victims defined their experience as a crime, while only four in ten chronic female victims did so.

As one can see from these figures, there is a general risk to both men and women from partners within relationships. For women who are economically deprived, ill or who have been the victims of partner violence before, the risk appears to increase as does the likelihood of sustaining physical injuries.
1.4 Theories of Partner Violence

There are currently a number of explanations put forward to explain physical violence between partners who are in an intimate cohabiting relationship ('domestic violence'). Jukes (1999) estimates that the literature on violence and aggression consists of in excess of 20,000 publications and while it is clearly beyond the scope of this review to summarize this literature, it is important to examine the most frequently cited theoretical explanations for male partner violence.

Three broad categories for explaining partner violence have been suggested: (i) intra-individual theories; (ii) socio-cultural theories and (iii) social-psychological theories (Bersani & Chan, 1988; Kantor & Jasinski, 1998). A typology summarizing current explanations for partner violence can be seen in Table 1.2.

<table>
<thead>
<tr>
<th>Theoretical Explanations</th>
<th>Risk Factors</th>
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<tr>
<td>Intra-individual Explanations</td>
<td>Biological or neuro-physiological factors; personality factors; substance abuse factors</td>
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<td></td>
<td>Psychodynamic explanations</td>
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<tr>
<td>Socio-cultural Explanations</td>
<td>Gender free and gender determined social-structural explanations</td>
</tr>
<tr>
<td>Social-psychological Explanations</td>
<td>Violence as problem solving, intergenerational transmission of violence, helplessness and violence.</td>
</tr>
</tbody>
</table>

To structure the review the theoretical literature that does not specifically address violence during pregnancy will first be reviewed. The literature on violence during pregnancy will then be examined before asking whether those theories that do not have pregnancy as their focus provide a satisfactory explanatory framework for violence during pregnancy. Given that the main focus of this review is on male violence during pregnancy, the growing literature on violence in lesbian, bi-sexual and gay relationships will not be discussed (Merrill, 1998; Renzetti, 1998; West, 1997). Currently there are no reported cases of male violence during surrogate pregnancy.
1.5 Intra-individual Theories of Violence Between Heterosexual Partners.

1.51 Biological or neuro-physiological disorders.

Hearn (1998a, p.18) notes that biological approaches to male violence have been "founded on one or more of the following: instinct; territoriality and physical size; chromosomal differences; hormonal difference and human interventions on the biochemistry of the body." Of particular note has been the research into men with an XYY chromosomal structure and men with high levels of testosterone (Turner, 1994). While both abnormalities seem to be associated with higher levels of aggression in some men, they appear neither sufficient to explain the vast majority of male violence, nor to explain how many men with such abnormalities do not commit violence. This has led researchers such as Kemper (1990) to suggest that we need to develop a discipline of socio-psychoendocrinology in which "reciprocal links are recognized between testosterone, aggression, dominance/eminence, social structure, and indeed sexual behaviour" (Hearn, 1998a, p.19). McKenry, Julian and Gavazzi, (1995) in a study of 102 married men (both violent and non-violent) provide some limited support for a bio-psychosocial model of domestic violence in that biological, social and psychological factors were all significantly related to male domestic violence. However, when considered together only the biological and social domains yielded significant independent effects.

Other researchers have found differences between those batterers whose heartbeat increased during simulated marital conflict and those whose heartbeat decreased (Gottman, Jacobson, Rushe, Shortt, Babcock, Tailade & Waltz, 1995) suggesting some physiological difference between batterers.

1.52 Personality Factors

A number of personality factors have been implicated in partner abuse including dispositional sexual jealousy, low self-esteem, difficulties in expressing and controlling anger and clinical personality disorders, and these will be briefly reviewed in turn.
a) Sexual Jealousy

The research literature points to a connection between sexual jealousy and partner violence, including murder (Mowatt, 1966). Thus, Hilberman & Munson (1978) found that 57 out of 60 battered women who were interviewed reported pathological sexual jealousy on the part of their husbands. Brisson (1981) similarly reported jealousy to be the main topic surrounding outbreaks of violence in 41% of the abusive men in his study. Mullen and Maack (1985) arrived at an even higher figure in their analysis of 138 patients admitted to the Maudsley Hospital, with a diagnosis of ‘pathological jealousy’ between 1967 and 1980. They found that in 111 cases there was “a clear history of either threatening or actually perpetrating violence on their partners” (p.121). Interestingly only 1% of this sample had ever been charged with a violent crime (Pines 1998). However, a more recent study of 180 cohabiting men divided into four groups on the basis of marital violence and marital satisfaction found that although maritally violent men were jealous, so were the non-maritally violent discordant group (Barnett, Martinez & Bluestein, 1995). The implication being that jealousy in and of itself may not be the “primary precipitant of battering” and that other variables may be interacting (p.473). Some of these other interacting variables may be low self-esteem (Neidig, Friedman & Collins, 1986) and self-criticism (Else, Wonderlich, Beatty, Christie & Staton, 1994) both of which appear to be implicated in male partner violence.

b) Communication Difficulties

Many intervention programmes focusing on anger control strategies have as their underlying assumption that male violence occurs because of communication difficulties (e.g. Dutton, 1994; Sonkin, Martin & Walker, 1985). Empirical support has remained scarce however. An exception is provided by Holtzworth-Munroe and Anglin (1991) who using vignettes of problematic marital situations with 56 violent and non-violent men, found that violent men offered responses that were less competent in certain situations namely those involving rejection, jealousy and challenges by the wife. Competency was defined as a response “that would solve the current problem and make problems of the same type less likely in the future” (p.261). The authors hypothesize that it is this lack of competency in certain situations that instigates a less competent behavioural response, in the form of violence.
c) Specificity of Partner Abuse
Another focus of study has been the extent to which men who abuse their partners differ from other violent men. Saunders (1992) cluster analysed data on 165 male batterers and identified three types: (i) family-only aggressors; (ii) generalized aggressors and (iii) emotionally volatile aggressors. This typology explained 90% of the variance. Family only aggressors were found to have low levels of anger, depression and jealousy and the highest scores on a measure of social desirability. Generalized aggressors reported low levels of anger and depression and high levels of alcohol abuse. Emotionally volatile aggressors had the highest levels of anger, depression and jealousy. However, other research by Maiuro, Cohn, Vitaliano, Wanger and Zegree (1988) which Saunders does not discuss, found little difference between men who were violent outside of the home and those inside.

d) Clinical Personality Disorders
The studies reported so far have tended to focus on specific personality attributes, with Saunders (1992) going some way towards a more complex model. Other researchers have attempted a more global understanding of male partner violence by focusing on clinical personality disorders, particularly antisocial personality disorder (Hamburger & Hastings, 1991) and borderline personality disorder (Dutton & Starzomski, 1993). O'Leary (1993) has identified a number of psychological styles or disorders that are implicated in the etiology of domestic violence including impulsivity, suspicion of others, antisocial behaviour and compulsivity. Such factors, O'Leary notes, while significantly related to low levels of violence, are particularly associated with men who show high levels of violence. Dutton (1995) has developed a psychological profile of men who batter their partners, particularly cyclical batterers. Dutton suggests that such batterers have borderline personalities arising from their early life experiences of emotionally rejecting or absent fathers.

e) Drug and Alcohol Use
While the intra-individual explanations described so far have focused on factors broadly internal to the individual's biology or psychology research tends to implicate alcohol and sometimes drug use in partner abuse (Kantor & Strauss, 1985; Mirrlees-Black, 1999). Two main explanations have been suggested, first that the disinhibiting
effects of alcohol lead to a disregard for social norms for behaviour. Secondly, a socio-cultural explanation "allows drinkers to place the responsibility for violent behaviour on alcohol" (McKenry, Julian & Gavazzi, 1995, p. 309). However, the causal connection between alcohol and violence remains difficult to prove (Collins, 1986; Fagan, Barnett & Patton, 1988). Moreover, it is clearly a matter of debate depending on one's theory about the cause of alcohol dependency, whether one views such abuse as an intra-individual factor or not. While some authors accept a disease model of alcoholism, others have no hesitation in viewing it in terms of socio-cultural factors (Gomberg, 1982). Jukes (1999) for instance, notes that men who abuse alcohol rarely hit anyone else except their partner thereby undermining what can be called the 'control by alcohol' theory.

1.53 Psychodynamic Explanations for Partner Violence

There is no one single explanation for partner violence from a psychodynamic perspective, the model encompassing as it does drive theory, ego psychology, object relations theory, self psychology and attachment theory (Buchelle, 1995; Jukes 1999). However, explanations can broadly be divided into two groups, those that are gender specific and those that are gender neutral.

a) Gender Specific Explanations for Male Violence

Gender specific psychodynamic explanations of male violence are derived from Freud's early work on drive theory and the sexual instinct. Freud clearly distinguishes between the sexes both in their biological construction, development pathways (the Oedipal and Elektra complexes) and mature adult attitudes towards each other. In terms of biological construction, Freud acknowledges a difference between male and female sexual drives:

The sexuality of most male human beings contains an element of aggressiveness - a desire to subjugate; the biological significance of it seems to lie in the need for overcoming the resistance of the sexual object by means other than the process of wooing (Freud, 1977, p.71).

Moreover, Freud sees in the male experience of the Oedipal Complex and the resolution of the castration complex, the roots of male hostility to women. In particular he talks about "a certain amount of disparagement in their attitudes towards
women, whom they regard as being castrated" (Freud, 1977, p.376). Jukes (1999, p.98) notes that "If Freud is correct that the resolution of the Oedipus complex for boys involves the development of normal contempt for women, all healthy men will have this contempt and a belief in male superiority. To the extent that the Oedipus complex is unresolved this contempt will be rather more primitive and misogynistic.” What Jukes appears to be suggesting, although he doesn’t say it, concerning the unresolved Oedipus complex is important.

In Freud’s model of the development of male sexuality, the Oedipus complex occurs at the point that boys recognize that they are not going to be castrated by their father and “the authority of the father or parents is introjected into the ego and there it forms the nucleus of the superego” (Freud, 1977, p.319). The libido is thus to some extent de-sexualized and “changed into impulses of affection” (ibid.). These impulses in turn are later transformed into fully genital sexual impulses. Where resolution of the Oedipus complex has not been achieved none of this occurs, “If the ego has in fact not achieved much more than a repression of the complex, the latter persists in an unconscious state in the id and will later manifest its pathogenic effect” (ibid.). This for Freud is the borderline between the normal and the pathological.

Thus a gender specific analytic account of male sexuality results in two specific ways in which aggression towards women may manifest itself. On the one hand, a resolved Oedipus complex results in hostility to women because of the sexual drive to subjugate, along with an attitudinal stance of disparagement towards women who are viewed as being castrated. On the other hand, where the Oedipus complex has not been resolved there remains continual fears of castration from other men, an id unconstrained by superego prohibitions, a lack of affection towards women and the likelihood of perverse sexual aims (Freud, 1977). Psychoanalytic research at the Portman Clinic has attempted to provide a methodology - the psychodynamic interactional matrix - to assess the interplay between internal and external factors operative in the violent act (Glasser, 1994). Results remain to be published.

b) Gender Neutral Explanations for Male Violence

Although Freud posited a second aggressive instinctual drive from around 1920, he did not believe this superceded the sexual drive (Pedder, 1992). Thus, Freud never
really held a gender neutral explanation of male violence and the idea of the death instinct has to be understood as working in opposition to the sexual drive. Thus when Freud (1985, p. 130) stated that "every intimate emotional relation between two people which lasts for some time - marriage, friendship, the relation between parents and children - contains a sediment of feelings of aversion and hostility, which only escapes perception as a result of repression." It is the male desire to subjugate that explains the higher preponderance of male violence. It may also explain why even where women are as likely to instigate an attack on their partner, men use more violence in their response.

What though, if one does not want to accept Freud's strong differentiation between the expression of the sexual instinct between men and women? Does psychoanalytic thought have anything to say about the separation of aggression along gender lines in later adult life? As Jukes (1999, p. 36) puts it "if women are subject to the same influences...then one has to account for why it is that most human aggression is instigated by males, or why it is...that women are not equally violent."

Sadly there is very little explicit theorizing on this topic; neither attachment theory nor self psychology really address the question of why men are more violent to women than women to men. Jukes (1993) in his book 'Why Men Hate Women', focuses on boys' difficult attachments to their mothers which he argues is a persistent focus for hate in their adult lives. However, he later suggests that "female children are subject to the same influences but that differential developmental methods, gender role learning and culturation determine that female aggression and destructiveness follow different developmental pathways from those of males" (Jukes, 1999, p.37). This echoes Suttie's (1988) psychoanalytic work published in the 1930s on the taboo of tenderness in boys which serves to differentiate them from women. Such explanations result in a very weak version of psychoanalysis and one that is almost entirely determined by environmental factors. Another explanation is provided by De Zulueta (1993, p237) who explains the lack of female violence on the basis that 'relations with others' is the primary method of self-identity.
For women, the core self-structure is a relational self that evolves and matures through participating and facilitating connection with others and through attending to the components of the relational matrix, especially affective communication.

De Zulueta focuses on early disrupted attachment experiences, such as witnessing and being the recipient of violence as central to why men may be violent. However Jukes suggests a figure of under 35% for those men he has worked with who witnessed parental violence or received corporal punishment. Early failed attachment does not seem to be a sufficient explanation for male violence and De Zulueta moves away from seeing male violence simply in terms of attachment and argues instead that:

Perhaps even more important to this study is the realisation that it is essentially the dehumanisation of the 'other' that is at the root of all human violence: this process appears to be almost intrinsic to the development of male-female role differentiation that exists in patriarchal culture. (De Zulueta, 1993, p. 277)

This, like Juke's later work seems to move psychoanalysis a long way from its traditional focus on internal functions and representations to a more socio-cultural explanation. From some perspectives this balancing of its traditional, resolutely 'interior' focus is a very welcome move that enriches it and renders it more useful.

Psychodynamic ideas then, provide a rich source of theory regarding the role of male to female aggression. Gender based psychoanalytic explanations appear to situate male aggression in terms of at best 'normal contempt for women' while non-gender based theories rely extremely heavily on social processes. Neither explanatory framework is particularly well researched and even Jukes (1999) who states he has worked with over 1000 violent men, notes that there are mixed motives at the time of the attack. Primary motivations include a desire to inflict pain and punishment with its attendant satisfactions and violence as a form of instrumentality in order to get immediate satisfaction and ensure future compliance. The theoretical ideas of psychoanalysis are difficult to transpose into routine clinical case presentation.
1.6 Socio-cultural Theories of Violence Between Heterosexual Partners.

There is a large body of research, both psychological and sociological, relating social-structural variables such as social location, social class, education, income and employment status to partner violence (Kantor & Jasinski, 1998). Kantor and Jasinski (1998) divide socio-cultural theories of intimate violence into two kinds. The first a relatively gender free socio-cultural theory, the second a clearly focused gender account informed by feminist research.

1.61 Gender free social-structural explanations for partner violence

Gender free social-structural explanations for partner violence are premised on the assumption that it is socio-cultural factors themselves and not gender that are most influential in determining and explaining partner violence. Explanations tend to assume that men and women are equally likely to inflict violence upon each other, a fact which, although disputed (e.g. Kurz, 1998), is borne out by at least one current survey (Mirrlees-Black, 1999). This is an important premise given that we know that partners tend to share many of these demographic factors such as social class, education, income, and employment status (Wellings, Field, Johnson & Wadsworth, 1994). If it is not accepted that men and women are equally likely to batter each other (albeit with different consequences in terms of severity of injury) then one needs to explain why such shared variables as social class, education, income, and employment status impact differently on men and women. Such explanations tend to view the determining factors in terms of biological or psychological variables as described earlier. What then is the evidence for the effects of social structural variables on partner violence?

Probably the single variable most frequently studied to date is that of marital quality. A number of studies have focused on the way in which spousal relationships can act as both a protection from and instigator of partner violence. Rounsaville (1978) found that a deterioration in intimacy preceded almost half of all incidents of domestic violence. Similarly, Leonard and Blane (1992) found that partner conflict preceded partner violence. Other research has suggested that conflict mediation skills are related to class (Steinmetz, 1978) and that lower income families have fewer resources to call upon to solve problems (Straus, Gelles & Steinmetz, 1980).
Gelles (1997) has also proposed something of a gender-neutral explanation for partner violence in his exchange/social control theory of intimate violence. Gelles suggests that family members will use violence when the costs of being violent do not outweigh the rewards. Gelles identifies a number of structural factors that make families prone to violence. These include: inequality, privacy, the absence of social controls and the relation between violence and what he calls the "real man." Thus although Gelles holds a clear exchange/social control model it is not gender neutral and explains male partner violence more readily than female to male violence.

1.62 Gender based socio-cultural explanations for partner violence
The second way of examining socio-cultural influences is to focus on traditional gender roles. The literature in this area is extremely large, particularly feminist analyses of power inequalities.

Gelles (1987, 1989) has noted the consistent relation between violence and stress and particularly stress on men. In particular he notes the relationship between threats to traditional male roles and spousal assault. In terms of overtly feminist analyses of partner violence, the main explanation is one that focuses on gender inequality within society generally. Partner violence is seen as the most overt manifestation of the way that men oppress women (Kelly, 1988). Thus Gelles (1997, p. 132) states "the central thesis of this theory is that economic, social and historical processes operate directly and indirectly to support patriarchal (male dominated) social order and family structure." Moreover, abusive behaviour by men is seen as 'decisive, instrumental and purposeful - it is to ensure the continued provision of services from women' (Jukes, 1999, p.96).

Some feminist researchers combine elements of a gender free and gender determined socio-cultural theory. Thus Johnson (1995, p.283) talks about 'patriarchal terrorism' which is the result of the way men structure society to control women and 'common couple violence' which is gender free and used in 'conflict situations that get out of hand.' Such a distinction seems a useful one to make and has been adopted in further research work on couple violence by Gaertner and Foshee (1999).
Chapter 1 Theoretical Background to the Study and Review of the Literature

1.7 Social-Psychological Theories of Violence Between Heterosexual Partners

There are a number of social-psychological explanations of male to female violence, among them the use of violence as a problem solving activity, violence as intergenerational and violence as a form of helplessness.

1.71 Violence as a Problem-Solving Activity

In terms of problem solving, the conflict resolution thesis explains violence in terms of its overt function at solving problems within the family. Some theorists suggest that such conflict resolution is a piece of learned childhood behavior (Straus, Gelles & Steinmetz, 1980), but there seems no reason to accept this as a necessary feature of the theory. After all it is quite possible that both parties have learnt as adults that violence used instrumentally to solve problems works. The theory can thus be understood as an intentional psychological process. This theory also tends to accept the fact that partner battering is a two-way activity, although, as stated, where women assault men they are far less likely to cause serious injury (Mirrlees-Black, 1999).

1.72 Inter-generational Transmission of Violence

One of the most well known social-psychological theories is the *intergenerational transmission of violence theory*. This theory suggests that children who are abused or who are witness to the abuse of a significant other are more likely to use violence as adults when in similar situations. The theoretical backbone of the theory is one of social learning. However while there is evidence to show that the likelihood of violence is higher in those exposed to it, the majority of children who are exposed do not go on to be violent themselves (Kaufman & Zigler, 1987; Spatz-Widom, 1989). The theory only explains currently a small subset of children exposed to violence and highlights the possibility that other masked variables are involved.

1.73 Helplessness and Violence

A third social-psychological theory focuses on the question of helplessness. Interestingly there are two theories of helplessness that are used to explain aspects of violence in intimate relationships. The first developed by Jukes (1999) focuses on the helplessness of the man as a cause of aggression, the second developed by Walker (1989, 1993) focuses on women and is used to explain why women do not leave abusive relationships. Jukes suggests that many men operate in terms of a polarity
between control/authority versus helplessness/vulnerability and that the latter category is experienced by men as life-threatening. Jukes situates this feeling in terms of the “natural link between the separate, frustrating object and the absent or abandoning and therefore persecuting object” (p.124). Although Jukes does not make the connection, it is important to highlight the role of jealousy as a social-psychological variable and one in which a sense of helplessness/vulnerability is at the fore. Male jealousy also appears to be a time of high risk for partner violence (Hilberman & Munson, 1978; Brisson, 1981; Mullen & Maack, 1985; Stamp & Sabourin, 1995).

1.74. Multi-Factorial Explanations

Clearly then, there are a number of different theoretical models put forward to explain violence between partners. Multi-factorial explanations of partner violence on the other hand tend to be based on statistically significant risk factors and do not attempt to provide coherent theoretical accounts of domestic violence. For instance two recent surveys (see Table 1.3) include both intra-individual factors (drug/alcohol abuse; disability/ill health), socio-cultural factors (financial pressures, low educational level, young children) and social-psychological factors (witnessing parental violence as a child or teen).

Table 1.3 Survey Based Risk Factors in Domestic Violence

<table>
<thead>
<tr>
<th>• marital separation</th>
<th>• sexual aggression toward the wife/partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>• young children</td>
<td>• violence toward the children</td>
</tr>
<tr>
<td>• financial pressures</td>
<td>• witnessing parental violence as a child or teen</td>
</tr>
<tr>
<td>• drug/alcohol abuse</td>
<td>• working class occupational status</td>
</tr>
<tr>
<td>• disability/ill health</td>
<td>• excessive alcohol usage</td>
</tr>
<tr>
<td>(Mirrlees-Black, 1999, UK)</td>
<td>• low income</td>
</tr>
<tr>
<td></td>
<td>• low assertiveness</td>
</tr>
<tr>
<td></td>
<td>• low educational level</td>
</tr>
<tr>
<td>(Sugarman, Aldarondo, &amp; Boney-Mccoy, 1996, USA)</td>
<td></td>
</tr>
</tbody>
</table>

The majority of studies cited so far tend to be based on quantitative studies and before moving on to discuss what is known about violence during pregnancy it may be useful to look at men’s own narrative accounts of violence and to say briefly what some of
Chapter 1 Theoretical Background to the Study and Review of the Literature

the potential explanations are for why women remain in violent relationships generally.

1.8 Men’s Own Narrative Accounts of Domestic Violence

Stamp and Sabourin (1995), Hearn (1998) and Ptacek (1998) have all recently interviewed men who have been violent to spouses or partners.

Stamp and Sabourin (1995) interviewed 15 abusive males in the mid-west of the USA all of whom were participating in a treatment programme for men who batter. Using a grounded theory approach, Stamp and Sabourin identified a number of attributional dimensions to explain the violence. These were: the wife’s behaviour/personality; jealousy; verbal or physical abuse by the wife and loss of control. In terms of the men’s accounts, by which the authors mean ways in which actors can “relieve themselves of culpability for untoward or unanticipated actions” (Scott & Lyman, 1968, p.48), they identified: excuses; justifications; minimization and denial.

Hearn (1998a) in his three-year study of 75 men in West Yorkshire who had been violent to known women also focused on the men’s narrative accounts. Hearn (1998, p. 108) identifies 5 broad clusters of accounts: repudiations; quasi-repudiations; excuses and justifications; confessions and composite and contradictory accounts. Moreover, as Hearn notes “it is important in making sense of these explanations of men not to understand them as strictly distinct and discrete types of accounts” (p. 144). Finally Ptacek (1998) interviewed 18 men in Boston, USA, who were attending counselling for wife battering. Again Ptacek focused on batterers’ excuses and justifications, identifying four types of account: excuses, through denial of responsibility; justifications, in terms of denial of wrongness; patterns and contradictions, and socially approved rationalizations of violence.

What is so marked in all of these accounts is the almost total absence of explanation, particularly social-psychological explanation for the violence. It is clear that the primary task of these men was to give an account of their own actions and not to explain male violence at a more general or theoretical level.
1.9 Why do Women Stay in Violent Relationships?

Intra-individual, socio-cultural and social-psychological explanations all put forward different reasons as to why women remain within violent relationships. From an intra-individual perspective the notion of ‘relationship investment’ either in a partner or father are seen as particularly important. Moreover, hypothesized from a biological perspective, partner violence can be tolerated as long as protection is provided against external attacks or intrusions. Also, violence does not preclude love, particularly where the violence is not continual and is punctuated by apologies and declarations of emotional involvement (Hearn, 1983). The feminist account of socio-culturally constructed violence is particularly well placed to answer the question of why women who are abused remain in relationships. From this perspective, while women are patently not safe within the family, they are it is suggested not particularly safe outside of it, due to the widespread nature of male aggression. Moreover at the individual level there is evidence to suggest that women are at increased risk of physical and sexual violence if they threaten or actually attempt to leave their partners (Wilson & Daly, 1993). Social-psychological explanations have focused on issues such as learned helplessness (Walker, 1989) reciprocal exchange (Gelles, 1997) and the trade off between violence and other factors such as economic safety (Strube & Barbour, 1993). Walker (1993) suggests that battered women experience post-traumatic stress disorder thereby explaining why women both remain in abusive relationships and in rare instances make a decision to kill their partners. It is likely that within each relationship a number of these factors will be involved.

1.10 Methodological Issues concerning Violence during Pregnancy

How one defines a term is a crucial first step in measurement of any kind. The wider ranges of statistics given for the incidence of domestic violence in general is partly a result of this fluidity of definition and often makes any comparison between one set of findings and another problematic. This is particularly true in the case of violence during pregnancy. One figure that is widely quoted is that a third of domestic violence cases begin in pregnancy (Sommerville, 1999). Such a figure is based on the most recent Department of Health confidential enquiry report into maternal deaths (DoH, 1998).
which uses a very liberal definition of violence in which violence can be either physical,
sexual, emotional or psychological. Such an all-inclusive definition makes it difficult to
know what exactly is being researched (the DoH does not state how it arrived at this
figure) and makes comparisons between studies difficult. Ballard et al. (1998) have
identified some of the other problems in researching partner violence during
pregnancy. Focusing on measurement issues in particular they note that current
research suffers from (i) poor specification of time periods associated with pregnancy;
e.g. did the violence continue, did it start, did it stop? (ii) little knowledge of the social
context of violence e.g. was the same person involved, was the pregnancy intended, did
the perpetrator know of the pregnancy? Moreover it seems that "debates are still
common among those trying to answer questions about the best instruments to use to
collect data, theoretical perspectives, definitions of violence, types of intervention and
so on" (Bergen, 1998, p. xi.). Research by Gelles (1988) found that while pregnant
women were more likely to be hit and abused by their partners, this was an artifact of
age with women under the age of 25 being at greatest risk of violence. Given these
caveats, Gazmararian et al. (1996) put the prevalence of women experiencing violence
during pregnancy between 0.9% and 20.1% based on a review of all the available
international evidence. It is likely that this includes cases where the pregnancy was
unwanted, where paternity was in dispute or where the partner was unaware of the
pregnancy. Mezey in her current study study of women in London puts the figure at
6% (www.domesticviolencedata.org/database/fi...vrp/dvrp_gm.htm).

Finally, Gelles and Loseke (1993) in discussing some of the problems in investigating
family violence, note that this is a very contentious field of investigation. This is even
more so for male violence during pregnancy, which is not only a sensitive topic (Lee,
1993) but one which has potential legal consequences for research participants and
ethical and emotional demands on the researcher (Dunn, 1991; Hearn 1998a). Thus
there are a number of methodological issues surrounding male violence during
pregnancy, including a discussion of definitions, prevalence and research difficulties
which make it a challenge to research in a meaningful and clinically useful way.
1.11 Heterosexual Partner Violence During the Pregnancy Period: The research evidence

There is only a very small literature specifically focusing on explanations for violence during pregnancy, a literature that began with Gelles' work in the mid nineteen seventies. Gelles (1974) found in an exploratory study of violence between husbands and wives that out of 80 families interviewed 44 reported conjugal violence. In ten of these families violence had occurred while the wife was pregnant. From interviews with these pregnant women and research on family transitions and violence, Gelles (1975) suggested five major factors which contributed to pregnant wives being assaulted by their husbands. These were: (i) sexual frustration; (ii) family transition, stress and strain; (iii) bio-chemical changes in the wife; (iv) pre-natal child abuse and (v) defencelessness of the wife. Although Gelles is clear that his research is limited due to its non-representative nature, other criticisms can be levelled at it. In particular, while Gelles states that the interviews used unstructured informal procedures, he does not say what these were. This is a serious limitation in terms of following up his work. Gelles' work also suffers from some of the methodological limitations noted by Ballard et al., (1998), in particular it is not known whether the pregnancy was planned or unplanned, and whether there was any history of partner violence prior to the pregnancy.

Borkowski, Murch and Walker (1983) found in a study of marital violence in the community that practitioners (solicitors, local authority social workers, health visitors and GPs) occasionally noted the onset of violence to occur during pregnancy or shortly afterwards. Although the findings were not statistically significant they quote one health visitor as saying that the violence was precipitated by "tension and emotional upheaval resulting from pregnancy and birth of first child. The mother is prone to depression and is particularly anxious. She had a forceps delivery and fears a second pregnancy. She is too engrossed in the baby to the neglect of her husband who feels irritated and rejected" (p.64). This essentially jealousy-based explanation exemplifies the tendency by some psychoanalytic writers to "attribute violence to the personality of the victim" (Hearn, 1998, p21.).

Noel and Yam (1992, p.872) in a non-empirical overview of domestic violence during pregnancy note that the male partner may feel "slighted, even ignored, and may grieve
that he is no longer the centre of his partner's attention.” This is of course true for both men who batter and those who don't. However this paper does not delve any deeper into male motivations and psychological factors associated with male abuse of the pregnant women; but, given that the explicit focus of the paper is to “develop a female consciousness about violence directed toward the pregnant woman and her unborn child” (p. 872), this may not be surprising.

Campbell, Faan and Bullock (1993) in an exploratory retrospective study examined reasons why men might beat their partners during pregnancy from the perspectives of the women. They compared 27 women who had experienced abuse during the pregnancy with 24 women who were also pregnant but had not experienced any abuse at this time (they had previously). The women were identified using the Conflict Tactics Scale and asked an additional question of whether they had been beaten by their partner during pregnancy. If so, they were asked to comment on why they thought this had happened. The only significant difference between the two groups was that women abused during pregnancy were more severely and frequently beaten throughout the course of their relationship. This group of women put forward four explanations for the abuse: (i) jealousy of the unborn child; (ii) anger towards the unborn child; (iii) pregnancy-specific violence not directed towards the unborn child and; (iv) ‘business as usual.’ These categories were derived from interview data and thematically analyzed. However there is no data in the paper about how such analysis took place, nor the assumptions behind the analysis. While the accounts of these women are important, the extent to which they overlap with men's accounts of the same phenomenon is of interest. Some concern must be expressed that the response categories derived from the women are discussed as if they are in fact the reasons why men batter during pregnancy. The validity of extrapolating from women to men remains open to question. The issue of jealousy is also raised by Kraemer (1994, p.21) who notes “men are peripheral to the business of making babies. The biological task is over 40 weeks before the baby appears. From this biological point of view the father is redundant within seconds. Mothers are needed for months at least, both before and after the birth. Here I think, are the conditions for intense jealous rivalry and envy”.

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Surprisingly these studies appear to be the main sources of theorizing concerning violence during pregnancy. Given this fact it is worth considering briefly whether it is possible to extrapolate from the explanations cited earlier for male partner violence outside of pregnancy.

**1.12 The Application of Theoretical Accounts of Heterosexual Partner Violence to the Pregnancy Period**

Hearn, Edwards, Popay and Oakley (1998, p.3) suggest that “men's violence, delinquency, competition, uncooperativeness and lack of involvement have and continue to be explained by reference to biology.” While the authors want to broaden out the explanatory field, it is clear that biological explanations for male violence during pregnancy are difficult to understand. After all this is surely the one time when men have a specific and biological interest in their offspring and indirectly therefore in caring for and protecting their partner. Yet violence still occurs. We know that where the pregnancy is unwanted or where the partner is unhappy about the pregnancy violence is more likely (Gazmararian, Adams, & Saltzman, 1995) but this does not seem to rule out violence where such conditions do not hold. One way around this is to focus on some biological or psycho-physiological abnormality within fathers-to-be, that results in fathers putting their foetus at potential risk. This assumes of course that male violence during pregnancy is directed as much at the foetus as the mother, and this is not necessarily the case. However it seems difficult to believe that potential fathers can somehow forget or discount the pregnancy and does not explain why men would endanger their potential offspring at any level at all. Those forms of personality disorder in which empathy and concern for others is absent of course provide no such difficulty. Thus, antisocial personality disorder in which empathy for other is absent is one clinical profile that does hold some explanatory power for male violence during pregnancy. However, even in this scenario one would need to explain why a child was wanted in the first place. Substance abuse provides some level of explanation for male violence during pregnancy. With inhibitions diminished, one could possibly explain the occurrence of violence; but one would expect some level of remorse and an attempt to inhibit the substance abuse between episodes with the recognition by the man of the potential harm they have caused to their child.
Social-psychological theory would also seem to have some ability to explain male violence during pregnancy. Both learning based accounts and accounts that locate immediate psychological difficulties within the man, such as poor stress control could be hypothesised as overriding any long-term consequences to the child. Yet the main question here is why only some men are violent during pregnancy, particularly those who begin during pregnancy and why some men desist from a previous career of violence during pregnancy. Finally the weakest of the three theories in terms of explanatory power is the socio-cultural theory. Domestic violence is not directly related to economic wealth and the evidence for cultural patterns of male violence are thin. The feminist socio-cultural theory fares no better, although the limitations of the review in this area are acknowledged. Even if one could accept the psychodynamic view that men routinely resent women, this neither translates into violence nor explain why one would seek to harm one's own offspring.

As one can see the number of accounts as to why men batter during pregnancy is depressingly small with accounts focusing on male explanations non-existent. Given this minimal exploration of the male perspective on pregnancy, birth and fatherhood, it is perhaps time for this research to be carried out. There is obviously a danger in this of “forgetting women, of losing women from analysis and politics” (Hearn, 1998b, p.18). This is a particularly important point to consider in relation to pregnancy where it is easy to view the pregnant woman as nothing more or less that a vessel for carrying children. Yet as things stand the absence of any account of male violence during pregnancy by men limits the development of theory in this important area.
Chapter 2. Research Aims and Identification of Violence During Pregnancy

2.1 Research Aims
This study originated in part from a separate review of the academic literature by the researcher into non-romantic pathological jealousy (Hill & Davis, 2000). Findings from this review indicated that jealousy may have played a small part in male violence post birth. This motivated the researcher to consider whether such violence could occur during the partner's pregnancy and to review what was known about violence during this period. Of specific interest were those factors that could explain male partner violence during a wanted pregnancy as this seemed to be a paradoxical state of affairs.

The initial research aim was to interview a small number of men who had been violent during pregnancy. However there were difficulties in tracing such a sample. Contacts with two prison Psychology Departments in London indicated that no men were currently serving sentences for violence during pregnancy. As a result contact was also made with a specialist psychotherapy prison service (population of 150) which searched its database and found no men who were convicted of offences around violence and pregnancy. Moreover, they could not think of any men in their service known to have committed such an offence in the past. Importantly however, the service also stated that they didn't "specifically ask questions about pregnancy". The same response emerged after enquiries with a local forensic health service in which the researcher was then working. These initial responses suggested a number of possibilities concerning the identification of violence during pregnancy: (i) that it goes largely unreported; (ii) that where it is reported men were not being charged or sentenced on this account; (iii) that it was simply not occurring and (iv) that men were simply not asked about violence during pregnancy by agencies unless it was their index offence. It is known from research (Hearn, 1998) and from the responses by the two prison services that domestic violence per se is rarely the index offence. It is also known that violence does occur during pregnancy in this country (Mezey & Bewley, 1997). This left three possibilities: that where it was being reported men were not being charged; that it was going unreported; or that men in contact with forensic services were simply not being asked about violence during pregnancy.
The difficulty in identifying a local sample of men who had been violent during pregnancy, resulted in the project being conceptualized as two halves. First it seemed important to answer the research question generated by the initial attempts to find a sample, namely whether tracing such men was a local issue or whether it was more widespread and whether there was an awareness by NHS clinicians of the importance of identifying and treating such a group of men. Secondly, whilst it did not seem possible to interview men who had been violent during pregnancy within the constraints of the research, it seemed valid to explore male accounts of this phenomenon using a theoretically driven choice of sample. It was decided to focus on the three different scenarios of violence during pregnancy identified in the literature: (i) continuation or escalation of violence; (ii) inhibition and (iii) commencement.

A detailed research proposal was submitted in writing to the University of Surrey Ethics Committee and Guy's and St. Thomas' Ethical Committee. In addition an oral presentation of the research was given to Guy's and St. Thomas' Ethical Committee. Research approval was given by both committees with minor changes to the wording of the informed consent forms (See Appendix 1).

The remainder of this chapter outlines the first half of this project, while the remainder of the thesis deals with male accounts of violence during pregnancy.

2.2 Identifying Violence During Pregnancy: A Survey of NHS Medium Secure Facilities

In order to quantify to what extent screening for violence during pregnancy occurred among health service personnel, it was decided to survey staff working in medium secure units in and around London. The rationale for approaching these services was twofold. Firstly forensic services represented a range of professional agencies - medical, psychological, nursing, social work - and secondly these services would probably be operating some form of screening and assessment procedure for violent men. The fundamental question of interest was whether they included the period of pregnancy in their assessment procedure with violent men who were known to have a family or a pregnant partner.
2.3 Measures
A two-page ‘forensic survey questionnaire’ was developed to assess the extent to which services routinely assessed their male clients for violence during pregnancy (See Appendix 2). The questionnaire contained both closed and open questions and respondents were given the option of whether they wanted to identify themselves or their service. The questionnaire was piloted on five individuals in the secure service that the researcher was then working in and a small number of changes were made to the format as a result.

2.4 Sample
Medical, psychological, social work, senior nursing and occupational therapy staff in all of the medium secure units surrounding the M25 motor-way in London were contacted by questionnaire and letter (See Appendix 3). Staff lists were drawn from the current Forensic Directory (Rampton Hospital. 1999).

2.5 Procedure
140 questionnaires were sent out to 11 medium secure units between March and April 2000. Each questionnaire was sent with an explanatory letter and a SAE.

2.6 Results
The overall response rate from the local secure survey was 25% (See Table 2.1).

Table 2.1 Response by Professional Group

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Psychiatrists</td>
<td>13</td>
<td>37.1%</td>
</tr>
<tr>
<td>Senior Nursing Staff</td>
<td>3</td>
<td>8.6%</td>
</tr>
<tr>
<td>Psychology</td>
<td>10</td>
<td>28.6%</td>
</tr>
<tr>
<td>Social Work</td>
<td>9</td>
<td>25.7%</td>
</tr>
<tr>
<td>Occupational Therapy (OT)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Broken down the response rate for each professional group revealed some response rate differences with 40% of consultant psychiatrists, 35% of clinical psychologists,
27% of social workers, 11% of senior nurses and no senior, or head occupational therapists responding.

Asked whether they routinely assessed men with children (or a pregnant partner) and who had a history of violence about violence during pregnancy, 91% of the sample said that they did not (See Table 2.2).

**Table 2.2 Routine Collection of Information on Violence During Pregnancy**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>32</td>
<td>91.4%</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>8.6%</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Of the three professionals who reported collecting this information on a routine basis, one was a clinical psychologist, one was a consultant psychiatrist and one was a psychiatric nurse. They all worked for different secure units. Two of the respondents reported using an unspecified structured assessment tool and one an in-house risk assessment tool.

An open-ended question asking for the reasons for not collecting such information was asked of the remaining respondents (see Table 2.3).
Table 2.3. Reasons for not Routinely Collecting Data

<table>
<thead>
<tr>
<th>Area</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask about violence, but not about pregnancy</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>Only where domestic violence is known about</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>None on caseload/seen</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>In some instances (not specified)</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Rare for partner/children to be involved</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Form of violence not highlighted</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Interview covers all aspects of violence</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Not in routine assessment</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Routine data on domestic violence not collected</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Depends on whether clinically relevant</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Unhelpful for relationship</td>
<td>1</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Given that the above question focused on current practice, respondents were also asked whether they thought it would be useful to collect information on violence in pregnancy as part of a routine assessment procedure. Two thirds of respondents (67%, n=20) thought that it was a good idea, while a third did not.

Those who thought that it would be a good idea gave the following reasons (see Table 2.4):
One respondent noted that 'There was one female patient on the ward who killed her husband by way of arson. During their relationship he constantly verbally, physically and sexually abused her, also allowing his friends to sexually abuse her. Another female patient systematically killed all her four children. I do not think this question was asked as part of a routine assessment and I think it would be useful to collect this information as routine' (Forensic Psychiatric Nurse).

Those who did not think that the collection of such information would be of use, gave the following reasons (see Table 2.5):
Table 2.5 Reasons why it would not be useful to collect information in violence during pregnancy

- It may not be germane
- I am unclear of the evidence for such a proposed routine assessment of violent men and their pregnant partners
- Not sufficiently prevalent and bizarre to only focus on violence during pregnancy
- Not very common, best conducted on an individual basis
- I think it would be useful to have a structured intervention assessment tool which looked at violence generally. In the course of this work, information could be collected about violence and pregnancy, but I wouldn’t want to focus on this particular issue in a separate assessment procedure
- It is diagnostically interesting but much more contextual information would be required to draw firm diagnostic conclusions.
- Unsure that this would add to the assessment if not directly relevant.

Respondents were also asked whether there were ‘any circumstances where they did (or would) ask for this information (see Table 2.6).

Table 2.6 Circumstances in which such information is or would be collected

<table>
<thead>
<tr>
<th>Area</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>If violence in relationship</td>
<td>12</td>
<td>41.4%</td>
</tr>
<tr>
<td>If history of violence in pregnancy</td>
<td>5</td>
<td>17.2%</td>
</tr>
<tr>
<td>If partner pregnant or young children involved</td>
<td>3</td>
<td>10.3%</td>
</tr>
<tr>
<td>If going to live with partner</td>
<td>3</td>
<td>10.3%</td>
</tr>
<tr>
<td>As part of parenting assessment</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td>If referred for anger</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td>Will in future</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>10.3%</td>
</tr>
</tbody>
</table>
Finally respondents were asked whether they would like to receive a form for the routine assessment of violence during pregnancy were one to be developed. 75% (n=25) responded affirmatively to this, 25% (n=8) did not.

### 2.7 Discussion

This survey found that most professionals working in forensic settings do not routinely assess violent men who have children or a pregnant partner for violence during pregnancy. The reasons for not collecting this information on a routine basis could be classified into three categories: (i) that it was situation specific; (ii) that it was relatively rare; and (iii) that it was not part of the current assessment procedure. Five respondents simply stated that they asked about violence but not about pregnancy and four that it was asked about in some instances. These data would suggest a lack of awareness by the majority of respondents concerning violence during pregnancy and in one instance a worrying assumption that asking about violence during pregnancy would be somehow unhelpful.

Although two thirds of the sample thought it would be a good idea to collect such information, a third questioned the relevance of such a procedure. Two respondents commented on what they took to be the low prevalence of violence during pregnancy.

All of the respondents were able to think of a situation in which they would ask about violence during pregnancy in 'certain situations.' Such situations included 'violence in the relationship', 'a history of violence during pregnancy', the parent being pregnant or there being young children involved. While at face value this appears perfectly logical and sound, it is unclear where such information is going to come from if it is not being collected as part of a routine assessment process. In other words the decision as to whether to ask about violence during pregnancy appears to rely to a great extent on whether violence during pregnancy has already been identified. As this survey appears to show the routine assessment and therefore identification of violence during pregnancy is not currently taking place. It is not known whether other agencies such as child protection services routinely focus on violence during pregnancy and this may be worth investigating.
Chapter 2 Research Aims and the Identification of Violence During Pregnancy

The fact that two-thirds of respondents thought that it would be a good idea to collect routine data on violence during pregnancy raises a number of interesting questions concerning the status attached to screening for violence during pregnancy. Clearly it is seen as of some importance and at a practical level 75% of respondents requested a form to assist in the assessment of such violence. Yet at the same time the data indicate that violence during pregnancy is seen as somewhat unusual and rare. It must be acknowledged that the survey asked about men who had been violent and who had families and/or a pregnant partner and this does not necessarily entail domestic violence. Although there are no clear figures for the segmentation of violence, some research would indicate that the characteristics of men who are violent outside of the home are no different to those inside it (Maiuro et al. 1988).

There were however, a number of limitations in the present study. Firstly it was acknowledged that although the numbers of men in relationships and with children/or expectant partners entering forensic health services, particularly secure services, may well be low, many of the services would be providing a tertiary and/or filtering service for clients with forensic histories or difficulties. Moreover the majority of individuals contacted would hold a separate non-secure unit forensic caseload. Notice was thus taken of Hearn’s (1998, p.175) comment that “violence to known women is not usually defined as a psychiatric problem” but that “taken together there are thus a large number of possible reasons for men’s involvement with health care agencies in relation to violence.” Even so the decision to focus on secure units may well have introduced some bias into the sample of men being considered.

Secondly the overall response rate was low. For some professional groups such as consultant psychiatrists and clinical psychologists the response was higher, for others such as senior nurses and OT’s the response rate was very low. This may reflect their current level of responsibility in terms of assessment procedures. The lack of response from senior occupational therapists may simply reflect their lack of involvement in initial assessment procedures.

Thirdly it may have been helpful to have distinguished between violent men whose partner was pregnant and those who already had a family. This may have affected professionals responses, as one set of circumstances can be seen as prospective and
Chapter 2 Research Aims and the Identification of Violence During Pregnancy

the other as retrospective. There is undeniably a great deal of difference between asking a twenty-five year old man whose partner is pregnant and a fifty year old man with grown up children about violence during pregnancy. By including both situations in the questionnaire the relevance of assessing for violence during pregnancy may have been diminished.

Finally it would have been useful to have been given more details from the three respondents who were routinely assessing for violence during pregnancy about what they were doing, particularly as their colleagues in the same service were not routinely assessing for violence during pregnancy.

2.8 Conclusions
This was a small-scale survey of a number of secure services in order to quantify the extent to which the issue of violence and pregnancy was being picked up on by forensic health professionals. Although the response rate was low (25%) the response from those with major responsibilities for client assessment was higher.

The conclusion to be drawn from this research, though tentative due to the response rate, is that violence during pregnancy is not routinely examined in forensic mental health services even where there is a history of violence and where partners are pregnant or have children. On the whole respondents responded in a positive manner to the questions asked and appeared to give considered answers as to why such information was not collected. Interestingly, asked in what circumstances services would collect such information, a high proportion responded in terms of whether there was a history of violence and or a pregnant partner or young children involved. This suggests that the routine collection of such data is absent because of a lack of consideration of the issue of violence and pregnancy rather than reasoned objections to the collection of such information. There was however a small group of professionals who did query the relevance of such data collection.
Chapter 3 Explanations for Male Violence During Pregnancy: Epistemology and Study Methodology

3.1 Introduction
In order to develop explanations for male violence during pregnancy a qualitative methodology - grounded theory - was adopted. This chapter outlines some of the methodological assumptions behind the method, the technical procedures entailed and description of the sample.

3.2 Epistemological and Philosophical Issues
Clinical psychology is currently appraising the relative merits of both quantitative and qualitative approaches to research questions (Henwood & McQueen, 1998). This is particularly welcome if one agrees with Moscovici (1972) that “no discipline can remain in good health if it prioritises the way in which questions are investigated over the way in which questions are asked “ (Reicher, 2000, p.1.)

The dominant epistemological model of science adopted by psychology has long been the experimental method or hypothetico-deductive model of science (Danzinger, 1990; Richards, 1992), in which scientific reasoning progresses by setting up hypotheses, and then undertaking experiments to show whether or not these conclusions are sound (Popper, 1972). In the last few years challenges to the underlying methodological assumptions behind this model have emerged from both philosophers, psychologists and sociologists (Gergen, 1985; Rorty, 1980; Rose, 1996) with an increasing recognition and emphasis on the way in which meaning is socially constructed.

The hypothetico-deductive method and social constructionism offer two very different and opposing views of the world. There is a middle ground however, provided by those who adopt a ‘critical realist’ position. Taking their cue from Kant, ‘critical realists’ acknowledge the material reality of the world (the realist view) but argue that our knowledge of it is always mediated by individual and social processes (Pilgrim & Rogers, 1997). The critical realist position seems a particularly helpful position to adopt when discussing issues related to male and female biology and as Lupton & Barclay (1997, p.10) note ‘the emphasis on the social construction of gendered
positions...tend to discount biological explanations for gender differences...women, unlike men, have uteruses, the capacity for menstruation, becoming pregnant, giving birth and breastfeeding, and this has profound implications for their life experiences.' Critical realism is thus a middle way between biological determinism and social relativism.

Qualitative methods are one way in which both social constructionism and critical realist views of the world can be explored, and while critics of qualitative methods remain, particularly what Mary Boyle (1998, p. 34) calls 'the subtle denigration of qualitative research as a sort of hand-maiden to quantitative analysis' (cited in Morgan, 1996), such inductive methods are increasingly being used within mainstream academic psychology and health related research (Hayes, 1997). They are particularly suitable for accessing areas not amenable to quantitative research (Pope & Mays, 1995).

One qualitative method that is increasingly being used in psychology is grounded theory. Henwood & Pidgeon (1992) argue that grounded theory is used to investigate topics on which existing theory is inappropriate, incomplete or absent. Given the lack of previous research and the lack of a strong theoretical base specific to male violence during pregnancy grounded theory was seen as a particularly appropriate form of methodology to employ.

Grounded theory starts with individual cases, incidents or experiences and develops progressively more abstract conceptual categories to synthesize, explain and understand the data so that patterned relationships can be identified within it (Charmez, 1995, p.28). Pidgeon & Henwood (1997, p.266) outline three ‘possible goals of grounded theory work: (i) taxonomy development; (ii) local theoretical reflection and stimulating creativity; (iii) “fully-fledged grounded theory.”

Grounded theory is non-discipline specific and has been used in clinical and counselling psychology to account for interactional aspects of professional care in a learning disability service (Clegg, Standen & Jones, 1996) to theorise lesbian and gay affirmative psychotherapy (Milton, 1999), lesbian experiences of clinical psychology services (Annesley & Coyle. 1998), experiences of AIDS related bereavement among
gay men (Wright & Coyle, 1996; Coyle & Wright, 1996) issues of bereavement and identity change within the field of learning disabilities (Clegg & King, 1998) and suicide and self harm in Asian women (Sayal-Bennett, 1998).

Grounded theory uses theoretical sampling in which participants are selected for inclusion in the study on the basis that they will add information of interest to the research question or are thought to have a ‘disconfirming potential’ (Henwood & Pidgeon, 1992, p.107). Such ‘negative case analysis’ as it has been called (Smith, 1997) is less to do with ‘falsificationism’ in the Popperian sense, and rather more to do with ensuring that no bias is occurring, by intentionally looking for as many perspectives as possible on the subject under study. Thus, within grounded theory participants are selected on the basis of their knowledge or experience of the subject under study. The aim of the sampling procedure in grounded theory is not representativeness, but to gain in-depth knowledge of the subject under study. There is no stipulation as to sample size within grounded theory. Glaser and Strauss (1967, p.63) note that adequate sampling is attained when ‘further sampling fails to reveal additional categories, properties or interrelationships.’ Glaser & Strauss (1967, p.111) refer to this as ‘theoretical saturation’ when data collection “only adds bulk to the collected data and nothing to the theory.”

Within grounded theory data collection and data analysis take place at the same time, and analysis occurs throughout in a process of ‘constant comparison.’ This process facilitates the exploration of areas of theoretical interest. Grounded theory acknowledges the impossibility of entertaining a perspectiveless stance on the world, while acknowledging the need to ensure that researchers use their subjectivity in a transparent way. The use of explicit analytical steps and the method of constant data comparison is one way of achieving this, as is clarity about epistemological assumptions held. This researcher’s epistemological position was essentially ‘critical realist’ in that there was a recognition that certain events, such as pregnancy and birth were more than just social practices, while recognizing that they are always mediated by our understanding and to some extent naming of what is occurring.
3.3 Choice of Sample

It was clear that a decision had to be made concerning the type of sample that could be employed to enable an exploration and initial generation of ideas concerning male violence during pregnancy. Men who were fathers were acknowledged to be appropriate sources for seeking explanations for violence during pregnancy as it was thought that they could comment from their own perspective on some of the routine stresses and strains of pregnancy. While it was anticipated that selective sampling would take place, groups of men had to be identified for the purposes of gaining ethical approval. It was thus decided that three groups of fathers would be approached: (i) those that had some professional knowledge and experience of male violence (key informants); (ii) fathers who reported never using violence as an adult; and (iii) fathers who did report using violence as an adult, although not necessarily domestic violence.

There was no stipulation as to how recently the men’s partners had given birth, although it was seen as important to interview a reasonable number of recent fathers. The rationale for this was less to do with memory attrition, which it was thought would be unlikely to significantly deteriorate around such a personally significant event (Blane, 1996; Brewin, Andrews & Gotlib, 1993; Neisser, 1994; Ross & Conway, 1986; Rubin, Wetzler & Nebes, 1986; Wagenaar, 1986), but more to do with changing cultural expectations and practices of fatherhood (Marsiglio, 1993).

Inclusion and exclusion criteria for the three groups were as follows:

Group 1 ‘Violent Men’ were recruited from men referred to the local trust in which the researcher was then working and from personal contacts. Men were included if they (a) were biological fathers and (b) acknowledged using violence as an adult. Men were excluded if they self reported a major mental illness accompanied by psychotic features. Four men were interviewed in this group, although only two of these came through the forensic service. This low number reflected the difficulty of identifying appropriate men within the selected time-period.

Group 2 ‘Non-Violent Men’ were recruited from the general population and social networks known to the principal investigator and colleagues. Men were included if:
(a) they were biological fathers; (b) reported never having been convicted or cautioned for a violent offence; (c) had not, nor never received treatment or therapeutic support for violence and (d) did not report using violence as an adult. Men were excluded if they self reported a major mental illness accompanied by psychotic features. Five men were interviewed in this group.

Group 3 ‘Key Informants’ consisted of mental health professionals who had knowledge or experience of men who had been violent. These key informants were included if: (a) they were biological fathers; (b) had some knowledge or experience of men who had been violent. Exclusion criteria were the same as for group 2. Eight men were interviewed in this group of whom three mentioned behaviour that could be construed as violent during the interview (see Table 3.6, page 214). These men were included in the analyses.

3.4 Taking into Account the Researcher’s Position

Given that grounded theory rules out any perspectiveless stance by either the researcher or the researched, it is useful to be explicit about the researcher’s perspective.

In this study the researcher was not himself a father. There was no research evidence to suggest that this would be problematic. However, the influence of the researcher’s gender was thought to be significant. Lorna Mckee and Margaret O’Brian (1983, p. 149) report that in their interviews with expectant fathers, the men were less likely to self-disclose than women, more likely to control the interview ‘in diverse ways and for diverse ends’ and to reenact male stereotypes in the interview. Interestingly and perhaps slightly disingenuously, Mckee and O’Brian (1983, p. 154) conclude from their experience that ‘a woman interviewer was both more “like” their wives and other women, and by her gender in a “closer” and less hostile relationship to the topics of pregnancy and babies.’ Other researchers have adopted a different position and seen some benefit in men interviewing men, without discounting other methodological issues such as ‘men’s effects on men’ (Hearn, 1998, p.42).

It is also important to consider the effect of cross-gender interviewing when gender violence is being discussed. It is quite possible that men’s accounts or explanations of
violence will vary simply in respect of the interviewer’s gender. This is particularly salient for men who may have been violent themselves, and where issues such as denial, minimization, excuses, justifications and removal of the self and intention may already play a part in their 'description and explanations of violence' (Hearn, 1996, p.105).

The researcher had no personal experience of violence during pregnancy either directly or indirectly, although he had assessed one clinical case in which violence during pregnancy was cited as an important factor. Interestingly, the husband and wife involved in this case provided entirely opposing accounts of this and without corroborating evidence on either side it was extremely difficult to assess the validity of the claims being made. The researcher was thus approaching the issue of violence during pregnancy with minimal case experience and no personal experience. These factors undoubtedly had some effect on the emotional salience of the issue and hopefully allowed the researcher to approach the issue with a minimum of preconceived ideas based on negative case or personal experience.

3.5 Measures

It was decided to use vignettes to explore the question of violence during pregnancy and although their use in psychology has to date been somewhat limited (Miller, Velleman, Rigby, Orford, Toid, Copello & Bennett, 1997), they are particularly useful when it is important to present material in small manageable summaries and to highlight distinctive features of a case (Miller et al., 1997).

The vignettes were developed between April 1999 and October 1999. There were three goals in their development: (i) they needed to be acceptable and meaningful to potential participants; (ii) they covered the domain of content under study (the different scenarios of violence during pregnancy) and (iii) they would be sufficiently open so as not to bias responses in any one direction. The vignettes were rewritten a number of times until these three goals were considered to have been met by the researcher and research supervisors (see Table 3.1, page 207).

Alongside the vignettes an interview schedule was developed in order to discuss the nine-month period of pregnancy from the man’s perspective. A number of key
questions and prompts were developed in order to provide some level of structure to the interview. It was anticipated that areas of interest would be followed up during each interview and that the basic interview structure would develop over the course of the interviews.

The vignettes and interview schedule were piloted on three individuals, one from each of the three groups of fathers. Each interview was conducted face to face and would follow the same format, namely a reiteration of the purpose of the interview, an explanation of confidentiality procedures and the obtaining of informed consent. The first interview was not recorded, but notes were taken during and after the interview. This did not prove satisfactory and the remaining two interviews were recorded and transcribed verbatim, a procedure that took about six hours per tape. Interviews lasted from one hour twenty minutes to one hour forty minutes and were undertaken in participant’s homes.

Information was sought from respondents both about the content and structure of the interview and the style of the interview. No changes were suggested to the interview structure or to the vignettes. All three interviews from the researcher’s perspective seemed to flow and the transition from fathers talking about their own experiences to the three vignettes appeared to work well. As the interview schedule or vignettes did not need to be amended the two pilot interviews that were recorded have been included in the overall analysis. The interview schedule is provided in Appendix 4 and the vignettes are shown in Table 3.1.
Table 3.1 Vignettes.

<table>
<thead>
<tr>
<th>Vignette 1. Steve and Ann</th>
</tr>
</thead>
<tbody>
<tr>
<td>To discuss the relationship between pregnancy and violence I want to start with a situation in which the pregnancy doesn't seem to make any difference to their partner's behaviour</td>
</tr>
<tr>
<td>Steve and Ann have been living together for three years. During their relationship Steve has pushed and shoved Ann a number of times and on occasions has hit her as well. Steve and Ann had agreed it would be a good idea to have a family. Ann thought that when she told Steve she was pregnant Steve would stop hitting her. However, her pregnancy doesn't seem to have had any effect on Steve at all.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vignette 2. Peter and Dawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>The second example I want to talk about, involves a situation in which a man who had previously been violent to his partner stops when he finds out she is pregnant.</td>
</tr>
<tr>
<td>Peter and Dawn have been together for three years. During their relationship Peter has pushed and shoved Dawn a number of times. He has also hit her on a number of occasions. Six months ago they decided to try and have a baby and Dawn conceived shortly afterwards. Peter has not been violent towards her since she told him she was pregnant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vignette 3. Simon and Theresa</th>
</tr>
</thead>
<tbody>
<tr>
<td>The final example I want to talk about involves a situation in which a man who has never been violent to his partner before, becomes violent during the pregnancy.</td>
</tr>
<tr>
<td>Simon and Teresa have been together for three years and they both wanted children. Until Teresa became pregnant Simon had never been violent towards her. However, since Teresa became pregnant he has pushed and shoved her a number of times and has now hit her on a number of occasions.</td>
</tr>
</tbody>
</table>

3.6 Procedure

In order for the research to be feasible all participants needed to be within reasonable distance of the researcher, which meant the South East of England.

Contact with fathers was made either by phone, in person or through an intermediary (the Head of Forensic Psychology Services). Six fathers were recruited via the partner of a work colleague, four came through the researcher’s own personal contacts and seven through the forensic psychology service the researcher was working in. With the four participants known to the researcher prior to the research study, no discussions had previously taken place with them either about their children or about the issue of violence during pregnancy.

All interested participants were then given or sent an information sheet (see Appendix 5) and an interview date arranged. None of the respondents who expressed an interest
in the research declined to be interviewed, although one who agreed was unable to make time for the interview and another had to be excluded on the basis that he was an adoptive father.

Fifteen participants were interviewed between March and April 2000. As with the pilot study the interview followed a standard format namely, a reiteration of the purpose behind the interview, an explanation of confidentiality procedures and obtaining of informed consent. While participants signed the consent form, the interviewer set up and checked the recording equipment. Ten interviews were carried out in participants’ homes, four at participants’ places of work and two on health service premises. The interviews lasted between one hour ten minutes and two hours, with the average interview lasting one hour forty minutes. Each interview was transcribed verbatim by the researcher, a procedure which took between 90-100 hours in total.

In terms of consent, participants were asked to sign either a patient or non-patient consent form after the research had been explained to them. (see Appendix 6). Participants were informed that talking about violence during pregnancy could be upsetting and that they could terminate the interview at any point they wished. Participants who were receiving psychological or psychiatric treatment were also informed that non-participation or termination of the interview would not affect their treatment in anyway. Confidentiality was assisted by transcribing all tapes without any identifying names or places and by the storing of research data (both written and tapes) using a numerical system only. Participants were informed that all tapes would be erased when they were no longer required for research purposes and that all participants could receive a copy of the tape if they wished. Only one participant requested this.

A follow-up letter and response pro-forma was sent to all the participants approximately two months after their interview thanking them for their participation and asking them for any comments on the process and any final thoughts on the topic (See Appendix 7).
3.7 Transcription
In each transcript the lines were numbered to facilitate coding and any pauses or particularly noteworthy responses marked (e.g. laughing or sarcastic tone of voice). Only 6 sentences on two tapes could not be transcribed because of background noise or lack of clarity. A full interview transcript is provided in Appendix 8.

3.8 Coding of the interviews
Transcripts were read a number of times and any segments of text that the researcher perceived as interesting or important were underlined. Pidgeon, Turner and Blockley (1991, p.161) suggest asking “what categories, concepts or labels do we need in order to account for the phenomena of importance in this paragraph?” At this stage the aim was to produce as full a coverage of the relevant data as possible.

3.9 Initial documentation of labels
Each category once identified by a label was noted on 5-inch by 8-inch cards and an extract from the data, along with where it occurred noted. These cards were continually sifted and sorted and notes made of connections between categories based on their conceptual similarities. Attention was also given as to whether any provisional concepts could be subsumed by another category. Possible interpretations were also noted down. An example of this initial coding is given in Table 3.2.

Table 3.2 Example of a Coding Card

<table>
<thead>
<tr>
<th>Male Stigma/’Rules’ (associated with stopping hitting during pregnancy) Vignette 2.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V1, 450-454</strong></td>
<td>Peter certainly ain’t gonna be bragging about it coz he’ll go down to work and say my Mrs. was giving me a bit of grief last night so I gave her a bit of a slap and told her to shut up. The lads would be going “she’s pregnant isn’t she?” and you’re likely to get a slap back.</td>
</tr>
<tr>
<td><strong>NV3, 488-490</strong></td>
<td>Could be the fact that hitting your wife is acceptable, hitting someone who is pregnant is a complete no, no</td>
</tr>
<tr>
<td><strong>NV4, 473-476</strong></td>
<td>I suppose I could construct a situation where Peter has to in his mind, in his world, its fair game to hit a woman and push and shove her if she’s not a mother, but um, somehow the idea of hitting her if she’s a mother fills him with revulsion and he can’t do that anymore</td>
</tr>
</tbody>
</table>
Originally this was coded in terms of the category ‘stigma’; however there also seemed to be something about male assumptions and unspoken rules of conduct. Respondent P2 who spoke of “male mythology” almost captured this sense and notes were made to other points in the text in which men had referred to pregnancy as a “sort of elevation of status” (NV4, 480). Thus there was some awareness at this stage that the labelled category may be more meaningfully enclosed within a wider category. The final category used was ‘Role and Relationship Changes’ as a connection could be drawn between the men’s experiences with their partner and with other men.

These initial categories were then recategorised into more meaningful/inclusive concepts until the point was reached at which concepts could be said to be ‘fully saturated,’ that is when no more of the interview data added or changed the concept identified. Thus the aim was not to record all the instances of a particular phenomenon but to note all of those instances which constructed and illuminated the concept. The process of moving from categories to concepts was ongoing throughout the research process with the aim of moving from the initial coding categories to more inclusive and abstract concepts. As is usual in grounded theory this was undertaken by the researcher alone, using the ‘principle of explicitness’ (Glasser, 1994) whereby any “proffered ‘understanding’ was supported by specific data” in the transcripts (Glasser, 1995, p. 313). For this reason references to specific transcripts give both the respondent and coding line where the information can be found.

3.9.1 Core Analysis

As Pidgeon, Turner and Blockley (1991, p.164.) note ‘for the indexing to be of any use, the coded concepts must be refined, extended, checked against further data and related to each other.’ The processes by which this is undertaken are refining the indexing system, memo writing and category integration.
3.92 Refining the Indexing System

Refining the indexing system firstly produces a better fit between the data and the overall explanatory categories, this is important as the initial categories given to data do not always fit, particularly as more data is collected. Secondly, refining identifies the point at which a category is saturated. At this point the researcher writes an explanation as to why each of the textual elements have been included under the category. Both Glaser and Strauss recommended that this process of refining and defining, occurs alongside that of writing theoretical memos (Glaser, 1978; Strauss, 1987).

3.93 Theoretical Memo Writing

Memo writing documents the findings in a grounded theory investigation (Strauss & Corbin, 1990). It is a key component within grounded theory and is a useful way of keeping track of tentative hypotheses and thoughts concerning the data. It is also an important way of integrating data collected from other sources into the overall theory. This is particularly the case with the literature review which unlike many other research methods is undertaken during the process of research and not before. Table 3.3 gives an example of a theoretical memo written during the initial categorisation of the data.

<table>
<thead>
<tr>
<th>Table 3.3 Example of a Theoretical Memo written During the Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example of a memo about men’s discussions about becoming fathers.</td>
</tr>
</tbody>
</table>

Men have commented on the difference between talking to fathers and non-fathers about being a father or father-to-be. Men’s conversations about fatherhood to expectant fathers was reported as fleeting and focusing on disruption and disjunction. It is perhaps not surprising that one man spoke about preparing for death (‘I would compare almost, it’s a bit dramatic, to learning you were about to die.’ P5 36-7). This is metaphor and representation of feeling. It is about telling stories (of presenting persona or character according to Lipton & Barclay, 1997, p.9). The men I interviewed all recognised the surface-level conversations about fatherhood to non-fathers. Explanations given were sub-cultural (‘I think sometimes you say things because that’s what you think you should say V3, 85-6); habitual (‘it’s jokey because everything they talk about is a joke’ V3, 89) functional (‘I think it’s partly an initiation ceremony or initiated into the brotherhood of fatherhood. I almost relate it to the tribe and the elders. I think it’s a good social practice’ P5 286-8); personal (‘It’s not macho to talk in that way...If I’m honest I think men would love to talk about it,’ V3 84, 94).

Question- Given the historical dominance of men over women-why is there no current dominant discourse of fatherhood? Was there ever one? Has it been lost? Did men play a leading role up until industrialization? Was it perceived as peripheral or detrimental to male economic concerns? Was it too closely associated with motherhood? What did Aries say about fatherhood? Male violence during pregnancy-historically what is known?
Memo writing allows connections to be drawn, the posing of questions and speculations. However, it is important during this process to remain focused on the main questions of interest (Strauss, 1987).

3.94 Category Integration

The final stage of core analysis is integrating emerging categories, either diagramatically or using the written material produced to date. The aim is to obtain a coherent model based upon the documented data. The use to which these categories are put, depends to some extent on the aim of the project.

3.10 Description of the Sample

Seventeen fathers were interviewed in total. The mean age of respondents was 40 (range 29-60). The mean age at which respondents had their first child was 30 (range 21-43). Eight respondents had only one child, five had two children, three had three children and one four. One couple were actively trying for a second child and two couples were currently awaiting their second child. Ten of the respondents had become fathers in the last three years (See Tables 3.4, 3.5 and 3.6).

Table 3.4 Fathers with a Known Violent Past

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (Age at first child)</th>
<th>Profession</th>
<th>Marital Status</th>
<th>Current Pregnancy</th>
<th>Admission of Violence (* to other men)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>34 (22)</td>
<td>Builder</td>
<td>Married</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>V2</td>
<td>33 (21)</td>
<td>Unemployed/Forensic Client</td>
<td>Cohabiting</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>V3</td>
<td>38 (37)</td>
<td>Musician</td>
<td>Married</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>V4</td>
<td>41 (33)</td>
<td>Unemployed/Forensic Client</td>
<td>Separated</td>
<td>No</td>
<td>Yes*</td>
</tr>
</tbody>
</table>

Key V= Violent
Table 3.5 Non-Violent Fathers

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (Age at first child)</th>
<th>Profession</th>
<th>Marital Status</th>
<th>Current Pregnancy</th>
<th>Admission of Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>NV1</td>
<td>35 (33)</td>
<td>Senior Civil Servant</td>
<td>Remarried</td>
<td>Trying</td>
<td>No</td>
</tr>
<tr>
<td>NV2</td>
<td>31 (28)</td>
<td>BBC Project Manager</td>
<td>Married</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NV3</td>
<td>29 (22)</td>
<td>Finance Manager</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>NV4</td>
<td>31 (28)</td>
<td>Banker</td>
<td>Married</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NV5</td>
<td>29 (27)</td>
<td>Web-designer/Juggler</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Key NV= Non violent

Table 3.6 Key Informant Fathers

<table>
<thead>
<tr>
<th>Subject</th>
<th>Age (Age at 1st child)</th>
<th>Profession</th>
<th>Marital Status</th>
<th>Current Pregnancy</th>
<th>Admission of violence during interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>60 (25)</td>
<td>Educational Psychologist</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>P2</td>
<td>51 (25)</td>
<td>Nurse/Psychotherapist</td>
<td>Remarried</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>P3</td>
<td>59 (26)</td>
<td>Forensic Social Worker</td>
<td>Married</td>
<td>No</td>
<td>Yes+</td>
</tr>
<tr>
<td>P4</td>
<td>47 (43)</td>
<td>Group Analyst</td>
<td>Cohabiting</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>P5</td>
<td>39 (38)</td>
<td>Existential therapist</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>P6</td>
<td>42 (30)</td>
<td>Nurse/Researcher</td>
<td>Cohabiting</td>
<td>No</td>
<td>Yes#</td>
</tr>
<tr>
<td>P8</td>
<td>35 (34)</td>
<td>Forensic Nurse Manager</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>P9</td>
<td>43 (34)</td>
<td>Forensic Social Worker</td>
<td>Married</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Key

P = Professional
+ = Mutual battering
* = Violence towards other men
# = Pushing and shoving of partner

Quotations from the transcripts give each subject’s identifier and the line number or numbers of the text. Three dots indicates a break in the text.
Chapter 4 Men’s Experiences of being an Expectant Father

4.1 Introduction
Men’s own experiences of being an expectant father were used to begin the process of exploring the topic of violence and pregnancy. This initial grounding in their own narrative accounts of fatherhood was viewed as important as it served to provide a context for their responses to the vignettes. While much interesting data emerged from this part of the interview, space limitations preclude presenting this in full. Therefore, only those themes that provide an insight into factors that could impact upon men’s responses to pregnancy related violence are presented.

4.2 Getting to Know Each other
A number of the respondents spoke about the importance of getting to know their partner prior to beginning a family. One couple seemed to have agreed upon a specific time “We’ll give ourselves a year to settle in as a couple” (NVF4-32), while another focused on issues of adjustment “I think it would have been a very bad idea to have children in the first year or so, adjust to each other’s lives and stuff” (P5, 29-30). Some of the other respondents spoke about the need to prepare themselves for change “I’ve seen other people who had kids more quickly and they are finding it very tough” (NV5, 158) and a desire to do things socially that would be difficult once a child was born. One respondent used the term “a good death” (P5, 169) to describe the change between being with their partner and having a child:

All of those who openly discussed the issues of getting to know each other had planned pregnancies.

4.3 Planned/Unplanned Pregnancies
Only four of the seventeen men interviewed had unplanned pregnancies. Looking at the subsequent themes to emerge from the data, there did seem to be some differences between those men who had planned their pregnancy and those that had not. In particular those men who hadn’t planned the pregnancy with their partner appeared to be rather less effusive in their reporting of their initial response.
Chapter 4 Men's Experiences of being an Expectant Father

4.4 Belief Systems

Respondents referred to belief systems regarding pregnancy, birth, children or families. These ranged from explicit religious belief systems “they are God's really and we are just looking after them” (NV5, 67), belief systems about the world “leaving children behind you as you pass away is the reason why we are here to a large extent” (P8, 23) beliefs about the self “this is what in a sense I was made for, or one of my key purposes in life” (NV4, 241-42) and the relationship, “I knew I was ready for it, I knew I wanted a child, we was a strong couple” (V1, 25-27).

4.5 Emotional Responses

Men's responses to the news that their partner was pregnant can be divided into those that reported it as the most dramatic, positive and life-changing event that they had ever experienced, those that viewed it positively but not as life-changing and those for whom there was a degree of ambivalence. None of the respondents reported an entirely negative response to the news, although one man who had separated from his partner during the pregnancy noted that “It was always on my mind... but I didn't pay any attention” (V2, 21, 23) while another reported “surprise, a slight irritation, but also pleasure” (P6, 1) this following a termination six months earlier. Common terms used by the expectant fathers were “overjoyed”, “wonderful”, “excited”, “ecstatic” and “delighted.” For those who reported a degree of ambivalence, the main feature was one of apprehension “I thought my apprehension was about moving into a whole new ball game” (NV2, 14), and trepidation “You suddenly have this responsibility yourself, there was some trepidation.” (P9, 12-13). Concerns about the health of both the partner and child during the pregnancy appeared to be quite common.

4.6 External Factors

While it was clear that most of the fathers who were interviewed had not previously given much thought to the way their life changed during the course of their partner's pregnancy, virtually all were able to comment on some of the external changes that took place. These seemed to be related to three main areas (i) practical changes to living conditions; (ii) financial changes and/or considerations; (iii) involvement with antenatal and medical services. Thus a number of the men who were interviewed
spoke about the need to either move or to refurbish their house as a result of the pregnancy. Where this was reported, the decision was reported as mutual and surprisingly stress free. A number of respondents mentioned the anticipated financial ‘burden’ of having a child, or where they already had a child, the actual financial cost. However, none of the respondents spoke about this at length and this may have indicated some class bias towards those of a higher economic status in the sample. All of the men were involved to a greater or lesser extent with medical/maternity services during the course of the pregnancy. Involvement ranged from attendance at antenatal classes to attendance at scans. The men reported a wide range of responses to their involvement ranging from enthusiasm to dismissal. Although a mixed pattern of responses by health professionals was reported by respondents, the majority of men did not feel that their concerns as men were well met, particularly during the pregnancy period. However the majority did not think that this mattered given that the primary concern was on the women’s and unborn child’s health.

It is interesting to note what was not said in terms of external changes. Little reference was made to changes or adjustments in the men’s occupation, perhaps tapping into a dominant male norm that equates ‘good fathering with good providing’ (Thompson & Walker, 1989).

4.7 Reconceptualisation of Self

One key term used by a number of participants was “responsibility” (V3, 18; V4, 14; V2, 8; NV1, 36; P4, 72; P9, 12; P6, 250; NV3 245-6). While the men were referring in part to external factors already mentioned, they were also referring to the feeling of responsibility for their partner and unborn child:

You’re a different person and you couldn’t carry on the same, because your mind’s not thinking the same as before you found out, especially for the first one. You’re more carefree, you’re not too worried about money, you can plan your holidays, as long as you pay the rent the rest of your money you can spunk up the wall doing whatever you want to spunk it up on and then as soon as you find out you’re pregnant then that changes (V1, 78-84).
For others the responsibility referred to was a sort of extension of their responsibilities:

_The reality of bringing someone else into the world, really being responsible for that, having been responsible for yourself_ (P9, 12-13)

Another spoke about the different levels of responsibility:

_Maybe it's about different levels of responsibility, it's not just about me any more_ (P6, 249-50).

Some participants were explicit as how the pregnancy shifted their conception of self, mirroring work by Smith (1999) on transitions in motherhood. Thus one person spoke about it as _"the next step in growing up"_ (NV5, 143-4) while another recognised a change but was unable to specify exactly what: _"you know it changes your life forever, but you don't quite realize in what sort of ways"_ (P1, 155-6). For others the change only occurred post-birth, _"I stayed a while and then went to bed and then woke up and felt my life ought to change, basically my life had changed"_ (P6 141-43).

### 4.8 Role and Relationship Changes

Two main role and relationship changes during the pregnancy were reported, namely those with their partners and those with other men.

Changes in respondents' relationships with their partners were reported to be both positive and negative. Positive changes included an increase in _"touching and talking"_ (NV5, 119), _"loving"_ (V4, 15), an increase in intimacy or bonding (V3, 14; P6, 276), and for one a positive change in the form in which sexual intimacy took place (P9, 48). In terms of sexual relations, while these ceased for a number of couples, _"we became neutral beings"_ (NV1, 250) this was either openly discussed or it was described as naturally tailing off. Only one respondent was informed by his partner that she didn't want sex during the pregnancy and he was able to put this into some form of non-threatening context: _"I guess I did feel well you know we can sort this out afterwards, there was that and also the thought that well this is what fatherhood is all about and this is what every fathers had to deal with"_ (NV4, 237-240). Termination of sexual activity was therefore not reported as particularly problematic. Two men did however report that they were looking forward to their partner returning.
to their pre-pregnancy shape, but did not report any reduction in sexual activity while waiting for this. Two of the men reported the opposite experience, and spoke of a more transcendental quality to the pregnancy and noted that “there was a kind of aura around that wasn’t there when she wasn’t pregnant” (P9, 55), “she looked really beautiful when she was pregnant, it was incredible” (P2, 20-21).

While it was to be expected that changes with their partner would occur as the result of the pregnancy, changes in relationships with other men was rather more surprising and perhaps reflects the fact that “fatherhood is almost entirely a social relationship” (Kraemer, 1994, p.23). Most often such changes were described in terms of a change in communication, particularly the way in which the topic of fatherhood became restricted to a small group of like-minded people, usually other fathers. With non-fathers the topic of fatherhood, where raised, was treated in a “jokey sort of way” (V3, 89).

4.9 Problematics of Pregnancy

Three main problematic themes could be discerned: (i) the dominance of the pregnancy; (ii) feelings of exclusion and (iii) learning to cope with one’s partner’s changing moods.

4.91 Dominance of the Pregnancy

Six of the participants referred to the pregnancy dominating the relationship in some form or another. One of the participants noted that “everything seemed to become subservient to the pregnancy and everything that we chose not to do or do, had considerations about the pregnancy in it” (P3, 127). Another participant noted that “whereas as a couple we were equally influencing the mood of the relationship, once (z) was pregnant, her mood would influence it the more it seemed to me” (NV4, 86-7). This same participant spoke about being ‘fed up with running around in circles and fed up with her anxiety attacks and things’ (373). This particular participant who clearly experienced the pressure of the pregnancy went on to note that:

---

1 There was a wealth of interesting data concerning men’s conversations with other men which has been excluded from this analysis as the focus was often on fatherhood and not on expectancy.
I guess in practical terms wives want to get a lot of support from their husbands and maybe it’s too much to ask, it’s not fair to ask so much of a man, when in many cases it goes very much against how they think and often work and in reality it’s fair to say try to look at alternatives to just asking your husband to doing everything, or trying to make him do everything, I dunno things like that, may be difficult but possibly more constructive. (NV4 371-391)

Other participants found the pregnancy burdensome in different ways, "you spend nine months talking about nothing else and it gets a bit dull" (NV2, 149) and another that:

You do get caught up in that pregnancy trap that every other conversation is about pregnancy and sometimes you do come home and just want to watch something on TV or have a chat and dinner and not always dwell on it every second of the day. Sometimes that’s how things go wrong when you constantly focus on something (NV1 293-97).

The same respondent noted that “when you get into the last couple of months because (x) wasn’t sleeping so it gets a bit annoying at night because I couldn’t sleep because she was tossing and turning and obviously she was feeling very uncomfortable and after a while you do begin to think ‘how much longer’ it seems to be going on forever and ever” (NV1 222-234). Similar sentiments were echoed by another participant who spoke about being happy for the pregnancy phase to end as there was “that mixture of anticipation and ‘God this is a pain in the neck.’”(NV2, 113)

4.9.2 Feelings of Exclusion

Issues of exclusion were referred to by a minority of the men interviewed. Nevertheless, it seems important given the powerful emotions that it can give rise to. Two of the participants referred to this in particular, one focusing on feelings of jealousy, the other on feelings of envy.

By the time she had given up work she was spending a lot of time at home going for the checks and spending time with other people that were pregnant then I did feel a bit about ‘what is she talking about with others’ because she was obviously at home talking on the phone and she would spend hours and quite often she would come in and not necessarily say what she had been talking to her friends about not in detail...in the end I didn’t bother to ask,
partly because I felt that it was a private conversation that she wanted to have with another person, secondly I felt that perhaps there are some things that are in pregnancy that you can only really discuss if its happening to you (NV1, 279-287).

Although this was not that problematic for this particular individual, it was of importance. The man’s rationale and cognitive appraisal of the situation clearly helped him to reduce his feelings of exclusion. Another participant focused more on the experience of envy:

Well from my own experiences you’re both sitting there and she’s going oh yeah feel this and feel that and at first you’re putting your hand on her belly and she’s going can you feel that little throw, coz you can’t feel nothing and you’re like you want to experience all of it but you can’t you’re at a loss, you can’t experience it all and they can’t help but tell you so yeah there were things I felt I had missed out on. I wished that I’d been a woman, or if I could I’d be a woman just to experience what it’s like to be pregnant. (V1, 57-64)

As with the previous individual this was not a major concern to the individual and the envy spoken about can be viewed as non-malicious. However, as with the previous participant there is a sense of frustration on the part of the man in not being able to fully understand or capture the experience of pregnancy for himself.

4.93 Coping with One’s Partner’s Moods
A number of participants referred to their partner’s changing moods, moods which they often ascribed to hormonal changes consequent to the pregnancy “you will not know how she will react in terms of the changes on her body...could lead to what you perceive as irrational behaviour or unacceptable behaviour or being ultra pushy or whatever” (NV3, 279-281).

You realize that that person can be quite fragile in some ways so I suppose looking back you can walk on egg shells and you never quite know whether that other person can be quite close to the edge about something (NV1, 465-466).

Methods of coping with this included being “supportive and helpful” (V3, 74), an “open book policy” (NV3, 277), being “ultra-accommodating” (NV3, 295) or
having to “bend otherwise you clash” (V1, 37). The same respondent talked about frustration and “pulling one’s hair out” (V1, 104).

One participant noted that he found it “hard to deal with her slightly bad tempered mood” and that “it took me a long time to get used to the fact that she was basically entitled to sort of behave badly and lose herself completely and get annoyed and get rattty with me” (NV4, 80, 92-4). Interestingly the same participant found an explicit meaning to this mood change: “I suppose I was thinking this is what children is all about, having to endure because I may have to be enduring my wife the way she is but maybe that’s just God’s way of preparing you for having to endure your children which is probably even worse. This wasn’t terribly conscious, it was sort of a half-thought” (NV4 248-253). However not every change could be put down to the pregnancy “I certainly sat there and thought ‘well I haven’t changed, you’re the one who’s having the hormonal changes’, but you can’t put everything down to hormonal changes, after a while you just stop” (V1, 110-112). Respondent NV4 who was receiving psychological support for anger management noted that:

The thing I remember very clearly was being sent off on an errand for some vitamins or something and in the car just screaming my head off in the middle of a road junction, just because I had to shout and I couldn’t let it out in any other way and feeling a lot better after as well, at the time I thought to myself I’m holding a lot in and the thought came to me that it shouldn’t be like this, but there seemed very little I could do about it (NV4, 185-201)

This same respondent went on to speak in some detail about the stresses and strains of pregnancy:

Well just less time for myself really, I think learning, initially I didn’t know the language for asking and expressing my needs I would rather like do x y and z, saying that 2 years ago was something I didn’t find easy I just sort of go along and do this and that and alright and be ordered around much more, again because I felt again that was something I ought to be doing and not really seeing anything unhealthy in it, so at that stage it seemed to me that I didn’t really have any time to myself really. Neither in a way did I really feel I needed it, but then the need got bigger eventually and again I think that’s why tensions were greater on the 2nd pregnancy because by that time I was beginning to feel dissatisfied because I couldn’t somehow state my needs (NV4, 266-277)
Later in the interview he went on to describe the pressure he felt in relation to his own particular boundaries:

*Pressure, pressures on me, if you like it felt like here's my little finger which is my time and what I choose to do with it and when you're just married, x and I respected each other's boundaries because there was no need for each of us to encroach on each other's time, with the arrival of and impending arrival of the baby, x saw it as her needs to encroach on my boundaries and I had no way of asserting them or deciding for myself what my new boundaries ought to be and there were no new boundaries and it was all in fact just x's decision what happened. So it happened fairly gradually over the 1st pregnancy in that sort of way.* (NV4 347)

Relating these individual difficulties to the wider role of men in society, he noted that:

*I feel in general that men are often badly misunderstood and that our needs to have a quiet moment and be reflective and not talk and to lose ourselves in some way or other, little things like that are not understood by women, many women regard it as a sort of bit unhealthy and sometimes it's alright, at other times I think they are very wrong and it might be my own perspective again, but I feel as if we... often aren't given enough space for us to actually say something positive about why it is that we behave in this way, it almost stops because there seems to be a large head of criticism about things already, it stops the conversation in its tracks before it even starts, if you're trying to stand up for why you like to not talk all the time and just have quiet moments. I feel the same is true here in some ways, that unless men behave during pregnancy that is completely in keeping with what the mother wants and it's just sort of totally logical in their eyes, then it's considered to be unhelpful and so I definitely feel that there needs to be, somebody has to say 'well actually the man doing this, this and this is actually good in some way, it actually helps for whatever reason, this natural instinct the man has to behave in this way is actually good for the pregnancy and it's not necessarily good for the man to push down all his natural instincts and try and turn himself into a woman for 9 months so that he can, or that he can be a slave for 9 months' so I guess that's how I feel.* (NV4 347-370)

These powerful sentiments capture both the stresses and strains of pregnancy as well as some of the important underlying assumptions about pregnant women. As such they serve as a useful reminder of what some of the underlying dynamics may be which go unstated by some men during the period of pregnancy.
4.10 Relationship to the Unborn Child

The majority of men spoke about their relationship to the unborn child. The majority reported some form of bonding during the pregnancy, though this occurred at various stages. Some of the men only bonded at the point that they could see a visible change in their partner, when they named the child or when they went to the scan, “a scan makes you aware there’s a person there” (V3, 41). A minority of men reported no bonding during the pregnancy “wasn’t really a baby...it was just a thing inside rather than a baby” (P5, 202); another noted that “it was an abstract concept, not reality, I didn’t really think what was in there till the birth” (P6, 144). One participant summed up his feelings by stating that “it’s hard for a man to love an object that they don’t have physical contact with, whereas a woman’s already got that” (V1, 152-153).

4.11 Development of a Model

There were a number of themes that emerged in talking to men about being an expectant father. Although these themes initially appeared to be very much discrete areas, examination of the interview data indicated a certain sequential pattern in their occurrence across all of the interviews. Participants’ experiences can be plotted in terms of a number of stages, beginning with a process of getting to know their partner prior to the pregnancy occurring. While not every participant went through every stage there was such a level of commonality that a tentative model of expectant fatherhood seemed to be worth developing. Moreover, it was anticipated that such a model of essentially unproblematic (at least in terms of partner violence) expectant fatherhood would act as some form of yardstick by which to examine the men’s responses to the hypothetical situations of violence during pregnancy. A tentative model from the process of conception to birth has thus been developed in order to understand what it was that the expectant fathers reported experiencing (See Figure 4.1).
Figure 4.1 Stages of Fatherhood

The model can be conveniently split into two. The first part, culminating in what can be called 'emotional response', represents the immediate impact of the pregnancy on the man. This includes belief systems, whether the pregnancy was planned or unplanned and getting to know their partner before having children. The emotional response of the male partner highlights the extent to which there was an immediate response to news of the pregnancy and does not imply a necessary tailing off of emotion during the pregnancy.

The second half of the model focuses on the aftermath of the news of the pregnancy, particularly after the initial emotional response had died down. Two features emerged from the interview data. On the one hand there was the extent to which the news of the pregnancy resulted in changes being made to the external world, highlighted through financial considerations, housing and increased involvement with medical/maternity services. The extent to which each respondent's external world
changed was variable, but understandably it did emerge as a strong factor in each man’s account. On the other hand the majority of men spoke about a process of reconceptualisation, of how they thought about themselves in relation to the world. The notion of responsibility featured heavily in these accounts. What men described as occurring as a result of these external changes and reconceptualisation of self was a change in roles and relationships. While this was chiefly centred on their relationship to their partner, it also occurred with other men, particularly in the way that men spoke about the imminence of fatherhood. Finally there was the issue of the relationship to the unborn child which was an important feature of many although not all of the men’s experiences prior to the child’s birth.

It is these last four areas that I have termed the ‘problematics of fatherhood’ as they seemed to encapsulate both positive and negative features of expectancy and served as an important overview of some of the everyday lived experiences of expectant fathers. Although the interview intentionally terminated with the birth of the child most of the men alluded to post birth situations during the course of the interview in terms of a further transformation of self, role and relationship. For the men in my sample this was seen as positive and welcome.

4.12 Conclusion

This opening section has begun the process of developing a theoretical model for describing the changes that occur in men as a result of being an expectant father. Such a model is based upon men’s own accounts of what occurred during their own periods of expectancy and is intended to explain wanted pregnancies, irrespective of whether or not they were planned. It is also a first step in explaining what is happening in relationships in which partner violence has for the most part never occurred. It is worth reiterating that of the seventeen men sampled, only two spoke of violence in intimate relationships (see Table 3.6), although it is possible that there was hidden violence. The textual accounts and codes, particularly those around the ‘problematics of pregnancy’ are intended to serve as a guide to some of the stresses and strains that occur for expectant fathers during the period of expectancy. The model may be used as a first step in explaining what may be occurring in relationships in which violence in or outside of pregnancy is not the norm.
The literature review suggested that there are different responses to pregnancy, with some men continuing or escalating their violence during pregnancy, others inhibiting it and a third group actually starting it. This chapter and the two that follow examine each of these patterns of violence in turn.

5.1 Male Violence that Starts Before and Continues During Pregnancy

Following on from the discussion on fatherhood, respondents were asked to comment on a situation where there was both violence before and during the pregnancy (see page 42) There was no specification as to whether the violence had remained stable or had increased.

Before examining some of the explanations given by the men for this situation it is useful to give some indication as to the men’s emotional response to the vignette.

5.2 Emotional Responses to Steve and Ann

Where participants articulated an emotional reaction to Steve these were almost exclusively negative. Terms used to describe Steve were “bastard” (P5, 315; P6, 288; P2, 170) “tosser” (V1, 266) “complete animal” (NV3, 447) and an “absolute pig” (NV3, 311). Three respondents offered to sort Steve out in some way with one noting “I‘ll go and sort the bastard out” (P6, 330) and another that it was “Appalling, he needs a good slap” (P6, 285). One respondent viewed Steve’s behaviour in a wider context and noted that he’s the “sort of bloke that gives every man a bad name” (V3, 124). Such comments are interesting since they repudiate the connection between family violence and being a “real man”(Toby, 1966) and highlight some of the ‘status costs’ in terms of status of being labelled a wife beater (Gelles, 1997). Interestingly two respondents did speak about being a “real man”.One in relation to his own experience stated: ‘I’ve heard it said before that ‘you’re not a real man until you’ve had children, children are somehow part and parcel of legitimising men, “real men”’(P2, 224-226), while another noted that
There might perhaps be a sense that having a child would change his status or position within the relationship or change his status or position within the society or change him in some way and stop him being violent. There might be some thought about a child being a symbol of his maleness. An example of a very physical real live breathing example of the fact that he is a real man. He is able to father a child. (P9, 191-194).

Three of the participants were rather more charitable towards Steve: “he’s the insensitive type, not deliberately cruel, but tough” (P1, 133-34), while another tended to ‘minimize’ the violence echoing the findings by Stamp and Sabourin (1995): “It sounds kind of childlike in a way. Pushing and shoving it reminds me of a playground or something. I mean obviously the occasional hit is something more severe and more direct, but pushing and shoving, it reminds me of bus queues and I can’t quite picture him doing it” (P9, 179-181). Another respondent gave a more psychological explanation by focusing on the difference between Steve’s behaviour and his feelings noting that “he wants to stop, but doesn’t know how” (NV4, 408).

The majority of participants made some reference to Ann, with a number commenting on her naivety in thinking the violence would stop. These responses can be understood as a form of attribution of blame. However, only one respondent came close to understanding why Ann thought this, “Well, she thought he would stop hitting her when she was pregnant, I mean saying that, anyone would think, well no man really would hit a pregnant woman, so perhaps it’s realistic” (P6, 293-5). While there was clearly some sympathy expressed for Ann “no woman should have to put up with that to be honest” (V3, 160) there was also a degree of blame attributed to her. Thus one participant noted that she was “hiding behind the pregnancy” (P4, 256), another that women “shouldn’t have babies with men they want to change” (P2, 177-8) and that “she should definitely get out and not get pregnant by him in the first place” (V4, 102-3). Two respondents were even clearer about Ann’s responsibility, one noting that “Ann’s compounding it because in a lot of relationships women would walk out straight away” (NV1, 547), and another that “Ann’s agreed to have a family for the wrong idea, for the wrong reasons really. And if her main motive was only that
she would stop Steve from hitting her, the best thing she could have done was to leave the home really” (P8, 245-6).

While such comments avoid seeing Ann as a “victim” (Hearn, 1998), they reflect an unrealistic level of existential and social autonomy on Ann’s part (Sartre, 1991). Although there was some understanding as to why Ann remained in this violent relationship, through a recognition of her financial dependence (P2, 237), most respondents simply focused on Ann’s hope that the violence would stop (P6, 307) that “little glimmer of hope” (P6, 324). Moreover there was little recognition that love and violence can coexist (Hearn, 1983) although one respondent did touch on this albeit with an element of disapproval:

_She is thinking with her heart not her head. You know there is an element of selfishness there for the love of Steve, by continuing in on it when she’s also got to think about the child. I mean she is responsible for the child at the moment. You know I think it’s a bit hopeful and naive._ (P8, 304-6)

A large part of the reason for the participants’ disapproval of Ann seemed to be the presumed effect of continuing violence on the child once born, either directly or indirectly. For some the risk was in the form of direct violence to the child “if it’s a long standing habit of hitting the wife, is the father going to hit the baby or the child?” (P1, 19708), while for others the risk was focused more on the child’s exposure to violence. A number of respondents spoke in terms of the intergenerational transmission of violence (Spatz-Widom, 1989), or what one respondent called “children and families” (P4, 270) with the possibility that the “child will see that behaviour, and will perhaps interpret that as acceptable” (P9, 218). One of the reasons that the participants were concerned for the safety of the child once born was not simply Steve’s past behaviour- “the only reliable predictor of violent behaviour is past behaviour” (P2, 207) but the increased stress and strain post- birth- “what’s going to happen when the baby is crying all night?” (P1, 199). This was a particularly salient concern for a number of participants not only from their personal experience of fatherhood but because Steve’s use of violence was viewed as being connected to
poor impulse control and substance abuse, factors which appear to be implicated in domestic violence (Mirrlees-Black, 1999).

Overall then, while there was some sympathy expressed towards Ann and some understanding of her motivations for remaining in a potentially violent relationship, there was also a strong subtext of disapproval about her either wanting to have children in such a relationship or remaining in that relationship.

5.3 Disputing a ‘Wanted’ Pregnancy

Before examining some of the explanations for the violence, it is important to note that ten of the respondents disputed the extent to which Steve wanted the child. Thus, one respondent stated, “I would probably cast doubts on the father’s sincerity wanting to have the child and how much he really thought about it as opposed to just going along with it” (P5, 405-6). Another two respondents stated that they couldn’t accept that Steve genuinely wanted a child “I don’t think he genuinely wanted to have children, he may have agreed to it, but I don’t think he specifically will have any pars with the kids at all” (NV3, 383-3). Such disputing of Steve’s fatherly intentions is important because it influences the explanations given for his violence. Given that this research was specifically concerned with violence in which the pregnancy was wanted by the male partner (at least at the conscious level), then explanations of Steve’s behaviour in terms of not wanting a child were not considered relevant to the research question being asked. As this became apparent during the course of the interviews, participants were asked whether they thought it was possible to genuinely want a child and yet be violent to the woman carrying that child. Only one respondent rejected this as a possibility, stating, “it was a bit too perverse” (P8, 279). Given that the remainder of the participants accepted this as a possibility and only disputed the extent to which Steve wanted the child, then it was considered both useful and appropriate to examine explanations given for Steve’s behaviour during Ann’s pregnancy. These were categorized into three types: (i) those essentially internal to Steve; (ii) external explanations; (iii) those focusing on the dynamics of Steve and Ann’s relationship.
5.4 Explanations Internal to Steve

There were a number of intra-individual explanations for partner violence given by the respondents. Thus Steve was seen as being “insecure” (V3, 121), having “low self-esteem” (V4, 80) and being “jealous” (NV5, 235; P8, 268; NV1, 540). The jealousy mentioned related specifically to the attention that the wife was receiving from others and echoes the comments on exclusion made by respondent NV1 (page 57). Although a number of respondents suggested that Steve enjoyed dominating and using his power (NV1, 498; NV3, 325; P5, 357), only two respondents suggested that Steve was actually unwell in some way (P2, 196), with one suggesting a “temporal lobe problem” (P8, 292). Two men referred to psycho-dynamically informed explanations for partner violence, one about “denial of the female object” (P3, 291):

In the sense that they are being denied their female object that was for a time maybe totally theirs or they felt it was totally theirs or available to them and now it’s being denied them or there is a restriction on it, it’s not, she may not be as attractive as she was or may not take as much care of herself or may not take as much interest in his pleasure or satisfaction. (P3, 291-294)

Another spoke about Steve “hitting out at something he couldn’t reach” (NV4, 412) and about deep seated resentment towards women by men: “My feeling is that he like a lot of men has some deep seated resentment towards women generally and his sense of confusion and frustration about any difficult situation results in him wanting to lash out and sort of hit at the problem and to him the problem is manifested in a physical sense by the woman, so hitting her seems like a good idea” (NV4, 399-404). This comment graphically illustrates Freud’s comment on ‘men’s normal contempt’ for women (Jukes, 1999).

Steve’s inability to express himself was mentioned as a major factor in his use of violence by a number of participants (P2, 209; P6, 231; P8 258; V4, 87). Such explanations were consistent with suggestions in the literature of incompetence in verbally resolving problematic marital situations (Munrow & Anglin, 1991). In terms of whether Steve’s violence was partner specific or that he was generally violent, there was a leaning towards a ubiquitous biological explanation: “this was part of his make-up” (P1, 370), he was “genuinely aggressive” (NV1, 536) and that he had a “violent nature” (V1, 275).
Drug and alcohol use was cited as a potential explanation by well over half of the men in the sample (P6, 319; V3, 112; P1, 159; V3, 112; NV4, 429; P5, 333; NV5, 227; P8, 267; V1, 281; P4, 282). The use of drugs or alcohol was viewed by participants as one of the few convincing explanations as to how Steve could forget or ignore the pregnancy when hitting Anne. Two possible explanations for this strong association by respondents suggest themselves: (i) their own experiences of personality/behavioural changes when drinking or taking drugs; (ii) a strong popular social theory that links alcohol to violence in a causal way. Interestingly the use of alcohol or drugs as a means of reducing tension or stress was not mentioned by any of the participants.

5.5 Explanations External to Steve

The intergenerational transmission of violence figured strongly in men’s accounts of Steve’s violence. About half of all respondents mentioned either being brought up in a violent family (V4, 86; P5, 319; NV1, 492; P6, 310; P8, 256; V1, 277; P4, 249; P3) and one specifically related this to the question of whether one can want a child and still be violent: “I think if Steve was brought up in a very violent family and there was still love there then the two can exist side by side” (P4, 249-250). Other participants focused on issues of poverty (P9, 216; P5, 223), employment (V3, 126), and lack of social support (NV4, 402). Other situational factors of a social-psychological nature such as stress response and external pressures, such as work-pressure were also mentioned (NV2, 333; P4, 272). These explanations appear consistent with what is known from the literature on partner violence (Straus, Gelles, & Steinmetz, 1980).

Interestingly co-existing alongside these social explanations was a host of economic or educational assumptions about Steve and Ann, this despite the fact that any such indicators were removed from the vignettes. Thus he was described as not “particularly well educated” (P5, 374), had challenged intelligence (V3, 153) and was ‘not bright’ (P4, 277), although in this last case there was recognition that violence could occur with men of all levels of intelligence (P4, 277). Steve was also regarded as working class “I have this picture of them being both working class” (NV4, 427; P3, 323). Another participant noted that “I immediately assumed they were poor and in
financial hardship, but actually it could be that he is a city slicker” (NV5, 225) There were also some more worrying assumptions or biases expressed, if not about Steve, then about cultures of violence: “I suppose I had in mind working class Irish drinking” (P5, 388). Another stated that “you can get any class of people that do that and I could be really nasty and say council house type of people, that sort of mentality” (V4 93-95).

Another speaking from his own experience noted that:

the kind of working class culture that I come from, men are kind of assertive, aggressive, dominant partners in the relationship and that's what they do to their women, push and shove them around, that's the way you kind of control what they do. 'Knock some sense into them' I've heard said on a few occasions, that's one possibility. It's horrible isn't it? (P2, 189-194)

5.6 Relationship based Explanations

The final body of explanation relates to Steve's relationship with Ann. Reference has already been made to Ann's perceived role in compounding the violence, but a number of men also hypothesised that she was in some way directly contributing to the violence. Thus Ann was variously described as “provocative” (NV1, 502; NV2, 305, V1, 369) as being “unreasonable” (P6, 339) and as “sparking something off in him” (P2, 197). One participant noted: “when she got pregnant he probably thought she was fat and lazy. Didn't do enough around the house and probably made him even more angrier than he was” (V4, 88-90). The participants explicitly stated that such explanations did not condone or excuse the use of violence, although one participant noted that:

I mean one can't condone that (violence) but I suppose is she having an affair, is there any indication from her basically that anything happened that she's done, perhaps she's unreasonable, perhaps there are explanations and there's me carrying on at Steve even though to hit a woman, shoving I think, shoving is alright, I know I've shoved partners before, you know not horrendously so” (P6, 336-342).

This assertion is a good example of a 'quasi-repudiation' in that the participant is recognising the use of a certain type of violence while at the same time 'minimizing
it’. He is also providing a level of justification for the use of violence. Moreover, this respondent when asked whether he had been violent as an adult had answered ‘no’ thereby repudiating the use of violence all together. This extract thus exemplifies what Hearn (1998) calls a composite or contradictory account of violence.

Some of the uncompromising language used by the participants about Ann, could be said to reflect or even surpass that used for Steve. Thus Ann was referred to as a "complete bitch" (P6, 334) and “a complete loon herself...is she throwing milk bottles at him first thing in the morning and he’s hit her basically to defend himself, I’d need to know that” (NV3, 452, 460). This last comment reflects the reciprocal exchange theory of violence (Gelles, 1997) and was mentioned by a number of the other participants as a possible explanation for the violence.

5.7 Summary

The explanations of what was occurring between Steve and Ann were consistent with the literature on partner violence more generally. Looking at the accounts of men’s own experiences of incipient fatherhood and the ‘problematics of pregnancy’, three major themes were identified: (i) the dominance of the pregnancy; (ii) feelings of exclusion and (iii) learning to cope with one’s partner’s changing moods. Explanations for Steve’s behaviour that can be hypothesized as pregnancy specific were feelings of exclusion, denial of the female object and changes in Ann’s moods.

What can be said about these three explanations in relation to pregnancy? In terms of feelings of exclusion, manifested as jealousy explanations highlighted views that pregnancy can heighten or actually instil these feelings in some men (Campbell et al., 1993). These explanations focused on women becoming the centre of attention when pregnant, a situation highlighted in the literature.

As can be seen from men’s own accounts of their partner’s pregnancy, emotional and behavioural changes were frequently mentioned. The dominant model to explain this was quasi-medical and focused on hormonal changes in the women. In the case of Steve and Ann there were suggestions that Ann was being unreasonable, provocative
or “fat and lazy”. It is not clear whether any of the participants were suggesting this as sufficient to explain Steve’s violence. However, in men’s own accounts of fatherhood such experiences did not lead to violence and this may well relate to the fact that the men had some frame of reference by which to explain the changes that were occurring in their partner. It is not known whether the explanations given by participants for Steve included any such understanding. Certainly none of the participants referred to it explicitly. However the assumptions that men made about Steve in terms of his communication abilities and levels of education could possibly indicate an assumed lack in his understanding of the relation between behavioural and emotional changes during pregnancy and reasons for this.

The third area that was mentioned was ‘denial of the female object’, which although involving jealousy was seen as much broader, and including factors such as “attractiveness” and “taking care of oneself”. Participants’ own accounts of their partners’ pregnancy reported relatively unproblematic sexual relations, although some were clearly relieved when the pregnancy was over. Where sex between partners stopped this appears to have been talked about and negotiated. In Steve’s case there was no reference to this.

The case of Steve and Ann far more than the two which follow is one in which the violence does not appear pregnancy specific. The explanations given are those that appear most closely related to the pregnancy and although not sufficient to cause it may well exacerbate such partner violence.
6.1 Male Partner Violence that Onsets Before but Discontinues During Pregnancy

In the second case participants were asked to comment on a situation in which a man who had been violent to his partner prior to the pregnancy stops during the pregnancy (See page 42).

6.2 Emotional Reactions to Peter and Dawn

Men's reactions to Peter were on the whole more favourable than towards Steve and Ann and ranged from the extremely positive - "he’s basically a good guy with a quick temper" (NV5, 288) - to the negative "What a shit" (P2, 154). One respondent stated that it was "good, but not good enough" (P3, 312) and another that "he’s a bit of a bastard to hit her in the first place, but hasn’t like given her the beatings that some do" (V1, 367-8). Another of the respondents viewed Peter’s behaviour in relation to Steve: "Steve doesn’t seem to have any idea about anything to be honest, whether she’s pregnant or not ‘I’ll slap my girl around’. At least this bloke is more sort of ‘I’ll hit her when she’s not pregnant, but I’ll stop when she is’" (V3, 191).

This way of judging Peter was to emerge in other men’s accounts, although a number of men acknowledged the absurdity of praising Peter because he was no longer hitting Dawn: “quite strange really thinking it’s more positive because he’s not violent towards his partner” (P6, 421).

Interestingly, and in clear contrast to the first vignette, there was very little condemnation of Dawn, although one respondent stated “what is she doing with someone who is physically violent towards her. It’s ridiculous” (NV3, 463-4). It is perhaps surprising that this was the only negative comment towards Dawn given that the vignette says nothing about expectations of the violence stopping. Perhaps part of the answer lies in the fact that far fewer queries were raised about whether Peter genuinely wanted a baby in the first place, thereby tapping into the assumption that if
you want a baby you are less likely to be violent to your pregnant partner. However, although no respondent directly disputed Peter’s wish to have a baby, a number of respondents found the scenario difficult to accept, noting that: “I find it very difficult to believe that he would continue not to be violent” (V4, 115), and “it doesn’t really ring true to me somehow” (P8, 324). The same respondent went on to state: “I mean if it was true, what would it say about him?” (P8, 325).

In fact, four main explanations for Peter’s behaviour could be discerned. The first suggested that Peter’s feelings towards Dawn had changed positively as a result of the pregnancy. The second, that Peter was genuinely concerned for the welfare of his baby but without any deep-rooted change in his feelings towards Dawn. The third suggested that Peter’s emotions had not changed at all and there was some external reason for him stopping his violence. This final explanation focused on cultural and moral constraints for Peter’s changed behaviour.

6.3 Feelings Changed Positively as a Result of the Pregnancy

It's either that he came to his senses when she got pregnant because I mean it's something amazing and I would imagine he saw Dawn in a new way and the relationship in a new way when she got pregnant (NV5, 268-9)

From this perspective Peter’s changed behaviour occurred because of a change in his emotions towards Dawn whom he appraised more positively as a result of her pregnancy. There was no suggestion that Peter was either indifferent or negative about the pregnancy.

The explanations given for this tended to reflect men’s own experiences, thus Peter was referred to as “more responsible and reflective” (P5, 407) (V3, 180), more “sincere” (P5, 405), and less “jealous/insecure” (NV1, 636). Another spoke about “elation sustaining him” (P1, 236) and that “he’s providing the cure by being an expectant father” (P1, 253-54). This all tapped into what fatherhood meant for the men interviewed, or what can be termed ‘the normal assumptions of fatherhood.’ On the basis of such assumptions the partner is regarded positively, not through
egotistical reasons or over concern for the child, but simply because both are central to the lives of the men.

### 6.4 Concern for the Welfare of the Child

A number of respondents stressed change coming from Peter's concern for the unborn child. While this was seen as of some value in and of itself, a number of the men were both dismayed at what this said about Peter as a person and about what would happen to Dawn once the pregnancy was over.

One respondent spoke of Peter as "selfish" and that he "doesn't want his baby hurt" (NV3, 468). This was viewed in terms of protecting his own biological interest in that "he doesn't want the baby damaged because his sort of natural interest to replicate oneself or reproduce to keep the family line going" (NV3, 484). Others found a degree of reprehensible functionality and control in Peter's behaviour through his ability to stop being violent during the period of pregnancy (P2, 278; P5, 411). A few respondents made the point that although Peter may no longer be being violent towards Dawn, he may still be acting negatively towards her (P6, 426). This highlights the necessity of having good operational definitions of the behaviour under consideration.

Many of the respondents painted a very bleak picture for the future in this case and spoke of Peter "storing it up" (NV1, 651) and his "pent up aggression" (P5, 436). One person went as far as to state that "I bet he can't wait for those nine months to end...He might think I've got nine months bottled up" (V3, 192-4). Others focused on the period of pregnancy being a "window of opportunity" in which to sort out whatever had been causing the violence in the first place (NV2, 437).

These first two explanations that Peter had genuinely changed, and that he was simply holding back for fear of hurting his unborn child were suggested as equally plausible by the participants. Although the birth was seen as critical in determining which of these two explanations was correct, this is probably too simple and ignores the emergence of new and perhaps even more overwhelming dynamics post-birth (Towne & Afterman, 1955; Kraemer, 1994).
6.5 External Factors.

External factors did not play a large part in terms of the explanations given. In fact only three explanations were given: that Peter had stopped drinking (P6, 407), that Dawn had modified her behaviour (NV1, 623) by changing the way “she behaves towards him” (P2, 269) and that she could be telling people about the violence, thereby putting pressure on Peter to stop (V2, 356). Interestingly, given what the men said about their own experiences of fatherhood and its problematics, only one respondent spoke about the tensions and stresses of pregnancy (P5, 421).

6.6 Moral or Cultural Constraints

If external factors were seen to play a small part in Peter’s changed behaviour, moral or cultural constraints figured largely. Some of the respondents focused on purely internal ethical considerations; others focused on external cultural or sub-cultural constraints; some on a combination of the two. One respondent noted “He’s stopped because she’s pregnant, because in his rule book that’s just unacceptable, so it’s a moral decision, it’s not an emotional decision” (NV4 496). This internal moral voice or superego ideal was acknowledged by one of the professionals interviewed:

Well it would be a bit like you know, you’re not allowed to murder someone it’s just something you just feel you can’t do, but you might feel like really murdering someone, but you know you can’t, so it could actually make you feel really terrible inside. You know if it’s just come along as a real absolute moral absolute you know I suppose he’s been you can’t hit a pregnant woman, you just can’t do it, so it’s not something that’s really internal to him that he’s thought through and felt but it’s just like an absolute that’s like stopping him then he could have a lot of internal conflict (P5, 437-440).

Another respondent spoke directly about Peter’s ‘moral decision’ in terms of unconscious motivations:

*I think it tells me that he is inclined to excuse his own behaviour in certain sort of reasons and is quite moralistic and allows himself to do things in certain situations, if certain conditions apply, but will stop himself from behaving badly if he feels that he’s stepped outside those conditions and possibly feels in a sense that he’s been quite principled because he is behaving within sort of boundaries, perhaps he’s letting himself believe that*
because he's behaving that way, he's actually quite self-controlled, but in a sense that there's a lie he's giving himself just to help himself cope with the fact that he's doing something which he subconsciously feels is unacceptable but to him there is no other way of dealing with whatever it is that makes him want to hit out. (NV4, 485-495).

Another respondent spoke of Peter having a bit of a "conscience" whereby he could "construct a situation where in his world, it's fair game to hit a woman and push and shove her if she's not a mother, but somehow the idea of hitting her if she's a mother fills him with revulsion and he can't do that anymore" (NV4, 473).

Another respondent widened this individual concept of morality to include not only the individual's own belief systems but what others thought as well and noted that "maybe from a moral sense he doesn't want the stigma attached to it." (NV5, 276).

He went on to state that "I think it's probably fairly standard street level moral code is you don't hit pregnant women...Sometimes the moral code they've got is strong enough to drag them back up so that they stop hitting, but more often than not the moral code slips" (NV5, 277, 282). Another spoke about the fact that it "could be viewed by peer pressure that hitting your wife is acceptable, hitting someone who is pregnant is a complete no no" (NV3, 488). Interestingly another respondent with a history of football related violence and who could be said to have been reasonably well immersed in a sub-culture of violence noted that:

You don't hear people talking about it, you don't hear the bloke in the pub going 'I gave my wife a good smack last night, you don't hear people at work going 'my Mrs. was pissing me off last night so I gave her a bit of a clump like you know, slapped her and pushed her down in the chair and told her to shut the fuck up' or whatever, you don't. It's not spoken about, it's not something a man can say to another man and think 'I'm one of the lads' because I would say 90% of the lads are going to have 'you bastard' look about them so it's not, it's nothing that a man is going to be proud of. (V1, 438-441)

Two respondents focused in on what it was about hitting a pregnant woman that was particularly problematic.

There is this sort of taboo about the vulnerability of pregnant women...you must look after them, you must protect them more than a new born baby, almost because it is an unborn baby, so both of them have this image really that you mustn't a) a taboo about hitting a woman and even more taboo is to hit a pregnant woman because of what they epitomize rather like a 'sacred
*cow* if I can use that expression, so perhaps he's got that, perhaps in some ways, *a lot of violent men also have principles* "I only hit my woman" in some form of perverse logic "when they're not pregnant" (P6, 249)

Another focused on the notion of what he called ‘male mythology’. What is interesting about this quotation is the way in which the respondent uses a form of ‘nominalization’ through the term “it’s just about all right” when talking about the violence:

*There's something also about male mythology in this, it's just about all right to push and shove your partner and belt her occasionally if she needs to be controlled, but belting a pregnant woman that's a terrible crime isn't it* (P2, 286).

Hearn (1994, p.14) in defining ‘minimization’ notes: “this can refer to the minimization of definition, extent, frequency, and effects. One of the most important examples of this is nominalization (Trew, 1979): the reduction of complex violent actions to a word, a name. Another is the use of the small word “just.”

The same respondent notes later that Peter probably listens to authority (NV4, 514) possibly suggesting a powerful constraining superego. However only one respondent focused specifically on the consequences of Peter’s behaviour “Is he thinking she's pregnant and I won't hit her because I don't want anything to go wrong or I don't want to get in trouble?” (NV2, 397).

### 6.7 Summary

Again one needs to ask how these explanations relate to male violence during pregnancy? This vignette, unlike the first, focuses on those factors that inhibit violence towards a pregnant partner. Four key inhibitors were identified: (i) A positive change in Peter’s feelings towards Dawn; (ii) Peter’s genuine concern for the unborn baby without any deep-rooted change in his feelings towards Dawn; (iii) that Peter’s emotions had not changed at all and an external reason for the violence stopping and (iv) cultural and moral constraints on Peter continuing his violent behaviour.
From the narrative accounts given by the participants of their own experiences of being an expectant father inhibitors (i) and (ii) appear crucial. Participants’ relationships with their partners were on the whole extended as a result of the pregnancy and in some men transformed. There was also clear concern articulated for the unborn child, although not to the exclusion of the partner. External factors played a small part in the explanations given as to why the violence stopped in this vignette, and cannot be seen as relevant to the behaviour of the participants in this study as there was no reported violence to inhibit. The fourth area, that of moral and cultural constraints, although not referred to by the participants in their own experiences, does have some relationship to the category of belief systems previously discussed.
Chapter 7. Male Partner Violence that Onsets During Pregnancy

The third scenario which respondents were asked to comment on involved a situation in which there was violence during the pregnancy, but none before (See page 42).

7.1 Responses to Simon and Theresa

Respondents’ reactions to this vignette included “surprise” (P9, 258), “dismay” (P6, 282) and “shock” (V1, 476). One respondent was more uncompromising and stated “Simon was a wanker and he couldn’t think of anything lower” (V3, 216). Yet despite these comments, overall responses to Simon were generally favourable. Thus, three respondents spoke about the situation being “sad” (V4, 165; NV1, 682; NV2, 525) while others spoke about feelings of “compassion” (V4, 173), feeling sorry for him (NV4, 560) and feeling sorry for someone who did that (NV3, 576). Other comments focused on Simon’s own sense of what was happening and respondents noted that “he doesn’t know what’s going on” (P5, 491), that “he wasn’t proud of it” (V1, 503) and that it was “something that he doesn’t understand himself” (NV4, 527).

Well, I feel sort of sorry for Simon in a way because he seems to be a sensitive type for some reason, I guess because I feel he’s been holding in his frustration, because he doesn’t want to hurt other people, he intentionally wants to protect them almost from all of this anger he sees inside himself and then to be unable to control himself and feel almost totally confused and very very blaming himself and feeling dreadful about what he’s done, almost sort of helpless victim of a rather uncompromising situation, an almost innocent bystander being clobbered over the head by something that he didn’t expect and came completely out of the blue and Teresa the same really. (NV4, 560-569)

There were very few comments made about Theresa, although again some of the respondents focused in on Theresa’s responsibilities to do something about the relationship (NV2, 529): “It’s very sad that they are in a relationship that he’s hitting her and she’s not got out of that relationship in terms of physically removing her presence somewhere else, given that she needs to protect her child” (NV1, 682-85).

There was a general sense that Theresa would be shocked by Simon’s change in behaviour (NV4, 567; P4, 354).
What then were the explanations given for Simon's behaviour? A number of themes emerged from the data and they can be categorised into five main areas: (i) regrets and doubts; (ii) jealousy, envy and other emotions; (iii) sexual access and attraction; (iv) behavioural changes in Theresa and (v) external changes.

7.2 Regrets and Doubts

As with the previous two vignettes there were those who disputed whether Simon really wanted a child (P9, 264; V3, 217; P8, 354; NV2, 476). Such comments were articulated in terms of regrets and doubt (V1, 504; P3, 375) arising as a result of the pregnancy and respondents did not dispute Simon's initial intentions or desire to be a father. One respondent spoke about Simon's ambivalence towards the pregnancy (P5, 506) and others about the way that the pregnancy hadn't lived up to the fantasy that Simon had held for it. Thus one noted that "maybe there's something about the experience of being a father to be, doesn't match up to his fantasies, he had a kind of romantic fantasy about what was going to happen and somehow that hasn't materialized" (P2, 334-337). This notion of having children as romantic was also noted by another participant (NV2, 473). One respondent spoke about the connection between fantasy and jealousy:

Well the first thought that came to me is that the wish is not the same as the thing, it's different. By that I mean there is a lot of fantasy around. In fact in all three of these cases this is something that comes into mind. There is a lot a phantasy around pregnancy. I suppose that is why we have phantom pregnancies. But there's a lot of phantasy because they have actually got a third person there but they are not visible so can project onto that phantasy all sorts of different things. You may have this huge wish fulfillment which is what drives us to have children, you know biological, psychological, emotional. But I mean basically it's biological and all the phantasy around won't it be brilliant, fantastic when you get pregnant, when we have this new baby you know. The world projects it on to you that's how you want to feel anyway. When she gets pregnant the reality is different and whatever's been latent somehow becomes actualised and here he is beating her up. I think we touched on it a couple of times what we were talking before, it could be jealousy (P4, 336-345).
7.3 Jealousy, Envy and Other Emotions

Jealousy and to a lesser extent envy played a very large part in the explanations that participants gave for what was going on. A number of respondents mentioned the emotions of jealousy (V2, 361; NV3, 573; P1, 305; P4, 346; V4, 158; V3, 222) and envy (P9, 265; P2, 344) by name, while many more spoke about feelings of exclusion (V4, 146; P2, 331; P8, 359; NV2, 452), of being usurped (NV5, 321), of being pushed away and feeling rejected (P6, 401; NV2, 369), of the competition (P6, 396) and of resentment (NV2, 448; V4, 148). Two respondents made some connection between these emotions and violence. Thus, one respondent spoke about rivalry in the context of the Oedipal conflict (P5, 523) and another about Simon’s resentment and wish to destroy the baby (NV5, 323). Generally however, explanations went unstated and participants spoke of jealousy and envy as if they were sufficient to cause or explain the violence. This is in line with the research by Campbell et al. (1993) which assumed a relatively unproblematic relationship between jealousy and violence. At one level this is not entirely unwarranted as jealousy can be defined as a “protective reaction to a perceived threat to a valued relationship or its quality” (Clanton & Kosins, 1991, p.40), and violence and aggression are often used as a response to such a threat (Storr, 1968). However, the literature would indicate that violence is not the automatic outcome of feelings of jealousy (Hill & Davis, 2000). A small number of participants did however look beyond the descriptive category of jealousy to explain its relationship to violence. Thus the participant who spoke about the Oedipal myth focused on the child as a threat “the child threatening, making him realize that he is getting old, that he is going to die and take over” (P5, 523-24). This is of course a slightly different emphasis to that proposed by Freud (1981) in which it is the child’s initial destructive impulses that are at the fore and not the father’s. In a similar vein to the urge of destruction, another participant stated “it could be a deeper thing, where he starts really resenting the baby and therefore wanting to destroy it” (P5, 323).

Another respondent spoke about Simon’s violence as way of gaining attention: “that’s how he gets attention now or maybe he is not getting any attention at all at the moment, by being violent to his pregnant wife he is getting loads of attention” (P8, 379-80). The same respondent spoke about the violence as a way of reclaiming lost power: “maybe it’s a control thing. Perhaps he’s got no control over her now and he
doesn’t like it, it feels threatening” (P8,362-63). This was echoed by another respondent: “he’s proving something by his violence to himself, exerting power perhaps” (P5,546-7). Thus, although there was a level of explanation given, jealousy tended to remain a powerful internal emotion that mysteriously brought about the dramatic consequence of violence within the relationship.

Whereas the jealousy response was clearly directed towards the third person and of a negative character, there were a number of other suggested internal emotional states that were less easy to categorize. Thus one respondent focused on unspecified anger as a cause and noted that:

In some way it’s making him angry, I guess he’s ambivalent, he wants her to be pregnant, he wants to have children, but there’s something about Teresa being pregnant that is related to him being angry, being angry to the extent that he wants to hit her and it’s to do with the pregnancy or otherwise something else’s changed around the same time as the pregnancy, but I think it’s to do with the pregnancy, on the one hand he wants to have a baby with her, but for some reason the whole process is making him angry and feel kind of quite mixed up and I imagine quite puzzled, especially by his own responses to it. (P2, 368-377)

Another respondent echoed this and noted that the pregnancy was “touching a raw nerve” (NV4, 526):

Perhaps now being pregnant, now the pressure is on and demands being made. It pushes him up against a hard wall that he finds he can’t seem to escape from, his difficulties seem to be touching a raw nerve and making him prone to lash out. I feel actually I don’t know but there’s a sense that both Steve and Ann and Simon and Theresa that their desire to hit and push comes from something that they in themselves don’t understand that they just have this overwhelming urge to hit and push and emotional response without any apparent reason, though triggered by something, the thing that triggers it seems possibly trivial and not necessarily warrants that happening. (NV4, 522-533)

The proposition that Simon was in some ways afraid was also mentioned by a number of respondents (V4, 160; P1, 277; NV2; 457; NV3, 572). Two respondents mentioned specific anxieties and concerns over fathering abilities (P1, P9 266). Tension release
and the removal of stress were also cited as potential explanations for the violence breaking through, although these were not explored in any great depth.

7.4 Sexual Access and Attraction

In contrast to the two previous cases issues of sexual access and sexual attraction loomed large in participants' explanations for the violence.

The connection between sex and violence was brought out clearly by one respondent who stated: "if he's not having sex with her then that might be something he resents...I suppose there are things to do with manliness, if she is not interested in having sex he might at some level fear that he is emasculated and maybe hitting her is a way of showing her he's not" (P5, 550-552). Another respondent talked about the relationship between restricted access and resentment towards Theresa (P6, 423) and between physical changes and resentment (NV2, 448). A number of respondents also spoke about the issue of attractiveness - "he feels she's not so attractive any more" (NV1, 714) - and physical changes in Theresa and "not being able to bear the changes in her body" (P6, 413). As one respondent stated: "maybe because she has got bigger, she has become less attractive for him" (P8, 358).

One respondent also broadened the issues of attraction out considerably to include material on recognising something animalistic in the experience of pregnancy:

There's something about pregnant women that I think does change, it changes one's image of them, you know you can go to these ante natal classes about breast feeding and stuff and they become less these you know sexy objects of desire and more milk machines or animals, and that could be an element. I'm just wondering whether that is possible that you know maybe she was before a dainty feminine object of desire perhaps you know she has become more of an animal, so less worthy of special respect. I don't know. There is definitely something about that in pregnancy... there is something to do with society 20th or 21st century society where we pretend we are not animals you know, dress up and cosmetics and all this stuff and this whole process reminds us that we are animals and we are subject to being you know, subject to all sorts of disfigurations during pregnancy and you know women can actually change, they can, you know they can start to belch when they didn't before and just be less ladylike and so I don't know. I suppose the whole thing around that is his image, his image of Theresa has changed, how he has constructed her, how he sees her, what he is allowed to do to her may have changed because of this,
because of pregnancy. That is one type of explanation I suppose (P5, 510-522).

7.5 Behavioural Changes in Theresa

This question of whether Theresa’s behaviour had changed was explored by a number of respondents. Some of these have already been discussed in terms of Simon’s jealous response, particularly in terms of being pushed away. There is however another group of responses which focused more on the changes in Theresa as a direct result of the pregnancy “Looking from the other side at Theresa, whether she’s doing anything to create this situation...it might be that Theresa has changed as a result of becoming pregnant, knowing the first few months of pregnancy a woman can feel very tired and sick and whatever else, maybe she’s just taken herself off and not been very communicative” (NV2, 481-84). Another noted that “it could be the stress and strains of pregnancy in terms of her own sort of moods, hormones, that she could have been someone who could have become violent herself and have big mood swings, it could be that she has become very emotionally dependent upon him and he’s finding it difficult to cope” (NV1, 704-708). Another participant spoke about the change in terms of an increased reliance on Simon “she may be a shit...she may have suddenly become bad tempered and feel sick and horrible...it may be that he relies on her to be his major carer...she’s feeling shit because of being pregnant and doesn’t do the things she used to do” (P2, 352-357). Another respondent focused specifically on the potential mood changes in Theresa:

Maybe she’s become so irrational, scatterbrained forgetful, she may be just driving him right up the wall. He may be sitting there as good as gold thinking ‘what the fuck’s she done that for, that isn’t my fault why is she having a go at me about that.’ He maybe very well being pushed to the limit and he’s never done it before and may be she is pushing him over the edge. (V1, 488-493)

7.6 External Changes

A few participants’ focused on external changes that may have been consequent to or coincidental with the pregnancy. Financial changes and a change in employment status were cited as potential explanations. One participant mentioned increased tension with in-laws, while two participants focused on changes in the couple’s social
life. On the whole though there were very few comments made about such external changes and none of the respondents put them forward as major causes or possibilities.

7.7 Discussion

A number of interesting points emerged when talking to men about this final case, in particular: (i) a noticeable degree of compassion for Simon; (ii) an emphasis on the role of jealousy; (iii) issues of sexual access and attractiveness and (iv) possible behavioural changes in Theresa.

Before looking at these it is worth exploring what it was about this case study that appeared to make the majority of men more understanding of Simon than in the previous two cases. One possibility is that this vignette is closer to the men’s own potential experiences than the other two and that they can understand something of the situation in which Simon found himself. This is possibly the case in terms of respondent NF4 who was currently seeing a psychologist for problems with anger and who reported feelings of being trapped and an inability to express his needs.

In contrast, comparisons with Steve made by some of the respondents indicated that they found this case “worse” (V1, 547; P3, 384; NV2, 534).

That’s the worst of the three. It’s got the potential of going on. There’s more potential of him hitting the kid. Yeah I know it sounds stupid, but fair enough he’s hit her all along. I mean it sounds stupid but they are both used to it. Ann and Steve are both used to it, it’s probably something that they had in their relationship throughout, but Ann has got a niggling doubt whether he’ll hit the kid, but Theresa has got more than a niggling doubt that he’ll hit the kid, because even though he’s hit Ann all the time she’s took it and they’ve both decided that they wanted a kid then it’s something they’ve decided even in that situation. These two haven’t had that situation and both decided they wanted a kid and now the situation has arisen since. (V1, 547-557)

Two respondents stated that this case was more worrying than the first and then reframed this in terms of it being more shocking (NV1, 698; V3, 249).
This is more worrying than the first, no that's a contradiction, more shocking both as worrying because they are both doing the same during pregnancy, but it seems less worrying, "poor woman she's had a right battering and you're used to it love". (V3, 249-52)

My general line is that it is equally as worrying whatever the history might be, but obviously for Theresa it's very worrying, because obviously he wasn't violent before, but now is in that relationship which makes you wonder about his commitment to her and the child, which makes you really wonder about the future of their relationship and the other one in some way there's some sort of perverse logic to say "used to hit me, hits me now, hit me in the future and that's the way of the world" but for this in some form it's worse because the woman knows that he was perfectly OK with me before and now I've got this child inside of me when he should be loving me more is actually violent towards me. So in some ways it is more shocking because there is no history of it. (NV1, 693-703).

One respondent spoke of this case as being more serious, "because this is a change in this guy's behaviour" (P2, 393) and another that it was the stronger because "it's like saying it's because she's pregnant, which is what it is saying. Where as the other guy is doing it all the time. None of them are saints are they... it sickens me to be honest, but in this case something should definitely be done about it, this is the stronger" (V3, 229-234). This idea that it is the change in behaviour that is of most concern and not the behaviour itself was summed up very aptly by the same respondent who went on to note that:

After reading about this guy it makes it more clearer how dangerous it is for the first one funnily enough. Because he's hitting her all the way through you sort of expect it. You expect fish and chips on a Friday night, so it's the norm and because this is only happening it makes you think about this guy again. (V3, 264-169).

There was a clear emphasis on jealousy as a factor in the men's explanations. While the explicit connection between feelings of exclusion and being violent was not always drawn, the interconnection between the emotional response and the behavioural consequence was not disputed. This is in line with research (Noel & Yam, 1992; Campbell et al. 1993) and raises the question of what is occurring when
jealousy leads to violence. Thus, an interesting question that needs to be addressed is whether the jealousy response is the same in all men and its behavioural expression is somehow inhibited in certain men or whether the actual emotional response is different. Given that pregnancy is a time in which there is increased attention given towards the mother this raises the likelihood of feelings of exclusion arising. From the men's own accounts of expectant fatherhood jealousy tends to be discussed by health professionals only in the context of the child actually being born.

Issues of sexual frustration were one of the five explanations for male violence during pregnancy proposed by Gelles (1975). In the explanations given for Simon's behaviour issues of sexual access and sexual attraction played a large part. This theme had emerged, in the discussion of Steve and Ann, and had been termed "denial of the female object" by one of the respondents. While such issues were mentioned by a number of the respondents when talking about their own experiences as expectant fathers, these were reported as 'negotiated transitions.' In other words there was some form of open discussion about sexual access between partners, although not necessarily of sexual attraction. In men's explanations of Simon and Theresa there was no sense of negotiation, simply one of Simon being 'emasculated'.

The final body of explanation again fitted Gelles' (1975) original hypotheses on biochemical changes in the partner's body. Men's own experiences as fathers highlighted this as a major theme and it appears to hold a great deal of power in that it combines elements of both cultural folklore and medical fact about what happens to women during pregnancy. Although none of the men interviewed had assaulted their partner during pregnancy, men did speak about the need to be "ultra-accommodating", having an "open-book policy" and needing to "bend otherwise you clash". In the descriptions of Simon no such changes took place and it is possible to see how many of the respondents made the connection between such moods and violence. Where respondents suggested that Theresa was behaving like a "shit...she may have suddenly become bad tempered" this was seen as sufficient to explain the violence. Within men's own experiences, the respondent who commented that "it took me a long time to get used to the fact that she was basically entitled to sort of behave badly and lose herself completely and get annoyed and get ratty with me" thus stands out as something of an exception.
In this final vignette the issue of violence first emerging during pregnancy has been explored. Three main bodies of explanation were given i) an emphasis on the role of jealousy; (ii) issues of sexual access and attraction and (iii) possible behavioural changes in Theresa. There was also a noticeable degree of compassion for Simon present.
Chapter 8. Theory Building and Theory Elaboration

8.1 Theory Building

The aim of this study was to begin the process of theory development for male violence during pregnancy. One of the noteworthy features that emerged from the review of the literature on pregnancy and violence was a complete absence of the male perspective. Of equal importance was the issue of whether ‘patterns of violence change during pregnancy’ (Gazmararian et al 1996, p.1919). The literature indicated that there were indeed different responses to violence during pregnancy, with some men continuing or escalating their violence, others inhibiting it and a third group starting it (Campbell, et al., 1992; Campbell, et al.,1993; Campbell, et al.,1995; Helton, et al., 1987; Stewart & Cecutti, 1993). This study attempted to explore these three issues by talking to fathers about violence during pregnancy and by using vignettes that broadly met the patterns of violence suggested by Gazmararian et al (1996).

Grounded theory aims to build theory from multiple sources and in this concluding chapter an attempt will be made to draw together data on men's experiences as expectant fathers, their responses to the vignettes and the literature on male violence during pregnancy. Methodological weaknesses of this present study will also be discussed along with the clinical implications of the research.

Table 8.1 summarizes the main explanations or theoretical accounts put forward in this research alongside those provided by Gelles (1975) and Campbell, et al., (1993).
## Table 8.1 Theoretical Accounts for Violence During Pregnancy

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Data Source</th>
<th>Explanation or Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant Fatherhood</td>
<td>Interview data</td>
<td>• Dominance of the pregnancy</td>
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<tr>
<td></td>
<td></td>
<td>• Feelings of exclusion</td>
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<tr>
<td></td>
<td></td>
<td>• Coping with partner’s changing moods</td>
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<tr>
<td>Violence Before and During Pregnancy</td>
<td>Vignette 1</td>
<td>• Jealousy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unreasonableness of partner</td>
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<tr>
<td></td>
<td></td>
<td>• ‘Denial of the female object.’</td>
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<tr>
<td>Violence Before but not During Pregnancy</td>
<td>Vignette 2</td>
<td>• Positive change in feelings to the partner</td>
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<tr>
<td></td>
<td></td>
<td>• Concern for the welfare of the unborn child</td>
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<tr>
<td></td>
<td></td>
<td>• External factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cultural and moral constraints</td>
</tr>
<tr>
<td>Violence During but not Before Pregnancy</td>
<td>Vignette 3</td>
<td>• Jealousy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sexual access and attractiveness</td>
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<tr>
<td></td>
<td></td>
<td>• Behavioural changes in partner.</td>
</tr>
<tr>
<td>Violence During Pregnancy (Pattern Unspecified)</td>
<td>Gelles, (1975)</td>
<td>• Sexual frustration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family transition, stress and strain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bio-chemical changes in the partner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-natal child abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Defencelessness of the wife.</td>
</tr>
<tr>
<td>Violence During Pregnancy (Pattern Unspecified)</td>
<td>Campbell Faan &amp; Bullock, (1993)</td>
<td>• Jealousy of the unborn child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Anger towards the unborn child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pregnancy-specific violence</td>
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<tr>
<td></td>
<td></td>
<td>• ‘Business as usual.’</td>
</tr>
</tbody>
</table>

These explanations provide information both about potential inhibitors as well as disinhibitors for violence during pregnancy. What then were those factors that can be viewed as more likely to inhibit violence towards the pregnant partner? Data emerges from two sources. Firstly there is the experience of the men themselves and what they did to cope with the problematics of their partner’s pregnancy. Although
the men interviewed reported a number of difficulties during their own partner's pregnancy, there was never any intimation that violence had either been used or considered. The main inhibiting factor that appeared from the interview data was an unquestioning concern for the welfare of their unborn child. All of the respondents were child-centred and it may be this more than anything else that may have explained men's reaction to the vignettes. Moreover, the fact that there was a degree of understanding shown by the men for the last vignette, does give some credence to the fact that pregnancy is a stressful time for men and that there was an element of empathy for a man who first becomes violent during pregnancy. The other important factor was that the majority of fathers reported very sustaining and loving relationships with their partner, with relationships that for the most part involved a high level of inter-personal communication.

Secondly there are the interpretations respondents gave to vignette 2 ‘Peter and Dawn’ in which violence was inhibited during the pregnancy period. The explanation given by the men prioritised two explanations, 'positive change in feelings to the partner' and 'concern for the welfare of the unborn child.' The remaining two explanations, namely that there was some external reason for stopping or that cultural and moral constraints prevented the violence from continuing while theoretically interesting were proposed in a far more tentative way by the respondents.

In terms of disinhibiting factors, jealousy was formulated as important in three of the four theoretical explanations and issues of sexual access and attraction were similarly important in at least three of the four explanations (see page 253). Campbell et al. (1993, p.347) use the category 'pregnancy specific violence' to mean a desire for power and control and stated: “Pregnancy seemed to interfere with the woman performing roles and duties that the male partner saw as necessary. Rather than accommodating her pregnancy or negotiating alternate strategies for accomplishing tasks, the partner apparently thought he was justified in abusing the woman for not doing what he wanted her to do.” Although Campbell et al. do not mention sexual access in this regard it is possible that this could be included as a form of asserting power (Bergen, 1998). Frieze (1983) found that 78% of wives who had been raped attributed it to their husbands need to control them and assert their manhood. The third issue to be shared across the theoretical accounts was that of changes in the
partner, of them not doing what their partner wanted or behaving in some way unreasonably. Gelles (1975, p.83) notes that “the bio-chemical changes which women experience cause them to become more critical of their husband’s behaviour.” This was clearly echoed in the men’s own reports of their experiences in this study. Table 8.2 summarizes the nature of these shared theoretical explanations.

**Table 8.2 Explanations for Violence During Pregnancy**

<table>
<thead>
<tr>
<th>Pattern of Violence</th>
<th>Explanation 1</th>
<th>Explanation 2</th>
<th>Explanation 3</th>
<th>Additional Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence Before and During Pregnancy</td>
<td>Jealousy</td>
<td>Denial of the Female Object</td>
<td>Unreasonableness of Partner</td>
<td></td>
</tr>
<tr>
<td>Violence During but not Before Pregnancy</td>
<td>Jealousy</td>
<td>Issues of Sexual Access and Attraction</td>
<td>Behavioural Changes in Partner</td>
<td></td>
</tr>
</tbody>
</table>
| Unspecified (Campbell, Faan & Bullock, 1993) | Jealousy              | Pregnancy-Specific Violence not directed towards the unborn child | • Anger towards the unborn child  
• ‘Business as Usual’ |                                                  |
| Unspecified (Gelles Theory, 1975) | Sexual Frustration     | Bio-chemical Changes in the Partner | • Family Transition, Stress and Strain  
• Defencelessness of the wife  
• Pre-natal child abuse |                                                  |

On the face of it explanations 1,2, and 3 would appear to be strong contenders in explaining from a male perspective, male to female violence during pregnancy. Without knowledge of what has been termed the problematics of pregnancy this would indeed be the case. However, as has become clear, two of the areas - ‘jealousy’ and ‘partners’ changing moods’ - also emerged as part of the normal problematics of pregnancy in the sample of men interviewed for this study. For the most part these
two areas were not openly discussed between partners, but were resolved by the men themselves by putting their partner’s pregnancy in context. Respondents tended to be a highly knowledgeable group with the majority attending ante-natal classes and/or reading literature on what happened during pregnancy. It could be hypothesized that they were thus able to cognitively reappraise the situation that was occurring and normalize it. Equally important was the behavioural consequence of learning to cope with their partner’s mood in some way. This is extremely important because pregnancy is a time when issues of exclusion may arise, as Campbell et al. (1993, pp.346-7) note “during pregnancy, the jealousy is expressed as resentment of the attention the woman is paying toward the unborn child, a normal facet of pregnancy as it advances…Thus, a normal development of pregnancy becomes a risk factor for women.”

While issues of sexual access and sexual attraction have been placed together it is possible that they represent two different things. The issue of sexual access does appear to be related to male power and dominance and restrictions upon such access could be viewed as a taking away of men’s power. The violence that is then directed towards the pregnant partner is thus a means of reasserting male power both in the abuser’s own eyes and in the victim’s. If this is correct then male violence during pregnancy may serve the same function that rape does in intimate partner abuse (Peacock, 1998).

The issue of sexual attraction is slightly different and does not appear to have been discussed in the literature before. While it was touched upon in a small number of the interviews with the men it did not play a large part in any of the explanations. However, the issue of attractiveness is also potentially about male power and subservience to a male ideal of attractiveness. It thus may be important to examine how men make judgments about the attractiveness of their partner particularly during the period of pregnancy.

Thus there are a number of potential explanations that may play a part in male violence during pregnancy, these can be diagrammatically represented as follows (See Figure 8.2):
Clearly such a tentative model needs both further development and empirical testing and is probably best viewed as form of taxonomy development as opposed to “fully-fledged grounded theory” (Pidgeon & Henwood, 1997, p.266).

### 8.2 Methodological Considerations

In terms of methodological weaknesses of the current study there are a number of important areas that need discussing

It is important before doing this to reiterate the fundamental assumptions that lie behind grounded theory, namely that the results are intended as a meaningful interpretation of the participants’ own perspectives and the systematic discovery of theory from the data (Glaser & Strauss, 1967).
This focus on the systematic nature of grounded theory hopefully counters some of the many critiques of qualitative research which have been usefully summarised by Mays and Pope (1995, p. 109):

The most commonly heard criticisms are, firstly, that qualitative research is merely an assembly of anecdote and personal impressions, strongly subject to researcher bias; secondly, it is argued that qualitative research lacks reproducability—the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions; and, finally, qualitative research is criticised for lacking generalisability. It is said that qualitative methods tend to generate large amounts of detailed information about a small number of settings.

8.21 Use of Grounded Theory

The first point that needs to be made is the relatively unusual way in which grounded theory was used in this research study. Generally grounded theory is used to access the voice of individuals in a direct way, as in the research with gay and lesbian affirmative psychotherapy (Milton, 1999), lesbian experiences of clinical psychology services (Annesley & Coyle. 1998), and experiences of AIDS related bereavement among gay men (Wright & Coyle, 1996). In this research study men were not recruited because they had themselves been violent during pregnancy. Rather they were recruited on the basis that the lived experience of expectant fatherhood would throw light on violence in that sphere and/or because they had some knowledge of male violence. While the survey of secure units and contacts with prison services highlighted the difficulty of identification of men violent during pregnancy, it remains an important source of data. Notwithstanding the potential difficulties of identifying, recruiting and engaging with such men, further research should include their views as a matter of priority.

8.22 The Sample

The second point to make relates to the sample of men interviewed. All of the men interviewed were white British and marginally biased towards the educated and the employed. No very young fathers were included and this may have been an important factor in terms of men's abilities to communicate as they get older. The issue of selective and purposeful sampling within grounded theory is an attempt to circumvent such issues particularly when they are acknowledged during data collection. However,
Chapter 8 Theory Building and Theory Elaboration

the practicalities of seeking ethical approval militates against too much open-endedness. Ethical committees require both a clear specification of the research participants and a rationale for participant selection prior to the commencement of the research. This is particularly the case for clinical research. Intentional sampling within grounded theory while theoretically sustainable thus can create an impediment to responsible research. Interestingly this dilemma seems to have received very little attention in the literature.

8.23 Validity of Self-Reports
Thirdly the research assumed that participants' reports of not using violence were accurate. While the research did not intend to compare and contrast the views of men who had been violent and those that had not, the research did assume that violence during pregnancy did not occur. This was important in order for some distinction to be made between what has been termed the problematics of pregnancy in which there was a non-violent response and hypothetical situations in which such violence did occur.

8.24 The Use of Vignettes
The final point to make is about the use of the vignettes. Six men responded to the follow-up letter and commented that they found the vignettes broadly helpful, one describing them as a form of Rorschach inkblot and another as sufficiently open that he could role play them in his own head. From the researcher's perspective they functioned as a powerful tool for uncovering opinions and male assumptions. However, there is a danger in the use of such content free vignettes that men held disparate assumptions about the cases which were not always articulated. While some of these were articulated in terms of the economic and class position of Steve and Ann (vignette 1) it is likely that other assumptions while held remained unarticulated. Moreover there is an important distinction between the use of vignettes and real-life violence. While the comments provided by the men on the vignettes open up areas of exploration they are not based in the men's own experiences of violence. Rather they are grounded in men's own experiences of fatherhood and further exploration of their relevance to male violence during pregnancy is required.

8.25 Scope of the Study
8.25 Scope of the Study

Finally the inclusion of three different violence scenarios created a mass of rich data (Charme, 1995). Given that there was no previous research to work from this was undoubtedly a necessary first step and a useful means of gaining an overview of the study area. However, it may be useful in future research, to focus on one pattern of violence only. Moreover no distinction was made between violence continuing and violence escalating and in retrospect this may have been a helpful distinction to have made. As things stand however, vignette 1 provided an interesting source of comparison and acted as a sort of baseline of violence for some of the men. However, it could be argued that the inclusion of a case in which habitual violence intensified during pregnancy would have unearthed some more theoretical explanations.

8.3 Clinical Implications of the Research

Male violence during pregnancy remains a somewhat neglected area and no research could be found that had included a male perspective on the issue. While many sex offender and domestic violence programmes tend to operate on the basis that men’s abusive beliefs need to be articulated and challenged, violence during pregnancy remains an area in which we simply do not know what the beliefs and assumptions held by men are. This research has attempted to redress the balance by purposely talking to men about what it means to be an expectant father and to talk to them in some detail about different situations in which violence during pregnancy occurred. As a result there are a number of clinical implications that can be drawn from this research.

8.31 An Area in Need of Assessment?

Firstly it is would appear from initial contacts with 3 prison services that male violence during pregnancy is unlikely to be a prisoner’s index offence. While there may be a number of reasons for this, the fact that one service acknowledged that they did not ask about violence during pregnancy raised the question as to whether this was a more general phenomena. The survey of secure facilities would appear to lend some weight to this finding, with over 90% of responding professionals stating that they did not routinely assess men with a history of violence and a family or pregnant partner for violence during pregnancy. The interest expressed by clinicians in receiving a form were one to be developed suggests that there is scope for assessing men for
violence during pregnancy and this may be one practical way in which this research can be taken forward. While we do not know whether other agencies are routinely assessing certain men for violence during pregnancy, it would appear warranted with a current prevalence figure of 6% being found for violence during pregnancy (www.domesticviolencedata.org/database/fu...vrp/dvrp_gm.htm).

8.32 Assumptions and Stereotypes
The second implication of the research centres around the assumptions that are made. It was clear from the comments made about the vignettes that a number of assumptions concerning class and economic status were being made. Some of these assumptions were held by professionals and this raises questions both about potentially misidentifying phenomena in certain groups of people while ignoring it or missing it in others. Perhaps there remains a prevalent assumption that domestic violence is a class and economic phenomenon to which those in the middle class are somehow inured. Research would not appear to bear this out and there may well be implications for the training of health professionals if one can extrapolate from the small group of professionals who were interviewed for this study.

8.33 Gender Determinants
Related to this but worth dealing with separately is the powerful role that gender may play in the types of explanations that were put forward. There was a clear underlying assumption of blame, moral disapproval and lack of understanding as to why women remain in violent relationships evident in a number of interviews. It was striking that responsibility for change was laid at the feet of the women in the vignettes and rather less on the man’s ability to change. This clearly exemplifies what Hearn calls the attribution of violence to the “personality of the victim” (Hearn, 1998, p21.). While one cannot say for certain that women would have responded in quite different ways in terms of their attributions to the vignettes it is at least possible and is worth further investigation. Examples of minimization were also evident in some of the interviews, both in terms of downplaying violence and in one instance a denial that pushing a partner was itself violent.
8.34 The Exclusion of Men
A fourth important implication relates to the status of the accounts given by the men. While we were not dealing with men’s direct experiences of violence during pregnancy we were dealing with theoretically driven accounts based upon men’s experiences of fatherhood. The data suggested in quite powerful ways in which some of the men felt themselves to be excluded, sometimes by health professionals sometimes by their partners.

8.35 The Stress of Being an Expectant Father
What became clear during the course of the interviews was the fact that pregnancy carries it’s own strains for men and not simply vicarious stress consequent to their partner’s pregnancy. Thus there were stress and strains on the men both in terms of dealing with their partners changing moods but also sometimes in terms of a change in their relationships with other men. Thus it would seem important for health professionals to be aware of these potential stressors. The third vignette in which violence emerged for the first time, elicited a high degree of sympathy and understanding from the men interviewed. This can be seen as positive in that men were able to acknowledge something within the vignette that they could relate to. It would be of major interest whether men who have been violent themselves during this period were able to do this as well or whether they would seek to distance themselves from it. Thus as things stand the implications for individual therapy with men who have been violent during pregnancy remain to be specified.

8.4 Theory Development
This exploratory research sought to include the male perspective in explanations for violence during wanted pregnancy. The draft model that has been proposed suggests factors that may both inhibit and disinhibit violence during pregnancy. As a tentative theoretical model this needs further examination. In particular the views of men who have either begun their violence during pregnancy or stopped it need to be included. As things stands such a model which has attempted to synthesize previous findings on the subject with the current findings, may be worth exploring more informally with men who are at risk of being violent in a domestic context.
This research has I believe increased our understanding of male violence through understanding some of the stresses and strains involved in being an expectant father as well as highlighting some of the underlying assumptions that men hold. It seems clear from this research that pregnancy is a problematic time for many men and that both the ability to communicate openly with one’s partner and to have some way of understanding pregnancy is important. In this respect the tendency by men to reduce their partner’s behaviour to hormonal imbalances may in fact serve some protective function for women, in that it allows men to depersonalize behaviour that otherwise they may object to.

*My wife is now half way through her pregnancy and I am finding it to be slightly reshaping my views on the whole matter. I am particularly aware of the mood swings, the experiences (perhaps due to hormones) at this stage, and find it quite hard, sometimes, to know how to respond to the demands she makes at these times. Again, because of the hormones (I suppose), she doesn’t feel attractive and doesn’t want to make love. This is quite hard for me to adjust to, even though I understand it. I often get the feeling that I am living with a very different person at the moment.* (Response from one of the participant’s to the follow-up letter)

Indications from this small sample of men would indicate that the needs of men during pregnancy are not particularly well addressed by health professionals and this is important given the possibility that jealousy may increase during this period.

Jeff Hearn (1983, p.52) commented that “Men give two gifts to women: love and violence” and although explanations for male violence during pregnancy remain something of a paradox, it is hoped that the data and theorizing in this study may provide some way forward in the understanding of male dynamics during this ever changing human season.
References


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4 January 2000

Dr Robert Hill
PsychD Clinical Psychology Trainee
Department of Psychology
University of Surrey

Dear Dr Hill

**Explanations for variations in partner violence during pregnancy: an exploratory study (ACE/99/52 Psych)**

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/99/52/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
    Dr Linda Dowdney: Department of Psychology
    Dr Adrian Coyle, Department of Psychology

Enc
Dear Dr Hill

EC99/192 Explanations for variations in partner violence during pregnancy: An exploratory study

Thank you for your correspondence dated 15.12.99 and for submitting a revised consent form and Appendix 5. These are now satisfactory and I am happy for the study to commence.

Please note that this project carries a reference number, noted above, which must be quoted in any future correspondence.

The project number and the principal investigator must be clearly stated on the consent form. If approval is given to named investigators only, these names must also be stated on the form.

In the case of research on patients, a copy of the consent form must be placed in the patient’s medical records, together with a note of the date of commencement of his/her participation in the research. A label must appear on the outside cover of the records when the patient is participating in the research.

The investigators must adhere to the published Guidelines of the Committee and provide the Chairman with annual progress reports and an end of study report. The research should start within 12 months of the date of approval.

The St Thomas’ Hospital LREC is compliant with the ICH GCP requirements.

Yours sincerely

Dr G du Mont
Chairman
Research Ethics Committee

Encl.
Male Violence During Pregnancy: 
Current Information Collection Procedure Survey

1. Name and Address of Agency/Professional Responding (optional)

2. Agency/Professional Responding (please tick relevant box)
   - Forensic Psychiatry (Medical) [ ]
   - Forensic Psychiatric Nursing Service [ ]
   - Forensic Mental Health Psychology Service [ ]
   - Forensic Social Work Service [ ]
   - Child Protection Team (Social Services) [ ]
   - Child and Adolescent Psychology Service [ ]
   - Probation Service [ ]
   - Domestic Violence Project (Voluntary Sector) [ ]
   - Police Domestic Violence Unit [ ]
   - Other Service (please state) ........................................... [ ]

3. When assessing men who have children (or a pregnant partner) do you routinely collect information on whether they have been violent to their partner during pregnancy? (please tick relevant box)
   - YES (please tick and go to question 3a) [ ]
   - NO (please tick and go to question 3b) [ ]

3a) If YES, could you please state what form the assessment takes? (e.g. structured interview, formal assessment tool etc.) and who or where do you get this information from? (e.g. case notes, professionals, partners)?

3a) Form of the Assessment
3a) Where or from whom does the information come from?

(please go to question 5)

3b) If you do not collect this information, why is this?

3c) Are there any circumstances where you do (or would) ask for this information?

4. Where you do not already collect information on the relationship between violence and pregnancy from men, do you think it would be useful to collect such information as part of a routine assessment procedure?

YES  
NO

What are your reasons for this?

5. If a form were designed for the routine collection of information on violence during pregnancy would you be interest in receiving a copy?

YES  
NO

If yes, Please leave a contact name and address .................................................................

6. Finally are there any other agencies in your locality that you feel would be particularly relevant for this study?

Thank you for your help
Dear Ms.

I am a third year clinical psychologist in training at the University of Surrey, undertaking research with John Dowsett (Consultant Clinical Psychologist) at the Forensic Psychology Team at South London and Maudsley NHS Trust.

We are currently undertaking some research into explanations for male partner violence during pregnancy. As part of this research we are contacting a number of agencies and professionals who may be involved with male offenders in the London and M25 area. We have selected participants on the basis that there is a secure unit based locally.

We are interested in whether you currently collect information on male violence during pregnancy as part of your normal assessment procedure with referred men who have children and/or a pregnant partner. We would be grateful if you could complete the enclosed questionnaire which should take about 10 minutes.

Our interest is in quantifying the extent to which such information is collected and whether there are any differences between professional groups and agencies. Respondents will be not be identified when the information is collated and written up. However, all agencies/participants will be circulated with a summary of the findings if they so wish.

If you have any queries about the project or the questionnaire please call Robert Hill on 0181-480-8983 or via email at rghill@rghill.fsnet.co.uk.

Ethical permission for the study has been granted by Guy’s and St. Thomas’ Hospital and the University of Surrey.

Yours sincerely

Dr. Robert Hill
Trainee Clinical Psychologist at The University of Surrey
Appendix 4.

Interview. Male Experiences of Pregnancy.

(The following will be read out to participants)

In order to begin thinking about the question of violence and pregnancy I would like to talk to you about your own experiences of being with a partner who was pregnant. This will enable me to understand some of the common experiences that men go through when their partner is pregnant. Let me stress again that there is no assumption that you have been violent yourself during this period.

Standard Interview Questions for all Participants

1. Perhaps I could begin by asking you a bit about your first child and your response on hearing about your partner's pregnancy?

1a. (If more than one child) Was there any difference in subsequent pregnancies?

2. What were some of the practical effects on you of the pregnancy?

3. Did things carry on pretty much as normal?

4. Emotionally how would you describe this period?

5. Women often state pregnancy to be a time of both stress and happiness. Was it the same for you? (PROBE QUESTION- why and what sort of things)

6. Did you feel included in the pregnancy by your partner, friends and professionals? (PROBE QUESTION- in what ways did this happen)

7. How did you feel about this?
8. Would you say that men need to be taken account of more during pregnancy or do you think that men are already included enough? (PROBE QUESTION- could you say a little more about this)

9. Finally, what if any advice would you give to other expectant fathers and their partners?
I am a clinical psychologist in my third year of training at the University of Surrey engaged in
doctoral research into male experiences of pregnancy and the relationship between pregnancy and
domestic violence. In particular I am seeking to understand why violence may occur between couples
during pregnancy. I am undertaking this so that I can help men and men's projects better understand
what may be happening during pregnancy from the perspective of men.

We know that in some relationships violence may occur before, but not during pregnancy, while in
others it may continue. We also know that in some relationships violence does not seem to occur at
all. While the views of women partners have been explored, very little attention has been paid to
men’s views about pregnancy, fatherhood or violence during relationships. For that reason, I am
talking both to fathers who have been violent (although not necessarily during pregnancy) as well as
fathers who haven't. I am also speaking to professionals who work in this area.

The interview is in three parts and takes between one hour and one hour and a half. In the first part I
am going to briefly ask you some questions about your background. I then want to talk to you about
your experiences as an expectant father. This area is important since men are rarely asked about what
it means to them to be a father. The final part of the interview uses a number of imaginary situations
to talk about the relationship between violence and pregnancy and aims to find out some of the
potential explanations for violence during pregnancy from the perspective of men. There is no
assumption that you have been violent during pregnancy yourself.

Each interview is entirely confidential and although I need to audio-tape each interview for the
purposes of transcription, tapes are stored securely in my office and are available only to myself and
my supervisors (both of whom are chartered psychologists at the University of Surrey). Your name
will not be recorded on the audio-tape and interview data will be stored in such a way that no third
party could link your name to the tape. The interview tape is erased at the end of the research project,
although you are welcome to have a copy of the tape yourself.

Simply talking about violence during pregnancy can arouse strong emotions. If at any point in the
interview you feel that you would rather not continue please let me know and we can take a break or
terminate the interview. I will then stop recording and switch the tape recorder off.

I will not be making any judgements about what you say in relation to this topic and will be asking
you questions simply to ensure that we cover all the areas that are relevant. Before we proceed I am
going to ask you to read and then sign (if you are in agreement) a consent form relating to the project.

You will receive a summary of the research findings.

Ethical permission for this study has been given by St. Thomas and Guy’s Hospital and the University
of Surrey.
CONFIDENTIAL

Informed Consent Schedule

I hereby agree to participate in an interview on men's views about pregnancy and violence during pregnancy. I understand that the interview will take between one and one and a half hours.

I give permission for the interview to be audio taped. The tape will be kept in a securely locked filing cupboard in order to ensure confidentiality. The audio-tape will be analyzed by Dr. Hill who will discuss details of the interviews with Dr. Adrian Coyle and Dr. Linda Dowdney both of whom are chartered psychologists and based in the Psychology Department at the University of Surrey. I understand that neither my name nor any other identifying information will be used in these discussions or in any subsequent transcription of the tapes. I understand that I will receive a copy of the tape if requested and that any tape in the researchers possession will be erased when no longer required for the research.

I understand that my participation in this study is entirely voluntary and that I will receive no payment for my contribution.

I understand that I may withdraw from the investigation at any stage without giving a reason for doing so and that this will in no way affect the care I receive as a patient (where this is relevant).

Signed........................................Name of Volunteer

Date...........................................

Signed........................................Witness: Dr. Robert Hill

Clinical Psychologist in Training

Date...........................................
Appendix 6 Patient Consent Form

St Thomas' Hospital Research Ethics Committee

CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS & CLINICAL TRIALS

Title of Project: Explanations for Variations in Partner Violence during Pregnancy: An exploratory study

Principal Investigator: Dr. Robert Hill.

Other Investigator/s enrolling patients: Ethics Committee Code No:

Outline explanation:
I am seeking to understand why violence may occur between couples during pregnancy. We know that in some relationships violence may occur before, but not during pregnancy, while in others it may continue. We also know that in some relationships violence does not seem to occur at all. While the views of women partners have been explored, very little attention has been paid to men’s views about pregnancy, fatherhood or violence during relationships. For that reason, I am talking with you and am very grateful that you are participating in my study.

Over the next hour and a half, I will be asking you a number of questions, and would like to tape our interview. The tape is so that I am not distracted from listening to you and also so that I can obtain relevant data which I will analyse myself, with the help of my university research supervisors, Dr. Adrian Coyle and Dr. Linda Dowdney. Only we will have access to your tape which will be stored absolutely securely. Your name will not be recorded on the audio-tape and interview data will be stored in such a way that no third party could link your name to the tape. I understand that I will receive a copy of the tape if requested and that any tape in the researchers possession will be erased when no longer required for the research.

Talking about violence during pregnancy is a sensitive topic and can arouse strong emotions. If at any point in the interview you feel that you would rather not continue please let me know and we can take a break or terminate the interview. I will then stop recording and switch the tape recorder off. Not participating will not affect your clinical treatment in any way. I should say that I will not be concerned with making any judgements about what you say in relation to this topic and will be asking you questions simply to ensure that we cover all the areas that are relevant.

While I have a duty to protect your confidentiality I am also under a duty to prevent harm to either yourself or identified third party. Thus there are limits to confidentiality and disclosure of serious harm to self or others will result in confidentiality being broken.

Before we proceed I am going to ask you to read and then sign (if you are in agreement) this consent form relating to the project. Before I ask you to do this is there anything you want to ask me about the background to the study.

I (name) ____________________________________________
of (address) ____________________________________________

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient.

SIGNED (Volunteer) ______________________________ Date ______________

(Doctor) ______________________________ Date ______________

(Witness, where appropriate) ______________________________ Date ______________

3 copies required:- one for researcher, one for patient/volunteer, one for patient's notes
April 10, 2000

Mr. X

Dear X

I am now in the process of writing up the research on fatherhood and pregnancy which you kindly participated in. Given that it is a month or so since our interview I wondered whether you had any further thoughts about being an expectant father and/or violence during pregnancy and whether anything has changed since the interview.

I would also be interested if you had any feedback on the interview and the use of vignettes.

I have enclosed a very brief form which covers these areas. If you would like to reply please do not feel constrained by this, it is there for your ease of use more than anything else.

Whether or not you are able/want to respond I would like to formally thank you for your participation in the research study and hope that you gained something positive from the interview. Personally, I have been struck by the willingness of all the men I have talked to share their thoughts and insight into what is a little explored but important area.

Yours sincerely

Robert Hill
Appendix 7 (cont.)

Expectant Fatherhood and Violence during Pregnancy
Follow-up Issues

1. Have you had any further thoughts about fatherhood, particularly the role of the father during pregnancy, since our interview?

2. Have you had any further thoughts on the relationship between male violence and pregnancy? The three examples used to explore this issue the study were:

   Steve and Ann (Steve continues to be violent despite the pregnancy)
   Peter and Dawn (Peter stops being violent during the pregnancy)
   Simon and Theresa (Simon starts being violent during the pregnancy)
3. Do you think that anything has changed as a result of participating in the research study? (e.g. a change in your thoughts, feelings, conversations, or behaviour).

Appendix 7 (cont.)

4. Is there any comments you would like to make about more generally about participating in the research?

5. Finally, do you have any comments about the methodology used (an open interview followed by the three vignettes)?

Name (optional)......................................

Thank you for your help
Interview V3 25/03/2000 Part 1

Q. What was your response to hearing your partner was pregnant?

A. 1. Um, well we had been trying for about a year and a half, so it
2. wasn't something that just happened, we had actually been trying, so
3. disbelief to a degree, nervous, when X found out she was a bit giggly and I
4. was the same. It's a bit like a new date, it takes the relationship to a new
5. level, so I mean obviously happy because that's what we wanted and then
6. obviously then start to think I've got to do this or do that, so have the checks up
7. here so that's always in the back of your mind as well, so definitely overjoyed,
8. and I suppose you want everyone else to be for you as well, in reality they are
9. not because it's only that important to us two really.

Q. When you say it took it to another level?

A. 10. It's hard to say really, it felt like your relationship takes, well it takes you've
11. got someone else to think about, it's not just the two of us, we can't just say we
12. can go away on a holiday like we used to, but also more than that you are
13. aware the you can start to enjoy your life through someone else, and its made us
14. sort of more closer in some ways, X is a definite physical example. I went away
15. and worked when X was 6 months pregnant, so prior to that I was nervous, was
16. everything going to be all right, getting the tests done, all this, that was what I
17. was worried about and then pretty much the same, I felt a great sense of
18. responsibility and when I was away it was easier to begin with and then it got
19. very hard, being 2 hours away. That was the worst bit for me. I was very
20. nervous at the end. At the beginning the elation going along on the crest of a
21. wave, floating on a dream almost which lasts, its always there and then you get
22. the other stage, which is making sure the nursery is decorated and when you do
23. that you can see something physical and you think my God it's really
24. happening.

Q. When you said nervous, what was that about?

A. 25. Because I've been ill myself I wanted everything to be ok. no one's
26. ever perfect but you want to make sure your child is healthy (more on
27. this) a protection thing that kicks in. There was a show of blood which
28. worried me more than her. You get these books and think I'll be a
29. good parent but I don't want to read about that (miscarriage) I want to
30. read about the positive things.. A lot of books did include things on
31. the expectant father e.g. jealousy when the child is born, one the
32. midwife gave you. It's all a short bit, a token bit.

Q. Sounds like this is post-birth?

A. 33. Yes it is, nothing is given during the pregnancy, it says what the
24. woman should do, but it doesn't say what the partner must ensure
25. that the partner should take it easy or attempt to take it easy, but that I
26. think, some people are different, I tended to leave it up to X, she
27. knows her body better than I do. I was away for 3 months arguably
28. the most important and I've always had that as a slight feeling of
29. guilt, it's backed up by the fact that I managed to pay for everything
30. while I was away. Its not an ideal trade off.

Q. Did it matter that there wasn't anything addressing you as an
31. expectant father?

A. 31. I don't think so no, to be honest I don't know if it would have
32. made any difference to me, I wasn’t there for 3 months. I liked to
33. think I did help. My only concern was for things to go as smoothly as
34. possible for x and x. Plus I wanted to be there, when I was away. I was
35. just in time. I can’t remember anything on how men should act during
36. the pregnancy, a lot on how women should act certainly but not on
37. what the men should do. Try and look at what it says about your
38. partner and work round that.
Q. Did you attend classes.
A. 39. No, x attended one, we went to the scans a couple of times. From
40. 12 weeks you could see the pictures, so like it was real. I think that’s
41. good because it makes you aware there is a person there. I felt happy,
42. proud, its the same feeling when he’s born, but it’s a much more
43. elevated feeling when he’s born. Didn’t see the need for classes to be
44. honest. Looked at books and said now he’s got x each week. We’d do
45. that now and again and treat him as if he was growing. It sounds
46. quite sad but I guess a lot of people do that, go all soppy. For some
47. reason I’d probably feel a bit strange going to classes, I don’t know
48. why, I’d feel like the matching tracksuits, I’m going to be a dad. I
49. don’t hold with sticking cushions up your jumper, I think I’m in touch
50. with my feminine side without having to resort to that.
Q. Did you feel included by the midwife?
A. 51. When I was talking to the midwife yes, I think the first time we
52. went for the scans you go there thinking T’m the father’ and of
53. course all the attentions on the mother because she’s the one having it,
54. so, but then after you sit down and realise that fact that they are not
55. going to sit down and ask and how are you today and let me take your
56. temperature, there’s no need for all of that, so I suppose I’d say yes.
57. Actual birth was brilliant. I missed him coming out anyway, by
58. turning around, fantastic, brilliant.
Q. What about bonding during the pregnancy?
A. 59. Yeah, it sounds easy to say oh I thought it would always be a boy,
60. but I did, its not that I wanted it to be a boy, I didn’t really mind. I
61. think I bonded I stroked the bulge and talked to it. I’ll probably
62. remember the three months that I wasn’t there, more than the six
63. months that I was. It was very difficult for x. The Holywood thing
64. to do would be get on the next train and come up, but that’s not
65. reality you need to think where the money is coming from. That
66. made it hard.
Q. What about some of the practical effects of being an expectant father?
A. 67. Um, I don’t think it did, it didn’t. For it did. I was trying to
68. do what was best for the family and if that meant going away then
69. that was something I had to so,
Q. How would you describe the role of the father during expectancy?
A. 70. I think you’re there in a supporting capacity, you respect what
71. your partner is feeling, its her body at the end of the day, be
72. supportive. Obviously during the pregnancy you will encounter mood
73. swings, hormones are all up and down, so you have to learn to be just
74. supportive, helpful as well.
Q. Did you talk about being an expectant father to other men and what sort of conversations did you have?

A. 75. Funny enough I had some conversations with x who was a security guard at the holiday camp who had a son. There was some serious talking going on there. It's easier to talk about it obviously to the fathers, didn't know any expectant fathers, my partner (work) had a couple of kids. I was asking about advice really and these were people who were 19/20 and that felt weird as I had more in common with their parents. That stuck in my mind as being strange. I was also getting advice from the mothers perspective.

Q. Men have suggested that men talk to each other in a jokey, superficial way?

A. 83. This guy wasn't with his child and it was obvious the regret. I've heard guys talking in that way. It's not macho to talk in that way. I think sometimes you say things because you think that's what you should say. The problem with blokes is you have to talk to them at a certain level and that's what they expect. (bit on villains loving their children and babies). They'd joke about it, but if you talk about it seriously they would change, it's jokey because everything they talk about is a joke. Everything is superficial, it's just a way of trying to ease in a conversation, just like a throw away comment, nothing to deep of meaningful. They aren't gonna ask how was your babies last scan they are going to say how's he doing. Maybe it is a male thing, women if I'm honest I think men would love to talk about it, but we just sort of walk up to complete strangers and say these things.

Q. From your own experience then what advice, if any, would you give to expectant fathers?

A 96. Listen to the mother/partner be understanding, supportive, respectful and be there when it's difficult because if you're not it's just something, you can't describe it, when you see it being born, the whole process, the partner does need someone, where she admits it or not she wants the partner, she wants the father. That's obvious and the father should be there and all these things I thought I would never be able to stomach, all in a few hours, so I think be supportive basically the rest takes care of itself.

Q. Is there anything else you would like to add about your own experiences.

A. 104. I was thinking about jealousy and insecurity and I think that's about the hormones, I think as a male that you just have to accept that, there's a lot of times when you think 'why did you say that' and I think you have to always remember that this person's body is changing. I was working away at a holiday camp and x was on her own and I would feel the same anyway if the roles were reversed. I think every man has to understand that.

111. be prepared to spend a lot of money and buy one of everything.
Interview VF3. Part 2: Case 1 (Steve and Ann).

Q. What were your first thoughts on hearing about Steve and Ann.

A. 112. Does he drink basically, that would be my first assumption.
113. People I know where the man has been violent towards the partner,
114. it’s always been because of drink (during pregnancy-no) certainly
115. either side. Its not something that I would have thought that females
116. would want to talk about (why?) well because its bad enough to be hit
117. and pushed around before having a family, but if you decide to have
118. a family and you know what this person is like and then it happens
119. during that. I would have thought that Ann must have been told that
120. this guy is pushing you around, basically he is no good, lets be
121. honest its not the sort of thing that should happen. Men are
122. physically stronger than women and I think you have to be aware of
123. that. I think that Ann must also be probably pretty naive. Personally
124. he’s the type of bloke that gives every man a bad name to be honest,
125. he should be prosecuted, father or no father and punished.

Q. Any other explanations?

A. 126. She might have nagged at him, but then that’s no excuse. It could
127. be drink, drugs, pressure of working of he is working, could be
128. pressure of not working if he’s unemployed, probably giving him a
129. hard tone about something or other, there may be other situations.
130. Could be anything. It sounds to me ‘a number of times and occasions
131. and been together 3 years.’ Counselling would definitely seem to be
132. in order, you don’t want a child brought up into an environment of
133. domestic violence do you really.

Q. Would you be worried about the child’s safety directly?

A. 134. No I ‘d probably, more indirectly as a result of him growing up
135. with that imagining that is the norm, that may be the circle, that
136. maybe what Steve had in his past. Might be where the whole things
137. starts. Was that why she wanted to have a child in the vain hope that
138. he may stop?

Q. What do you think this tells us about Steve as a person?

A. 139. A bully, but then he could be the meekest and mildest of people, I
140. don’t know. Not a very nice chap, can’t have very much respect for
141. her. Maybe he feels insecure. Its just not the done thing not in
142. civilized society. can’t have much respect for himself, since that sort
143. of behaviour is not exactly condoned. We all suffer from low self-
144. esteem at times, so you can’t even use that as an excuse can you. It’s
145. nothing to do with the pregnancy, it’s made no difference to him, its
146. though she’s some punch bug and being pregnant has had no effect
147. at all and being pregnant there is the risk that she could miscarriage.

Q. What do you think Steve thinks about the pregnancy?

A. 148. Well, it looks like it’s perfectly normal behaviour for him
149. doesn’t it, because he’s pushed and hit her before, its though
150. because it’s been accepted, nothing can be done about it, its perfectly
151. normal. It begs the question is he informed about anything, does he
152. know it would harm the child, he must do. There are some people
153. who intelligence is challenged. It’s getting worse let’s face it
Q. Do you think it is possible to want to have a child and still be violent to the person who is carrying that child?

A. 154. Yeah I can understand that. I could imagine that the male would want to see some kind of evidence of his existence, like offspring, but obviously may not particularly like or respect the person who is carrying that child, it doesn’t make any sense but I can understand it. Without knowing more about why? Cant really tell can you? I suppose you could say, the only people I’ve known are the drinkers.

Q. Do you think that Steve and Ann need to do anything about their relationship?

A. 160. Definitely yeah. I don’t think any woman should have to put up with that to be honest.

Q. Do you think that anyone else ought to do something then?

A. 162. Yeah, well. That’s the delicate situation. If you’re a friend of Ann’s I could imagine this Ann to be the type who would turn against a friend if she decided to do something against Steve. She seems like the loyal, devoted battered partner. They’ve been living together for three years and no mention of marriage, he obviously doesn’t sound that committed, but then that’s my personal view, I believe marriage or some type of commitment should come first. So a concerned person should. I can understand a female friend having reservations and they may seem very close the majority of the time and these situations they may not be seen.

Q. What would you do?

A. 172. Personally I would have a word with him. (what does that mean?). Um, well ask him why he’s doing it (would you use physical force?). Not unless he did, there wouldn’t be no need to. Just want to try and make him understand what the dangers could be first of all.. So you don’t want to inflame the situation and be aggressive towards him, because he may hen take it out on her. Which is exactly the thing you didn’t want. Any situation they may end up taking it out on their partner.
Interview (VF3) Part 2: Case 2 (Peter and Dawn).

Q. What were your first thoughts on hearing about Peter and Dawn?

A. 180. I know it sounds silly but he obviously seems more responsible than Steve (why silly?). Because he's hit her, and he's hit her in the past, so he's an idiot for doing that, but at least he's got responsibility, because at least he's aware of fact that he can't do that because he might hurt the baby. So he's got a sense of responsibility, so he's hopefully that may stop or it may start up again when the baby is born been, 6 months may be long enough, so he's a bit more responsible.

Q. So what are the explanations?

A. 188. I'd have to say he's a bit more educated, more informed. Steve doesn't seem to have any idea about anything to be honest, whether she's pregnant or not 'I'll slap my girl around' At least this bloke is more sort of I'll hit her when she's not pregnant, but I'll stop when she is. I bet he can't wait for those none months to end. (would that be a real concern?). Of course it would, yeah he might think I've got none months bottled up. I think it's still worrying yeah.

Q. What do you think Dawn makes of all this?

A. 195. I bet she's elated. Exactly like Ann wanted, I hoped it would stop and it has stopped. Brilliant. Why he's stooped would seem clear, he doesn't want to harm the baby.

Q. What do you think he thinks about the pregnancy?

A. 198. I'd say he was more informed. He was more cautious. If: may have read up 'it's not a good idea to.. 'I'd say he sounds more responsible, even though he's hit her in the past and it sounds ridiculous, its not something that I could condone. So he's still not a very nice person.

Q. Do you think that Peter and Dawn need to do anything about their relationship?

A. 203. It may be that the baby might bring them together, but if he's violent he's violent towards a woman. Do they really change, give them the benefit of the doubt, but he obviously wants the baby, whether he's that concerned about the partner is debatable. Again at the moment the violence has stopped so there's no need to do anything at the moment. Bringing the past up he may say well I haven't done it for six months, potentially there's a problem, but you can't say potentially. Every couple will argue to be honest, it's where do you draw the line. If he hasn't been violent there's no need to say it, unless he's one of these guys who needs a 'well done you haven't hit me.'

Q. Is there anything else you would like to add about Peter and Dawn?

A. 214. It sounds like she could always say she was pregnant in the future if she wants to.
Interview VF3. Part 2: Case 3 (Simon and Theresa).

Q. What are your first thoughts?

A. 216. (long pause) He’s a wanker isn’t he. there’s no excuse for that, he 217. obviously doesn’t want the child (you said earlier you could want a 218. child and be violent?). Yeah that was slightly different context that 219. guy had always been violent, this guy has only just started ‘Oh I 220. don’t really want it now I don’t; know, maybe he’s jealous of the 221. attention, that would be the stock, standard answer the textbooks give 222. I’ve read. I’ve never felt that jealous or my nose has never been put 223. out of joint. It’s hard for me to imagine it exists really I suppose it 224. must. I can’t imagine anything more lower than hitting a pregnant 225. woman, I’m staggered. Maybe its the thought of becoming a father, 226. the sense of responsibility, and they’re just kids really, that’s an 227. awful lot of responsibility for someone that young to have. Maybe he 228. can’t handle responsibility and thought my God ‘that’s it.’

Q. It sounded like you had a stronger reaction to this example>

A.229. Yes Because its like saying it’s because she’s pregnant, which is 230. what it is saying. Whereas the other guy is doing it all the time. 231. None of them are saints are they. It’s just not he thing to do. How 232. can I explain that. I don’t feel that men who are violent towards 233. pregnant women, it sickens me to be honest, but in this case 234. something should definitely be done about it. this is the stronger, 235. because obviously he was fine before, maybe sit down and day why? 236. This is more worrying because he’s just done it, more than the other 237. two. So I’d probably send in for the authorities and try and persuade 238. him to get a court injunction out against him. Does sh4e want that, 239. don’t know what she wants?

Q. Do you think he could really want the child?

A. 240. He’s got a funny way of showing it. That’s all I’d day. I suppose 241. he could, like the first one but because he’s just done it, it looks 242. more like he doesn’t. There might be some other reason. Maybe 243. she’s become such a handful to live with that he’s not being as I 244. would say supportive and sensitive as he should be, maybe he 245. can’t handle that. Maybe he could do well from realising what 246. he’s doing. If he really wants the baby and he’s hitting he can’t 247. realise what he’s doing then he can’t it would be a contradiction. 248. So he can’t do. Sit down and explain it to him it might do some 249. good. This is more worrying than the first, no that’s a 250. contradiction, more shocking both as worrying because they are 251. both doing the same during pregnancy, but is seems less worrying 252. poor woman she’s had a right battering and you’re used to it love. 253. Feel sorry for them all really, the women. I think they should be 254. removed from the environment to protect her and I would ‘ope 255. he would look back in years to come and support that decision. 256. As a father the very last thing you want to happen is harm to 257. come to the baby. So if you’re violent during the pregnancy and 258. haven’t been before and without knowing all the ins and outs you 259. can only surmise its because of the pregnancy which contradicts 260. the fact that he says he wants children. He’s putting a lffe in 261. danger and that’s too much for me, or its enough to suggest that 262. the authorities should be brought in and make it realistic for her 263. to have a safe pregnancy and the same could be said of the first
After reading about this guy it makes it more clearer how dangerous it is for the first one funny enough. Because he’s hitting all the way through you sort of expect it. You expect fish and chips on a Friday night, so it’s the norm and because this is only happening, it makes you think about this guy again. I suppose in some ways it makes you think that in someways Peter might be quite serious and might be trying to turn over a new leaf. Call the authorities for 1 and 3, “may have turned the corner and knew that he had done something wrong.

Q. Finally I have given you three different examples concerning violence and pregnancy, do you have any closing thoughts about the relationship between violence and pregnancy that we may have already touched on or that hasn’t been covered by these examples?

A. 274. I can’t understand it to be honest. I can understand the need for some people to be aggressive, but the lack of self control I can’t understand. Bearing in mind there is something so important at stake. That is what I would class as unforgivable. Really there’s no excuse. It’s as simple as that, no one is telling them to do it, no one is making them do it, it’s solely their decision, their choice so its their fault.

275. Being an expectant father, brilliant, fantastic. Get’s better. You have to remember when you are talking to non-fathers to try and not talk about everything ‘doesn’t he go on’ you have to be mindful of that. When you are talking to other fathers you can really go to town, when you talk to non-fathers a simple precis is sufficient. Yeah its brilliant. The birth is or it should be the best moment of your life.