A Portfolio of Academic, Therapeutic Practice & Research Work

Including an examination of the concept of codependency and women’s sense of self from a feminist perspective

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Introduction to Academic Dossier

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A Portfolio of Academic, Therapeutic Practice & Research Work

Including an examination of the concept of codependency and women's sense of self from a feminist perspective
Introduction to the Portfolio

This portfolio includes a selection of work carried out in fulfilment of the PsychD in Psychotherapeutic & Counselling Psychology at the University of Surrey. It is divided into three dossiers, each representing the three areas of training: theory, therapeutic practice and research. I have selected essays that reflect my interest in feminist studies described from various perspectives, illustrating theory, therapeutic practice and research. An emphasis is also on exploring the underpinnings and development of the discipline of Counselling Psychology.

Due to the confidential nature of therapeutic work, examples I use for illustrative purposes are either anonymous or I use arbitrary letters to denote my clients and identifying information has been omitted or changed to preserve confidentiality. Reports of therapeutic work are located in the Confidential Appendix, which is submitted separately and not publicly available.
Academic Dossier
Academic Dossier

The papers included in this dossier represent my word written on various topics. Two essays on 'Advanced Theory and Therapy' are selected. These discuss cognitive therapy and the role and importance of the therapeutic relationship and 'models' and 'tools' in therapeutic practice. The second paper explores some of Freud's theories on sexual development and how they have been critiqued in the light of feminist theories. As a relevant topic covered in the Options course on the final year, epistemology is discussed and explored by comparing and contrasting 'feminist epistemologies' with the traditional epistemology of science.

Finally, 'Issues in Counselling Psychology' are presented in two reports. The first explores the contribution and underpinnings of Counselling Psychology as a therapeutic and scientific discipline and explores views which may have contributed to its development as a profession. The second report briefly discusses the concept of codependency and the implications of traditional treatment models. It further suggests existing models within integrative and transtheoretical psychology and explores how one of those might apply in therapy with codependent women.
In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components which directly challenge the client’s faulty appraisals

Introduction

At the heart of cognitive therapy is an emphasis on co-operation between client and therapist. Another core feature is its structured and focused approach in sessions and therapy in general. Setting agenda and homework assignments play an important role in this structure. Homework and various techniques in cognitive therapy can be viewed as ‘active components’ of therapy, which the cognitive therapist uses as collaborative tools to explore and address ‘the client’s faulty appraisals’.

‘Collaborative empiricism’ (or Socratic questioning) is one of the main strands in therapeutic work; as such it provides an ‘active component’ and a valuable tool in challenging ‘the client’s faulty appraisals’. As a model, this reasoning is at the heart of cognitive theory (A. Beck, 1976). However, it may depend on many factors as to how effectively this ‘cognitive heart’ is working.

In this essay, I want to discuss cognitive therapy and how the therapist’s ‘delivery of therapeutic system’ may depend on how successfully the therapeutic process is facilitated in terms of communicating, making interventions, etc. I will also explore the importance of therapeutic ‘tools’ in this process, by using an example of my work with a client as an illustration.
Empirical Research: Therapist-client interaction

Despite its heavy emphasis on the cognitive model (see A. Beck, 1976; J. Beck 1995) cognitive therapy has always emphasised collaboration and a 'sound therapeutic alliance' as a requirement for successful work with the client.

Several client-related factors have been found to be important predictors of outcome. In their study, Burns and Nolen-Hoeksema (1991) quote research findings showing that "the expectation that therapy will help may be the most powerful predictor of outcome, regardless of the specific techniques the therapist uses" (Frank, 1973; quoted in Burns and Nolen-Hoeksema, 1991; p.306). This research suggested that confidence held by the client about the role of the therapist as a healer is an important factor for the effectiveness of therapy. Those factors/beliefs, held by the client, can be seen as variables created in the interaction between client and therapist. Motivation to engage in therapy (Sifneos, 1972) and active participation in the therapeutic process (Gomes-Schwartz, 1978) were also found as important predictors of clinical improvement among therapists of different theoretical orientations. Finally, Burns and Nolen-Hoeksema (1991) found that willingness to engage actively in cognitive-behavioural therapy (CBT) and homework compliance were found to be important ingredients of the therapeutic process.

In general, extensive research on therapy outcome has found that clinical improvement seems to happen regardless of the 'therapeutic system' (or theoretical approach), but rather due to other 'non-specific factors' (see for example Shapiro and Shapiro, 1982). This lack of evidence of differences in effectiveness between the different therapeutic orientations has led researchers to study why therapy works and to identify which ingredients are effective in the therapeutic process (Miller and Morley, 1986). Frank (1973) proposed a theory of interpersonal relationship to account for psychotherapeutic changes, including 6 factors, seen as necessary but not
sufficient for effective therapy. He noted that besides specific theoretical components, all therapies share some common factors. Clarkson (1995) has highlighted that this common factor, “more significant than theoretical orientation” (p. 5) is the ‘therapeutic relationship’, which is best predicted by the “properties of the patient, the psychotherapist and their particular relationship” (see also Norcross and Goldfried, 1992). Clarkson theorises five different relationship modalities, the first being established is the ‘working alliance’ and “involves co-operation between patient and therapist which underpins all effective helping” (1995, p. 7). In the formation of the “working alliance”, the three ‘core conditions’ are seen as fundamental by virtually all therapeutic approaches. Those conditions, ‘accurate empathy’ ‘positive regard’ and ‘congruence’ are according to the client-centred approach (Rogers, 1961) conceptualised as necessary and sufficient conditions for personality change.

In cognitive therapy and theory, the relationship between therapist and client has been implicit (Wills and Sanders, 1997) rather than explicit and often appears to be taken for granted. Devoting one line to the therapeutic relationship, Beck (1976) highlights that if the therapist shows certain characteristics, i.e. genuine acceptance, warmth and accurate empathy, a successful outcome is facilitated (quoted in Wills and Sanders, 1997). Similarly other books from a similar period (Foreyt and Rathjen, 1978; Kendall and Hollon, 1979) briefly mention the relationship in one of their chapters. In the former, Cameron (1978) described the therapeutic process by advising: “We must quickly to establish a “therapeutic alliance” or co-operative working relationship, with the client” (p. 236) ... and then the ‘real’ work is done! which then is described further with a focus on the client’s negative cognitions and resistance. In their chapter on children, Kendall and Finch (1979) state that the value of ‘empathy’ and the ‘therapist-child relationship’ as contributors to effective therapy are of interest and “requires further study” (p. 71). They supported their statement by quoting Hogan (1969) who found that there was significant correlation between therapist empathy and several measures of improvement. However, although in the background, the therapeutic relationship is important as the collaboration “may depend crucially on the interaction between therapist and client” (Gilbert, 1992, p...
407) and some therapist qualities may better facilitate this process than others. It seems that by the time Gilbert (1992) wrote those words, the therapeutic relationship was gradually coming more and more "to the foreground", in that it was seen as particularly relevant in therapy with severely disturbed patients, such as those suffering from schizophrenia (Perris et al., 1992), with drug abusers (Moorey, 1989), and in substance abuse in general (Beck et al., 1993).

"The Integrative Power of Cognitive Theory"

In cognitive therapy, the therapeutic alliance has always been considered as a base from which the cognitive work is "delivered" in collaboration with the client. Perris et al. (1992) consider this as similar to Bowlby's "secure base" from which the "patient is expected and encouraged to explore his or her environment and to build up a self-reliant self-schema." (Perris et al., 1992, p.316). Whilst the therapeutic alliance, most often referred to as "collaboration" or "collaborative empiricism", has always been an important part in cognitive therapy, other modalities of the therapeutic relationship have been discussed and explored (Wills and Sanders, 1997). It has been highlighted how both the therapist as well as the client can affect the therapeutic collaboration by transference or countertransference. Both may bring his or her own reactions into the session, resulting from their own schemata which may influence therapy and the collaboration in the therapeutic relationship (Wills and Sanders, 1997). This may affect or hinder the process of collaboration between client and therapist. However, if the therapist uses the "impasse" to explore the underlying reaction, invaluable information about the client's underlying schema may be discovered. Thus, cognitive therapy has paid attention to "therapist qualities" and elaboration of the "therapeutic relationship", as concepts which have been more and more integrated into cognitive therapy. As Alford and Beck (1997) have pointed out as a requirement, this integration seems to be quite easily translated into the cognitive system in a theoretically consistent way.
“Active Components” of Change
Examples from the Context of Substance Abuse

Substance abuse, although “pleasant” at times, has many negative consequences. Therefore, substance abusers come to therapy and want to change their behaviour which in the past has been intrinsically pleasant, although their addictive behaviour has often been an escape from the negative sides of their lives. Thus, the ‘benefits’ of addiction can be quite “attractive” and the ‘cost’ of drug abusing behaviour can have an enormous impact on how desirable is it for the client to change his or her lifestyle. From one time to another ‘motivation’ changes and often fluctuates easily from one extreme to the other. Moorey (1989) states that the first goal of therapy is to ‘engage the patient’ and ‘maintain motivation’ after which the next step is to identify which factors might act as ‘triggers for drug-taking’.

Motivational Interviewing (MI) can be seen as one of the ‘active components’ used to engage the client as well as move him towards motivation of change (Miller et al., 1988; Miller and Rollnick, 1991). This approach acknowledges that motivation is a dynamic process which is influenced by the relationship between the person, his or her behaviour and ‘external factors’. The therapist style is considered a powerful determinant of client resistance or change, and motivation is seen as emerging from the interpersonal interaction between client and therapist. MI places emphasis and responsibility on the therapist and clarifies that client motivation can be a function of a variety of therapist strategies.

One of the ‘tools’ the therapist uses is the ‘ambivalence’ held by the client towards the ‘desired goal’. Ambivalence is seen as normal and through the therapist-client interaction, the aim is to increase the discrepancy between present behaviour and the future goal, i.e. ‘to amplify the client’s perceived dissonance between ideal goal and
current behaviour’ (Miller et al, 1988) in a way that builds up or strengthens the
client’s self-esteem and self-efficacy. As an ‘active component’, this approach helps
the client explore the cost and benefits of both current and future (ideal) behaviour, in
a non-challenging way, with the aim of increasing ‘knowledge’ and ‘concern’ about
current situation, resulting in an increased sense of ‘competence’ to change present
behaviour. According to this technique, confrontation or challenging is not seen as
belonging to the therapist, rather as a goal which the client reaches by working
through the increased cognitive/emotional ‘dissonance’. Thus, the therapist ‘gently’
encourages the client to explore the assumption that he or she has to rely on drugs or
alcohol, and further look at what alternatives are there to make a change for the
better. This ‘exploration’ of MI already starts in the initial contact of assessment,
where the developmental and addictive processes are looked at, and the client is
expected to describe some goal, in a form of ‘ideal’ future and what to aim for.

The role of negative cognitions in the process of engagement and commitment to
therapy may play an important factor (Moorey, 1989); whether the client chooses to
start the engagement process or not. An example, can be taken from a recent
assessment with Mr T, aged 38, who wanted “support and counselling” in relation to
his addiction to di-hydrocodeine (an opiate termed DF118). Starting his use by the
age of 13, when “sneaking” his mothers tablets, he is now heavily addicted, using 32
tablets, 60 mg daily. Through a previous therapy, about one year ago, he managed to
stabilise his style of consumption from compulsive using to a more controlled way of
a fixed schedule by taking 4 tablets at two-hour intervals. Furthermore, he also
improved his drug related behaviour by stopping altogether to support his addiction
by illegal use of tablets bought on the ‘black market’. Now receiving his required
doses from his ‘new’ GP, Mr T asked for further help from the drug and alcohol
service where I am in training as a Counselling Psychologist. I noted when we (two
psychologists) went through the scheduled interview with him, he answered in a
rather nonchalant way that he “only felt suicidal when his drug was not available”.
With such a client who, in psychoanalytic terms, may use his drug of choice as a
‘mother substitute’, or as a form of mothering himself, it may be difficult to challenge

the client’s ‘conditional assumption’ - ‘(faulty) appraisal’- that he cannot live without having his drug.

In cognitive therapy, work on ‘faulty appraisals’, as described above, can be explored through various homework assignments. As an example, the advantages and disadvantages of using drugs can be examined through cost-benefit analysis. With my client, Mr T, it might be better to start with the advantages of drug taking, as its cost might feel too threatening for him in the initial stages of therapy.

In this work, drug related beliefs can be assessed through homework assignments. Beck (1993) has provided a model of the importance to “examine and test addictive beliefs” as well as to “practice activation of control beliefs” (p.171). Guided discovery, or Socratic questioning, is a valuable technique to explore and develop control beliefs, such as reinforcing ideas about the disadvantage of drug taking. It has been recommended that use of flashcards, or index cards, can be an effective tool for the client to strengthen his control beliefs, such as ‘When I use heroin, I run the risk of losing my daughters’. This statement might be used as a daily reminder for Mr T or others in similar situation.

Additionally, the style of Socratic questioning can be rehearsed and taught to the client in the form of weekly assignments. Beliefs such as “My life is miserable without using drugs” can be explored and challenged by the client asking: “What evidence do I have for that belief?” Beck (1993) sees this style of thinking as a long-term goal which can be reached through homework in cognitive therapy to effectively “assess, examine, and test these beliefs with the patient, in order to ultimately replace them with control beliefs” (p.186).
"Client’s Aptitudes"

My motivation to explore Mr T’s case as an example in this essay, is based on the fact that he did not turn up for his initial appointment offered to him following assessment. One assumption is that he may have been threatened by the ‘contract of therapy’ offered to him, or that the contract differed from the help he was really looking for when he asked for ‘support and counselling’. Mr T’s motivation for receiving support from our clinic may also be complicated by the fact that his GP may have wanted to withdraw prescription to Mr T, unless he would engage in some form of counselling. Wills and Sanders’ (1997) have discussed how transference may mirror core beliefs and assumptions “in vivo” (p. 61) and give ideas about the ‘client’s interpersonal schemata’.

Drawing on the assessment and case notes from previous therapy, in both cases he claimed that he was ‘emotionally blackmailed by his mother’, the likelihood of his eventually starting therapy again may depend, among other things, on how seriously he feels that his underlying conditional, and core beliefs are threatened; here formulated as: “If I stop taking my heroin tablets (DF118), I will feel suicidal”- “Without them, life is not worth living”. These conditional rules could be based on underlying ‘interpersonal schemata’, such as: “As a child, I was unlovable in my mother’s eyes”, “I am worthless” “I am used by others (my mother)” therefore: “I don’t trust women” (taken from his case notes). Based on relatively concise session notes, this conceptualisation might suggest that Mr T can only work with a female therapist, who would be able to establish trust in the therapeutic alliance, whereby she be able to ‘challenge’ the clients appraisal (faulty or not) that “women cannot be trusted”.

According to this formulation of Mr T’s case the first task/goal to be accomplished to make further therapy possible, would therefore be to form a ‘secure base’ (see Perris et al., 1992) on which the working relationship would be established. Only from this
'secure base', can the client be expected to have security enough to explore his conditional beliefs, such as “Only if I take drugs, my life is worth living”, perhaps sustained by his core belief: “I am worthless”.

Based on his tendency for manipulative behaviour in his previous therapy, it was recommended he be responsible for his own drug use, whilst in therapy he would explore the benefits and costs of his drug using. Sending a feedback letter, offering a certain contract following assessment, can be considered as the first contact of therapist with the client, and a tool that provides initial ‘delivery of therapy’. This offer, based on therapeutic ideas of personal responsibility for drug-taking may, in eyes of the client, be an ‘active component’ that challenges his assumptions, such as “If I behave in a compliant way, others will comply to my wishes and needs. - If not, I will do my own thing”. Whatever the response of the client, the therapist will never know, if the client chooses not to engage, perhaps because the thought of ‘contact in therapy’ was too challenging.

This part of my example may serve to introduce the idea, that no matter what the qualities of the therapist are, therapeutic change will always be dependent on the client’s current ability to engage in therapy and what sense he makes of interventions delivered at any particular time. Some clients may use a relatively simple intervention to challenge and change their behaviour, whilst for others (such as for Mr T.) a relatively simple contact/intervention may be too challenging and not congruent with the client’s expectation and understanding.

Beck (1993) mentions that implications for therapy might constitute several factors such as clients’ aptitudes, including psychological ‘mindedness’, objectivity, self awareness and accessibility and flexibility of automatic thoughts and beliefs. All those aspects might seem relatively inaccessible by ‘my client’, Mr T. This would not necessarily mean that he does not want to, or cannot change; however, change might simply seem too threatening at this moment in time. In terms of the Model of Change by Prochaska and DiClemente (1984), the client might psychologically be in the
'Precontemplation Phase'. If the therapist manages to respond in a way that increases client's self-esteem and a sense of competence, the client would be more able to work with other issues in relation to his concern about his opiate-addiction. When/if the client becomes interested in looking at his life in more detail, the 'real' work of 'collaborative empiricism' can begin.

In conclusion

In cognitive therapy, the therapeutic relationship is seen as a necessary factor but not sufficient for therapeutic change. I have discussed homework and cognitive models used in addiction as valuable tools to encourage change with clients. However, this process would always depend on the qualities/aptitudes of client and therapist and their collaborative relationship.

Finally, therapist qualities are important, but cognitive therapy also places responsibility on the client's contribution and participation in the therapeutic change (Alford and Beck, 1997).

For the purpose of this essay, I have consulted an unpublished handout used in a course on elaboration and integration of Prochaska and DiClemente's (1984) Model of Change, and Motivational Interviewing (Miller and Rollnick, 1991).
References


Psychoanalysis and Female Psychology: Feminist orientation of sexuality and penis envy

Introduction

In this essay on female psychology, I will examine the development of female sexuality and penis envy, as seen by Freud. I will also attempt to cast light on how this issue has been seen by several feminist psychoanalysts and other theorists who have criticised and/or developed Freud’s ideas. In order to do this I will explore how the development of boys and girls can be compared and contrasted.

In the psychoanalytic theory, the concepts of bisexuality, castration complex and the Oedipus complex are an essential background to the development and understanding of Freud’s theory of femininity. For the sake of the brevity and clarity of this essay, the castration complex will be discussed, at the cost of not dealing much with the Oedipus complex.

As the study of the Freudian literature is an extensive work, I consulted three references of Freud’s work (Freud, 1925; 1927 and 1930). In addition to that, I have found Mitchell’s (1974) excellent discussion on Psychoanalysis and Feminism a great support to clarify my ideas on Freud’s ideas on sexual development. Mitchell (who is highly interested in literature and the politics of feminism) uses Freud’s theory to explain how the influence of patriarchal society serves to produce women whose femininity equals passivity and inferiority, and men whose masculinity equals activity and superiority. She states that although an egalitarian account of sexuality might have been more pleasing, this account makes no sense and does not describe “the psychological formations produced within patriarchal societies” (Mitchell, 1984;
Despite being guilty of unconscious male chauvinism, Freud offered psychoanalytic theories about sexism that describe women's oppression under patriarchy, thus giving us an account of sexual development of women as developed within a male dominated culture.

**Freud's Theory on Sexual Development**

The development of infantile sexuality is important in psychoanalytic theory (Wollheim, 1971). Freud (1925) has described the development of sexuality and explains that infantile or pregenital sexuality already occurs in infancy and childhood. He divides this time into the oral and anal stages. During these stages the fulfilment of 'instinctual needs' are seen as crucial for later sexual development. The satisfaction of infantile sexuality is obtained by the infant's pleasure of being fed. This sexuality is not directed to a particular person i.e. it does not have an object but the child 'obtains satisfaction' through its own body. Freud (1925) saw this infantile sexuality as 'autoeroticism'. The earliest object of sexuality is the person or persons who satisfy these needs, usually the mother (Wollheim, 1971). Accordingly the 'self-love' or 'autoeroticism' experienced in the initial stage of 'infantile sexuality' is directed towards the mother.

In his theory of Narcissism, Freud discusses infantile sexuality. He states that the new-born baby directs its energy to itself. Like Narcissus at the pond, who discovered his own beauty, the baby discovers itself (Mitchell, 1974; Lemma-Wright, 1995). Thus, the baby is only aware of, and loves the self. It is only in later stages that the baby discovers its need for others, as objects for the fulfilment of its instincts and 'sexual drives'.

Freud (1925) saw the pregenital sexual development of children as the same for boys and girls. He described this development as 'bisexual' or symmetrical to each other,
meaning that boys and girls developed in the same way until puberty. The third stage of sexual development, the ‘phallic phase’ is according to Freud initially also the same. However, it is during this third stage, that girls and boys discover the ‘phallic power’ (Mitchell, 1974). Until these changes occur, the development of sexuality is characterised by attachment to the mother as the main caregiver. Besides being dependent on the mother as the source of food and comfort she is also the first object of sexual longing (Wollheim, 1971). The mother is perceived as the main love-object, and both girls and boys alike direct their ‘erotic’ love towards her. Freud (1925) considered this sexuality to be of ‘wholly masculine character’. In support of this claim, he stated that girl’s ‘leading eroto-genic zone’, the clitoris, was “homologous to the masculine genital zone of the glans penis” (Freud, 1925; p.142). Thus, according to Freud, both pre-genital development of both sexes is characterised by the desire to ‘possess’ the mother as their love-object. However, as Freud maintained, during the ‘phallic phase’ boys and girls discover the significance of the penis and its ‘phallic power’, leading to women seeing themselves as the ‘castrated other’ (Lemma-Wright, 1995).

Castration complex: Penis Envy

As an introduction to penis envy, an illustration of the castration complex is important. The castration complex describes the ‘horror’ experienced by men at the thought of losing their phallic power, which finally directs them to the path of masculinity. For women, the resolution of the castration complex is different:

the girl learns that she has no phallic powers and thus will not now or ever possess her mother or later substitute (a wife) - indeed that she is like her mother, without the phallus: she recognises her castration, envies the phallic power, and has to do her best to overcome this envy.

(Mitchell, 1984; p. 230).
When girls realise they do not have a penis like their brother or uncle, they are ‘overcome’ and filled with envy (Freud, 1925). Their task towards womanhood and ‘femininity’ is to accept the fact, that they do not have a penis and never will. In Freud’s terms, girls have to accept the fact that they have been castrated, while men are afraid of losing it. Freud saw the castration complex as the ‘dividing line’ between male and female sexuality which changes the symmetry of bisexual development and directs it towards femininity or masculinity (Mitchell, 1974). Freud contends that the little girl compares her ‘masculine’ genital to the real masculine genital, the penis. Thus, she discovers the superiority of the male organ and the inferiority of its feminine counterpart, the clitoris, leading her to abandon her ‘masculine’ genital as a source of sexual pleasure for the more ‘feminine’ vagina. This transference from her ‘active’ sexuality to the ‘passive’ (feminine) orientation to sexuality, is called the ‘positive’ resolution of women’s Oedipus complex (Mitchell, 1974).

Thus, the castration complex involves boys’ fear of the possibility of losing their penis and that girls and women suffer from ‘penis envy’. This envy is transferred to the desire of having a baby from her father, and later from another man. The child is equated with the man’s penis, and women ‘accept’ their femininity by suppressing their ‘masculine’ sexual desire and their envy for the penis by the desire of having a baby, that hopefully brings the missing penis (Chodorow, 1995).

**Castration, Penis Envy and Devaluation of Women**

It is interesting to note, that Freud uses Greek myths to illustrate sexual development (Olivier, 1989). These myths, like the story about Oedipus and Medusa’s Head, originate from civilisation and culture of strong patriarchy, where the power of the father goes undoubted. In Freud terms, this power is equated to the ‘phallic power’ of father’s penis. For women, this implies: ‘no phallus, no power’ (Mitchell, 1974).
Lerner (1988) discusses penis envy and highlights that within the psychoanalytic model it is "believed that penis envy is central to the understanding of women" (p.3). Psychoanalytic views contend that women's struggle for equality is a manifestation of penis envy. The psychoanalytic notion to equate penis envy with 'masculine strivings' and label this 'denial of the feminine role' as a problem (Lerner, 1988) is consistent with attitudes in a patriarchal society, whereby independence for women is not easily accepted. The psychoanalytic solution to penis envy in the form of substituting the penis with a baby (penis=child equation) also describes women's inferior status within society. Thus, Freud's account of feminine sexual development is consistently describing women's role and women's place in a patriarchal system, which has its roots in ancient Greek civilisation.

According to feminist critique, however, penis envy is not the desire for the masculine genital, but rather "reflects the attitude of an underprivileged or subordinate groups toward those in power" (Lerner, 1988, p.46). As Olivier (1989) has observed, Freud did not invent the inferior status of women, but "he did everything possible to explain it, make it logical and therefore inevitable" (p. 4). By doing so, Freud legalised the distinction between the sexes and 'gave it scientific appearance'.

_Castration and feminine inferiority:_ Chodorow (1995) has observed how often women are described as objects in Freud's account of female sexuality. They are described through men's eyes. Certainly Freud, as a man, could only do that. Thus, in the sexual development when the differences between the sexes emerge, it is only one type of genitals that are seen as worth having; that of the male. To Freud, this is so central and important that differences between men and women are seen in the presence or absence of the penis.

Freud describes how men desire women, especially their mother. However, he also talks about men's contempt for women (or mother), when they realise that she does not have the desired penis (Mitchell, 1974, Chodorow, 1995). Thus, women are
either idealised and seen as a source of love and 'nourishment' or they are devalued and seen as a threat to men's 'phallic power', and ultimately seen as inferior to men. Freud describes this in an excellent manner when he observes "the Chinese way of mutilating the female foot and then revering it like a fetish after it has been mutilated. It seems that the Chinese male wants to thank the woman for having submitted to being castrated" (Freud, 1927; p.157). Thus, the psychoanalytic model of 'femininity' seems to be analogous to the Chinese footbinding: Men are 'thankful' and worship women for being inferior to them. They idealise and have contempt for women's 'footbinding' which in Freudian terms is described as castration and inferiority.

'Penis envy', 'breast envy': Fear and devaluation of femininity: Envy for the qualities of the other sex is not only characteristic for women but may also apply to men as well (Olivier, 1989). Penis envy may well be a construction of the opposite, i.e. men's expression of their breast envy. This opinion was originally put forth by Melanie Klein (1957), when she compared and equated penis envy to the envy for the breast. She stated: "My work has taught me that the first object to be envied is the feeding breast" (Klein, 1957; p.183): by desiring a penis women, and men, are actually searching for the early attachment with the 'feeding breast' (intimacy with the first love-object). Chasseguet-Smirgel (1970) has emphasised this early relationship with the mother as the 'primitive maternal imago', which for both sexes is connected with the 'child's primary powerlessness'. She maintains that seeing women as castrated is a denial of this 'imago of the primitive mother' upon whom both men and women have depended for intimacy and nourishment.

According to this view, Freud's description of men's extreme horror at the sight of female genitals and of castration (1927) could be a male description of their fear of women, of intimacy, and fear of losing the so much valued masculine autonomy and independence. At the same time, they may unconsciously wish for 'reconnection' with the feminine qualities and the intimacy, which they had to abandon, while striving for their masculinity (Chodorow, 1978).
Thus, men's devaluation of women can be seen as a 'defensive reversal of an early matriarchy'. Instead of envying women's qualities, which in the early relationship with the 'omnipotent and powerful mother' are linked with dependency and regression, men fear these qualities and devalue them. Similarly, women's participation in depreciating their own sex may be originated in their difficulties of differentiating from an intrusive and powerful mother (Lerner, 1988). According to this critique, the emphasis of psychoanalysis on the penis and penis envy can be seen as a longing for the 'feeding breast', the desire for the qualities of the nurturing, good mother. However, these feminine qualities are defensively denied because they are connected with 'dependency, passivity, and fragility' (Lerner, 1988). Thus, Freud's account of feminine sexuality can be seen as describing men's need and longing for intimacy, and how their fear their own desire for that intimacy.

Perhaps, Gilligan's (1982) research can be viewed as a support for this argument. She has illustrated how men's aggressive fantasies increase when they fantasise about what might happen between people, men and women, when she found that the closer two people are to each other in a picture, the more aggressive become their fantasies. Thus, Gilligan's (1982) statement, that fear of intimacy is ingrained in the masculine identity, is consistent with the feminist views mentioned above. However, whilst Gilligan and other feminists of the modern world strive to give a respectful and egalitarian account of the development of both sexes, psychoanalysis seems to devalue femininity and feminine sexuality.

**Feminist critique of psychoanalytic views**

Mitchell (1974) highlights that when Freud discusses the symmetric pre-Oedipal sexuality of both sexes, he does not take into account that the first love-object for both girls and boys is the mother. The boy continues to have the mother as a love-
object, but the girl has to make a shift to her father as an object of love. Chodorow (1978; 1995), on the other hand describes this development in terms of identification and highlights that boys identify with a powerful, active father, whereas girls identify with a mother who gives maternal care, but she also represents submission and passivity.

While Freud emphasises the role of the father in sexual development, Chodorow (1978) has argued that women play an important part in the development of both sexes. She has underlined how women tend to ‘mother’ their children in a way that reproduces the stereotyped roles of ‘masculinity’ and ‘femininity’. Usually, women take on the mothering role, and boys and girls identify with their mother. In the Oedipal period, the boy has to give up this early identification with his mother. Girls, however, continue to be in ‘mother-infant’ relationship with their mother much longer than boys. The boy goes through a ‘crisis of identification’ for his sense of masculinity. Thus, he can more easily differentiate himself from this infantile relationship with his mother and is more able to express his sense of difference to her.

According to Pollack (1995) and his critique of the psychoanalytic model this separation is not without a cost. He describes this as premature separation and early abandonment of boys from their mothers. He criticises the psychoanalytic model for providing a ‘basis for a normative developmental trauma’ “which considers abandonment of and dis-identification from their mothers as necessary to achieve a healthy masculine sense of self” (Pollack, 1995; p.31). This is in contrast with female development. For the girl the ‘source of attachment’ and the object of identification is combined in the same person, leading to a sense of intimacy and identity which is strengthened in relationships with others (Gilligan, 1982).

Chodorow (1978), like Freud, claims that both sexes tend to be negative towards their mother in the Oedipal period. However, it is not because the mother lacks a penis, but rather because the mother presents ‘regression and lack of autonomy’. The boy learns to repress, reject and devalue “whatever he considers to be feminine in the
social world” (Chodorow, 1978; p.181). The girl, in contrast, despite being hostile to her mother, must identify with her and accept her own femininity. Thus, identification with mother’s ‘lack of autonomy’ may lead to a sense of powerlessness for girls.

Consistent with Freud (1925), others have observed that girls tend to respond to the time of adolescence with repression or depressive affect and a sense of helplessness (see Mitchell, 1974; Gilligan, 1982; Chodorow, 1995). In her discussion on ‘Women and Depression’, Jack (1991) has discussed how women learn to set aside their own needs and wishes. They learn to blame themselves, rather than looking at the how they learn to put the wishes of others first. This self-abnegating behaviour may lead to resentment and anger. Jack (1991) states that this behaviour increases power differences and ‘externalises’ the feminine power. She contends that the feminine ‘scar of inferiority’ (penis envy) is symbolic for the lack of mutuality in relationships between the sexes. Thus, the anger and hostility described by Freud, seen to characterise the discontent of women because of their ‘castration’, can be seen as a result of the differential power 'assigned' to men and women. However, this may have led women to ‘solve’ their lack of external power by searching “for recognition, success or other gratifications - in their children” (Maguire, 1995; p.110).

**Conclusion**

It has been argued that Freud explains the development of female sexuality from the male point of view. However, his theory describes ‘in a sensitive manner’ the psychological development of sexuality as it has been in the patriarchal society. Psychoanalytic feminists have argued that the phallus is symbolising the power of the father (men) and castration a symbol for women’s lack of external power, repression of sexuality and submission to the societal power of men. Thus, Freud’s concept of penis envy can be seen as longing for the power that men are entitled to, and women are not, according to the patriarchal culture.
Psychoanalysis provides a theory that narcissistically glorifies the phallus. But it is oblivious to the fact that there is no masculinity without femininity and there is no 'power of the penis' unless there is somewhere a hidden power of its sexual counterpart.

In conclusion, feminist approaches have used the psychoanalytic account to clarify the power and powerlessness of feminine sexuality and how women and men acquire their sexual roles, within a society which overvalues masculine power and devalues the power of feminine sexuality. Thus, feminist psychoanalysts have clarified the power of the mother's role in the development of girls and boys, and how women, according to the rules of society, reproduce 'feminine' and 'masculine' identity.

References


"Women’s Ways of Knowing"

Feminist Epistemology

Prologue

Epistemology is “the branch of philosophy concerned with the theory of knowledge” (Gregory, 1987). But what is knowledge and how do we know? Philosophy has proposed that we have knowledge when we have a true belief that something is the case and we can show that this true belief is supported by sufficiently good evidence (Rynin in Stroll 1967). According to this orientation, ‘I cannot know or have knowledge unless I am able to support it’. This approach assumes that there is a certain truth ‘out there’, which epistemology/philosophy endeavours to approach through identifying necessary and sufficient conditions that might specify what knowledge is and what it is not. Feminist orientation to this approach directs its focus on how the ideals of rationality and objectivity in the analysis of knowledge are made/constructed by the autonomous, ‘dislocated’ observer (Code, 1993). Perceiving at a distance, this knowing seeks to control and predict the objects known. In short, science favours objectivity, reliability and value neutrality. Useful for the material sciences, this paradigm has considerable drawbacks when it comes to knowing in the personal context and within complex human interactions and relationships.
Introduction

In this essay on epistemology, I would like to explore a feminist standpoint and how this may contribute to the understanding of counselling psychology and its underpinnings as a scientist-practitioner model. Woolfe (1996) highlights that “the link between science and practice is a crucial one for counselling psychology” (p. 13). However ‘crucial’, this link is difficult to establish whilst knowledge and ways of knowing are only geared towards one part and not the other. The epistemological underpinnings of the ‘scientific’ strand of counselling psychology was developed literally through ages in the practice of traditional philosophy and science. This paradigm has of course been adopted by psychology, that has endeavoured to be a part of the scientific enterprise and to be considered as a respected empirical discipline.

Traditionally, the scientific discipline is characterised by objectivity and rationality; an epistemological stance whereby, the observer/knower is distanced and separated from the observed phenomena or object. Emphasis is on value-free, objective science and the neutrality of the observer. In their discussion of, and introduction to “Rethinking Psychology”, Smith et al (1995) have reflected on this as the ‘old paradigm’, whereby the emphasis is on measuring, predicting, causation and reduction to numbers which then are reduced to ‘atomistic, context-free and objective universals’. They, however, point to a new way of knowing and doing research within psychology. This ‘new paradigm’, in contrast, includes: understanding, describing and finding meaning. Based on language rather than numbers, this epistemological approach emphasises subjectivity that is holistic and looks at particularities - rather than universals - as it endeavours to explore the cultural context. Smith et al (1995) suggested that ‘the ongoing shift’ towards a new paradigm involves a re-evaluation of the conceptual foundation of traditional psychology. It might be necessary to ‘rehear old voices’ - such as that of phenomenology, which has a focus on how the object is perceived; as
opposed to an exclusive and isolated attention to what is perceived. However, in this process, they claim it is also relevant to listen to ‘new voices’.

**Feminist Epistemologies**

*‘Listening to the voices of others’:* Whilst thinking about this project on ‘old’ and ‘new’ (and more feminist) epistemology, in a group of friends, I was told that the reason as to why there are more women than men in the world is “because there is more cleaning to do than thinking!” Being a derogation of women and a glorification of men, on a deeper level, this little joke may reflect more truth than apparent at first. Many feminists highlight that women’s ways of knowing and relating to the world is much more contextual than that of men (Belenky et al, 1986; Gilligan, 1982), which then encourages women to take the environment and other people into account a lot more than do men. In this way, women may have learned to think more about contextual things, such as ‘cleaning’ (‘because there is a lot of cleaning to do in the world’) whilst men base their development on an identity of separation through which they set themselves apart from the world (see Gilligan, 1982).

Fox Keller (1983) maintains that science is genderised. She argues that the high value placed on scientific objectivity is a ‘product’ of the masculine development characterised by strong emphasis on distinguishing self from not-self. Any blurring between subject and object tends to be equated with feminine issues. According to this, men may learn to ‘clean their thinking’ from things that seem to threaten their personal interests.

In their book “Women’s Ways of Knowing”, Belenky, Clinchy, Goldberger and Tarule (1986) have explored that ‘women’s ways of knowing’ often differ from that of men and how they make sense of the world. They argue that “women’s self-concepts and ways of knowing are intertwined” (Belenky et al, 1986; p.3) and the
ways in which 'they draw conclusions about truth, knowledge and authority'. According to this, it seems that women's sense of what constitutes as truth or knowledge depends on authorities, and not friends, as source of knowledge.

Based on William Perry's (1981) work, the authors divide different ways of knowing into epistemological positions. Thus, they maintain that many women can be very open to listening to what others have to say, yet having 'little confidence in their own ability to speak'. Belenky et al (1986) call this position 'received knowledge'. They theorise that women in this position look for others in search of truth and have no opinions or voice of their own.

'Connected Knowing' vs. 'Separate Knowing'

'Separate Knowing' in traditional epistemology and science: Belenky et al (1986) argue that men have an orientation towards 'Separate Knowing' which typically involves critical thinking (doubting rather than believing). They tend to use reasoning and ask for evidence. Through their tendency to analyse and evaluate arguments, they maintain an impersonal stance or objectivity, which makes them less vulnerable to attack. This objectivity has been described elsewhere by feminists as "the separation of the knower from what he knows" (Stanley and Wise, 1993). Thus, the observer describes the known as impersonal and set apart from any personal interests. Of course, this epistemological paradigm has successfully been used by the empirical and material sciences.

Historically, this 'position of separate knowing' has been divided into two main strands according to how we are seen to approach knowledge and truth. Plato, with focus on the ideal world (i.e. that of mind) and Aristotle, with more emphasis on the material world, argued for obtaining knowledge through observation (Marx and Hillix, 1979). Both favouring reason, Plato is seen as the 'father' of dualism that
divides the world into ‘mind’ and ‘matter’ and Aristotle has made an important contribution to observation methods, which has been seen as foundation of modern empiricism. This dualistic thought has been perpetuated through the centuries. Locke argued for the external: ‘Matter makes mind’ (i.e. we can only obtain knowledge through our observation of things) and Berkeley supported the internal: ‘Mind makes matter’ (i.e. we can only know directly what is perceived in our mind) (see Marx and Hillix, 1979). In his attempt to explore this relation, Descartes further increased the epistemological separation between matter and mind; mind and body. On one extreme, is the conviction that subjective knowledge, through the mind, is the only way to generate knowledge. This idealist position, solipsism, concludes that the knower can only know his own subjective truth: “I can only know my pain, what someone else means by ‘pain’ I cannot understand” (Dilman, 1975; p. 131). On the other side has been the development of ‘mechanistic determinism’ which sees scientific knowledge as causal consequences and allows us to live in a value-free and predictable world with “perfect law so that we can understand and foresee every response which we will make to every situation” (Thorndike, 1949, p. 362; quoted in Marx and Hillix, 1979; p. 56). Those conceptualisations of subjective vs. objective knowledge are not very helpful as a paradigm when it comes to understanding the client. Clearly, those epistemological positions would be a hindrance to empathic understanding and how to perceive the client’s ‘pain’ or personal values in life.

Like argued above, the foundations of the traditional epistemology is reason - rather than feeling, and observation - rather than listening. This separation between the knower and the known can at times be seen as necessary precondition for both science and love or empathy. However, as Fox Keller (1983) has argued, it may not be sufficient for either. A ‘new epistemological paradigm’ may be especially relevant as an underpinning within counselling psychology, both for therapeutic practice and research. It can be seen as greatly disturbing and misleading for the counselling psychologist to find ways in which she or he can understand and know the client, when the existing epistemological approach only values knowledge obtained through ‘context-free objectivity’ and ‘neutral isolation’.
'Connected Knowing': Belenky et al (1986) argue that whilst separate knowers learn through explicit formal instruction, connected knowers emphasise learning through empathy. With emphasis on listening, they tend to ‘use the lens of the other person’, not by judging but through understanding. They maintain that this includes collaborative explorations and involves feelings ‘because it is rooted in relationship’. This feminist epistemological approach with emphasis on empathy, non-judgmental listening and understanding of the other person fits very well to existing theories on the therapeutic relationship, through which the client is supposed to learn to know himself or herself in a better or different way - and is theorised to happen through the connection of the relationship (see Clarkson, 1995). Belenky et al (1986) have described ‘connected knowing’ as “an orientation toward understanding and truth that emphasises not autonomy and independence of judgement but joining of minds” (p.55). The purpose is connection and a response to others in their own terms, rather than justification. Collaborative exploration, or Socratic questioning, is emphasised in my cognitive-behaviourally oriented placement as a process that occurs through various channels. Talking, listening and reflecting back is an interactive process which contributes to client - and therapist - knowing in a different way.

'Constructed Knowledge': Belenky et al (1986) suggest that there is a position seen as “Constructed Knowledge” in which ‘the knower is an intimate part of the known’. They maintain that for their women as subjects, this way of knowing happens through a process of integrating the inner subjective knowledge (‘inner voice’) and ‘received knowledge’ adopted through listening to the ‘voices of others’. In this position the knower learns to integrate both voices. This is a process which requires careful listening and a language of intimacy, as a necessary condition in the relationship between the knower and the known. Describing well the therapist-client interaction, this model seems to be of help in understanding better the role of the therapist and the need to integrate inner personal and theoretical voices in a way that enables to construct knowledge that uses ‘the lens of the other’ as a main focus.
Concluding Words

The emphasis of this essay has been to bring attention to the traditional epistemological approach and its limitations, when it comes to explore phenomena within human relationships. Belenky et al's (1986) theory of differences between women and men in their epistemological orientation has been used as framework to explore possible inadequacies of this epistemology as a foundation for counselling psychology. Feminist analysis may provide an increased and fruitful understanding of how the epistemology of counselling psychology may need to look for new paradigms. Positivist-empiricist knowers have been described by some feminists as "detached neutral spectators" (Code, 1993). This rationale can hardly be seen as fruitful in strengthening the link between science and practice within counselling psychology, whose role is to combine scientific research and therapeutic practice. In this way, feminist criticism supports the insight that interaction between the knower and the known needs to be taken into account, within scientific research as well as practice on which the latter is based.
References


The tension between ‘art’ and science?
Counselling Psychology as a ‘holistic enquiry’

Introduction

Counselling psychology is based on two different strands. One is derived from the ‘art of counselling’, which in the past may have suffered from the lack of rigorous evaluation of the counselling practice (Woolfe, 1996); the other strand is intended to provide and introduce a more scientific perspective of empirical research, seen as necessary to “provide an appropriate theoretical foundation for counselling psychology” (Woolfe, 1996, p.10).

Counselling psychology can be seen as a reaction to the traditional paradigm of psychology as a “singular and prescriptive model of inquiry” which according to Smith et al. (1995a) “is clearly associated with psychology’s long-standing aspiration to claim the status of a respectable ‘natural science’”. However, the authors maintain that, ironically, the scientific approach which mainstream psychology apparently aspires to use as a model is not very helpful, or “in a sense, a redundant one” (Smith et al. 1995a; p.2). The development of this critique goes at least back to the viewpoint made by Koch (1964) who illustrated that:

There is a strange circularity, then in the predicament of psychology. Psychology has long been hamstrung by an inadequate conception of knowledge, one not of its own making. A world now in motion towards a more adequate conception begins to perceive that only psychology can implement it. Yet psychology is prevented from doing so alone in the scholarly community, it remains in the grip of the old conception.

Koch, 1964; p. 5-6

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In short, counselling psychology appears to be an attempt to fill 'the vacuum' (Woolfe, 1996) that exists between counselling as an art and psychology as a scientific enterprise. Some claim for objective criteria (Williams, 1991) whilst others maintain that 'too much devotion to narrow scientific principles' has prevented psychology 'to pay proper attention to what it means to be human' (van Duerzen-Smith, 1990).

In this paper I intend to look more closely at the implications of the traditional scientific paradigm as applied to psychology as well as exploring the ways in which counselling psychology has attempted to move towards a more adequate conception of its own making (see Koch, 1964). Thus, I discuss Counselling psychology as a model that comprises a holistic model of therapeutic practice. This includes an understanding of the individual within social, cultural and political context as well as the therapist. This orientation will be contrasted with the more traditional approach to empirical psychology. Finally, issues related to research as a part of a holistic approach within the discipline will be discussed.

'The old conception' of psychology is based on a model of objectivity, reduction-to-numbers and context and value-free science which according to its fundamental principles distinguishes very clearly between the observer and the observed; 'me' and 'not me' (Fox Keller, 1983; Code, 1993; Nicolson, 1995). This scientific paradigm may be limiting and likely to create a tension in its application to the understanding of the human life, which is full of value laden context.

Schotter (1975) questions the sole reliance on objective experimentation as a way of establishing how people actually 'work'. Going back to Plato he explains how there is "a bias in favour of searching for the ideals underlying the changing flux of experience [...] rather than flux itself [...] ; with forms - rather than meanings" (p.74; author's italics). Thus, science with the emphasis on experimental enquiry is devoted to the particular understanding of being able to predict behaviour and attain control,
rather than gaining insight and understanding. This paradigm, according to Schotter does not allow us to establish the whole truth; rather it can only be seen as a partial approach to what it means to be human.

A different value base

It could be stated that counselling psychology is based on a certain philosophy whereas the understanding of the clinical psychologist is based on science. This is not to say that counselling psychology does not have a scientific base or that clinical psychology is devoid of philosophical values. It may be difficult to distinguish one profession from another, for example a counselling psychologist from a clinical one, as both professions share many aspects in their approach to therapeutic enterprise, whilst these professions may differ considerably in their theoretical and philosophical approaches.

When books on clinical psychology are opened they seem to be characterised by diagnostic labels such as depression, anxiety, PTSD, diagnosis, DSM and testing. Thus, this approach focuses on problems, in terms of what might have gone wrong or which disease the client may have. Counselling psychology, in contrast, endeavours to have a focus on the individual. ‘Naturally occurring’ entities are used to explore the individual existence: women, sexual orientation, cultural differences, and lifespan events like parenting, divorce and loss.

This orientation is reflected in the Professional Psychology Handbook which defines counselling psychology as “that branch of applied psychology concerned with helping people make informed choices in their lives and to adjust to new and sometimes unwelcome circumstances. Counselling psychologists work directly with clients spanning the full human life cycle” (Watts and Bor; BPS, 1995; p.52).
A holistic and contextual model

The specific contribution of counselling psychology can be said to be its holistic view of the client, therapist, and the 'encounter' between the two, i.e. the therapeutic relationship. Definitions of counselling psychology underline the importance of the relationship between therapist and client. Thus, the emphasis has been on being with client, rather than doing something to that person.

According to its model, counselling psychology describes a holistic view of the client. The emphasis is on the understanding of how the person functions within a broader context. Interpersonal, social and political factors and the interaction with the individual functioning are seen as relevant and influential in the development of personal well-being. Within this framework, the client is not understood from a reductionist model explaining problems as diagnostic phenomena (Strawbridge and Woolfe, 1996). Instead, developmental approach with a focus on the development of the self (Woolfe, 1996) is seen as essential. Research of this orientation on Women's Sense of Self replacing the concept of codependency within this portfolio is presenting such an orientation. Clarkson (1994) highlights that "life-span developmental psychologies, and the social psychology of interpersonal processes are among the areas that supply the academic foundations of counselling psychology" (p.16). Clarkson (1994) quotes the BPS to give a definition:

The psychological understanding of counselling derives not only from formal psychological enquiry but also from the interpersonal relationships between practitioners and their clients. The essence of such relationships is one of personal exploration and clarification in which psychological knowledge is utilised and shared in ways which enable clients to deal more effectively with their inter- and intra-personal concerns.

(BPS, 1989; p.1)
A holistic model of the therapist

Within the framework of counselling psychology, the self of the therapist is seen as an ‘active ingredient in the counselling process’ (Woolfe, 1990). Personal development of the counselling psychologist is an important part of this model. Supervision is one of the main tools to reach that end. Thus, personal therapy as well as career-long supervision are seen as an integral part of training and professional practice. A continuing supervision is emphasised as a means to ensure personal competence, enhance knowledge and good practice within the discipline (Farrell, 1996). The discipline of supervision in Britain has been described as being at the adolescent stage of development not ready to be a discipline on its own, but ‘tied to’ counselling psychology. This metaphor of supervision being like a teenager “not quite ready for life on its own” (Carroll, 1988, p.395) seems to describe well the purpose of supervision for those who are still in training whereas continuing supervision in the profession might be seen as further training towards the developmental milestones of the counselling psychologist. The BPS guidelines describe the responsibilities and obligations of the practitioner as being: “to self and client; and: to self and colleagues”. One of the main obligations is to ensure competence. In this context: “The supervision/consultancy relationship is a key element in this process” (BPS, 1995; pp.3-4). Farrell (1996) underlines supervision “as the most important means of training for the profession” (p. 596) and he also describes supervision as a means to ensure quality control in practice and for enhancing continuing professional and personal development.
Interactionist model rather than reductionist

Psychologists have mainly been concerned with the diagnosis and treatment of disorders, however, psychology has increasingly directed attention to prevention rather than curing of illnesses (Woolfe, 1990). In contrast, the philosophical underpinnings of counselling psychology are originally founded on developmental orientation of the individual with a focus on well-being rather than sickness. Counselling psychologists may deal with problems related to pathology, but the main orientation is, however, a rejection of the medical model and a belief in an interactive and holistic enquiry, with and emphasis on what might be the individual potentials and how the person deals with problems that may be a challenge to his or her well-being.

Humanistic value base

Counselling psychology respects the individual as a separate and unique being. This does not mean that other branches within psychology do not respect the client's individuality. However, within counselling psychology this belief is one of the foundations of its value base (Woolfe, 1996). This orientation of the client is originated within the humanistic approach to clinical practice, which emphasises a holistic view of the client, rather than seeing him or her in terms of the medical model as having a particular disease. As Woolfe (1996) points out, the humanistic model emphasises an interactional process in which the therapist emphasises being with the client to enhance 'personal growth and potential'.
Empowerment and respect for individual autonomy
in a wider perspective

In his critique on psychology as a natural science of behaviour, Shotter (1975) proposed an alternative of "psychology as a moral science of action". He supported this by discussing the "responsibility which we all can have for our own actions" (p.84). This issue has been included as an aspect of science and practice, yet given a wider perspective:

An emphasis in the practice of counselling psychology is to devolve power to the client, and to seek ways of promoting the client's autonomy in matters pertaining to their life and relationships (Watts and Bor, 1995, p.56).

These models seek:
• to engage with subjectivity and inter-subjectivity, values and feelings;
• to recognise social contexts and discrimination and to work always in ways which empower rather than control and towards high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today.

(BPS, 1995; p.4)

The client's autonomy is highly valued within counselling psychology, and is based on two main values: "the freedom of the individual to make their own choices and the freedom to decide their own actions" (Shillito-Clarke, 1996, pp.557-558). Thus, the role of the counselling psychologist is to help the client to make an informed choice about their own lives. However, it needs to be kept in mind that autonomy is concept highly valued in Western society. It may differ between different cultures and socio-political context, to which degree individuals can or want to see themselves as autonomous beings.
Another contribution of counselling psychology is to look at the individual in the wider sociological perspective, social characteristics, such as gender, race and social class, need to be looked at and these may play a role in client’s presenting problems. Strawbridge and Woolfe (1996) highlight that failing to take these environmental factors into account “psychology could be said to be upholding the status quo by helping to paper over societal cracks, thus assisting in the preservation of inequalities of race, social class and gender, etc.” (p.606).

These authors (Strawbridge and Woolfe, 1996) also discuss the importance of individual autonomy: people are seen as responsible for their own problems and they also have the power to solve these problems. However, this includes the belief that people are always able to create their destiny. Thus, by respecting the individual autonomy, they will be able to solve their problems. However, by supporting this hypothesis, they contend that counselling psychologists may actively ‘assist in maintaining the status quo’.

In their critique, Prilleltensky and Fox (1997) have highlighted that mainstream psychology has not succeeded in being value-free when “it seeks to maintain things essentially as they are, supporting societal institutions that reinforce unjust and unsatisfying conditions” (Prilleltensky and Fox, 1997, p.3). Moreover, “psychology is not and cannot be, a neutral endeavor by scientists and practitioners detached from social and political circumstances: It is a human and social endeavor” (p.3).

This means that the pretension of neutrality, may often support the status quo. By emphasising individual responsibility in disempowering situations, the counselling psychologist may become part of the problem rather than contributing to its solution. Thus, awareness of, not only the person as a whole, but also of the socio-political context within which he or she is living is necessary for the counselling psychologist to be able to empower people.
In line with this discussion within counselling and critical psychology, feminist critiques have highlighted, that there is a tension between the humanistic emphasis on individualism, and the feminist philosophy that emphasises a perspective which takes the wider context into account (Waterhouse, 1993). The feminist paradigm has pointed out how social factors may influence personal experiences. It underscores how society oppresses women and that women’s experiences can be seen as common to all women, rather than seeing this experience as a problem of that individual (Taylor, 1996). This may also apply to other inequalities within society, like race and class. Thus, it has been underlined that personal responsibility for conditions that are inherently due to cultural, societal or political factors can be ‘profoundly disempowering’ (Waterhouse, 1993) for people in disadvantaged situations.

These two perspectives, the respect for autonomy and the influence of social factors, may pose a professional dilemma, but at the same time they may in combination give a model to guide the counselling psychologist when working with a client whose well-being may be influenced and diminished by oppressive societal attitudes. An example of this can be taken from my clinical experience with a female client, who comes from a low-class family in which patriarchal attitudes are highly valued. In her family, opinions and emotions were not expressed, and problems were put ‘at a distance’ in the hope that they would disappear. Having been brought up by this abusive family (emotional, physical and alcohol abuse), the same history is repeated in her marital relationship. Can this lady be expected to have opinions of her own? If so, does she dare, or know, how to exercise her own will? By respecting her wishes, I am perhaps respecting her upbringing as an oppressed woman, and supporting the ‘status quo’ in her life. But in my effort to inform and ‘re-educate’ my client, I also have to have in mind that at the ‘end of the day’, I have to trust her to make an ‘informed decision’ about her own actions.
Counselling Psychology and Research

As mentioned above, there is a strong emphasis on empirical enquiry and research, especially in relation to issues that might increase understanding of the therapeutic relationship (Barkham, 1988). In a recent booklet on guidelines for professional practice the emphasis on research, theoretical and humanistic values in professional practice is apparent. Thus, it defines counselling psychology as:

"a branch of professional psychological practice strongly influenced by humanistic clinical practice and research as well as the psychodynamic and cognitive-behavioural psychotherapeutic traditions".

(BPS, 1995, p.2)

Furthermore:

It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship.

(BPS, 1995, p.3)

It has been argued that there is an epistemological tension between the 'art' of counselling psychology as therapeutic discipline, and its empirical and scientific foundation. In academic psychology empirical enquiry has been based on the research methods of 'natural sciences'. Described by some as 'singular and prescriptive model of inquiry', the usefulness of this approach has been critiqued and seen as doubtful within the framework of 'philosophy and practice of contemporary science' (Smith et al., 1995a). Thus, the need of 'rethinking methods in psychology' has been highlighted and is seen as an essential and exciting development in the attempt of providing a more holistic approach to research with people rather than on people (Smith et al., 1995b; Kidder and Fine, 1997; Rowan, 1998).
However, the ‘positivist’ approach remains the dominant attitude when it comes to satisfy the empirical standards made by editors of academic journals (Kidder and Fine, 1997; Coyle, 1998). Coyle (1998) has discussed the method of ‘using the counselling interview’ in qualitative research. His attention was brought to the reactions from journals specialising in qualitative research, expressing the ‘mainstream’ attitude that “counselling and research interviewing were inimical” (Coyle, 1998; p.60). According to this view, researchers would need to keep social and intellectual distance to pursue ‘proper analytic work’.

However, it might be “naïve” to believe that an analytic and intellectual approach in the research situation will guarantee a ‘proper’ and uncontaminated insight into the personal world view of the participant. In fact, as Coyle (1998) argues, research interviews, like any other social interaction, tend to be a constructive process which affects the participants’ identity, “as they produce and reflect upon ideas about themselves” (Nicolson, 1994; quoted in Coyle 1998; p.61). Thus, it appears that the traditional positivist research attitude (even within qualitative methodology) does not sit comfortably with the more interactive and holistic aspects introduced within counselling psychology. Moreover, the emphasis of imposing an ‘intellectual distance’ seems to implicate that the method is made primary to the participant, who in turn may respond on a ‘subpersonal level’ (Reason and Heron, 1995). Thus, the ‘risk of bias’ may depend more on the skills of the researcher and his or her interaction with the participant ‘rather than on the interviewing approach used’ (Coyle, 1998).
In conclusion

Counselling psychology has offers a holistic model of 'human and empirical enterprise'. In Schotter's (1975) words, it endeavours to establish 'psychology as a moral science of action'.

Researchers have introduced and discussed qualitative and more 'holistic' approaches to research methods in counselling psychology. In this process, 'new voices' need to be heard (Smith et al., 1995a), and researchers have underlined how the "ontological and epistemological basis of psychology largely remains unquestioned" (Van Langenhove, 1995; p.10). This methodological orientation has an emphasis on subjective as well as objective orientations to research, in the hope that they may reduce the detachment and 'neutral distance' which has existed between the observer and the observed, knower and the known (Code, 1993).

References


'In the light of the other?'

Models of therapy with codependent women

Introduction

In this paper I want to introduce the concept of codependency and its origins within the AA, or Alcoholics Anonymous and the implications of using the AA-ideology as a treatment model for the wives of alcoholics. It is argued that this extension of including the alcoholic's partner (and even the whole family) is a bonus not only for the alcoholic but also for the alcohol industry. Additionally this can be seen as a conceptual 'parsimony': the problems of both are explained according to the same ideology: thus resulting in the convenience of both partners speaking the same 'language'. This language, however, that has been used to help alcoholics abstain from drinking, may not necessarily be efficient or theoretically sound when it comes to conceptualise difficulties encountered in the alcoholic relationship. Secondly, feminist perspectives will be discussed as providing an alternative focus on relational problem of women in relationships with their alcoholic partners. Important in this respect are the theories that emphasise the developmental differences between men and women. Finally, I will look at alternative models, and I will explore whether the application of models used for alcoholics and drug-addicts in a CBT treatment setting might be a helpful for therapy of their wives. It will be suggested, that the integration of feminist models might provide an interesting focus in offering help to wives of alcoholics in treatment. Otherwise, the wife would be seen as secondary to the primacy of her addicted husband within the alcohol treatment setting.
The Concept of Codependency

The concept of codependency has been popular in modern society. Books on codependency can be found in many bookstores. The most popular and frequently quoted defines a codependent person as “one who has let another person’s behaviour affect him or her, and who is obsessed with controlling that person’s behaviour” (Beattie, 1987). Thus, in the heart of this definition is the need to make a difference in the world and to be in control over one’s life. Or in Beattie’s (1987) words, the tendency to be affected by, and controlling others: characterised by obsessive ‘helping’, caretaking and “other-centeredness, that results in abandonment of self” (Beattie, 1987, p. 36).

The concept of codependency has its roots within the treatment approaches, that conceptualise alcoholism as a disease. With the disease model of alcoholism based on pragmatic reasons rather than theoretical evidence, its extension to include their spouses is apparently based on the pragmatism of ‘economy’ and ‘parsimony’ in the alcohol treatment industry rather than on scientific or ‘humanitarian’ grounds. As a result the codependent is implicitly or explicitly encouraged to accept blame and responsibility, which the disease model has so mercifully ‘explained away’ from the alcoholic. Furthermore, this pragmatism seems to exploit the “other-centeredness” and the “other-focus” as the model requires the ‘codependent’ define herself in the light of the other (see Babcock and McKay, 1995).

Feminist Perspectives

The main concerns of the feminist tradition is the inferior status assigned to women within the society. A strong emphasis is on taking the wider context into account and to explain how that may affect women’s lives in terms of societal and political factors (Nicolson, 1995). Another strand of feminism is the recognition that women may have
a ‘different voice’ (Gilligan, 1982; Wilkinson, 1997). This feminist tradition draws attention to how the construction of women’s experiences have either been neglected or explained in the light of men’s construction of themselves as a model for human experience (Gilligan, 1982). This might also prove to be right when the model of alcoholism is used to explain problematic relationships as yet another addiction and disease.

The concept of codependency has been strongly criticised within the feminist approach (Babcock and McKay, 1995). The feminist perspective highlights how cultural and societal influences on the individual are neglected. Some feminists have challenged the concept on the grounds that the codependency model defines behaviour and characteristics associated with women as pathology (Anderson, 1994). The feminist model suggests that the wife’s attempts to cope can be seen as signs of health, and appropriate to the circumstances. Some have pointed out that if the “so-called co-dependency is a disease, then almost anything in life is a disease - in fact, life itself is a disease” (Kokin and Walker, 1995; p.86).

Secondly, many feminists have argued that women are socialised to be dependent on men, depend upon others for approval and not to take care of themselves (Miller, 1979). Thus, by failing to take different socialisation into account, the model blurs the power imbalances between the sexes. Relevant in this respect are feminist theories on developmental differences between men and women which propose that women experience issues of dependence in a different way from men. Many of them are important contributions for the clarification of the concept of codependency. One of the best known is Gilligan’s (1982) theory on moral development based on ideas of men and women defining their ‘self’ in different ways, men through separation and women through connection. She has argued that women develop a morality based on care and responsibility. This is a challenge to Kohlberg’s traditional, and according to Gilligan, more male oriented morality of justice and individual rights (Gilligan, 1982). According to her theory, empathy and focus on others needs is ingrained in the female identity. Accordingly, Gilligan states that women have a ‘different voice’ to men.
which she sees as a strength rather than weakness. However, it is likely that through their socialisation, women’s ‘strength’ as caretakers has been over-emphasised at the cost of taking care of self. Accordingly, many women may not consider self-care as a personal right, when faced with a stressful situation in relationship with others.

**Alternative models of therapy**

It seems compelling to consider alternative approaches as an alternative to the model of alcoholism or AA-ideology which has been applied as a solution to problematic relationships labelled as codependency. There might also be need to look at codependency in a wider relational context, as an interpersonal process rather than a problem that is exclusively inherent in the particular individual. Research shows that there is “a growing emphasis on interpersonal processes within cognitive therapy” (e.g. Safran, 1990; quoted in Barkham 1992; p.254).

For the purpose of this essay, I want to mention two existing model which focus the individual’s presenting problems and describing the particular processes of change in several stages. Stiles et al (1990) have proposed a model in 8 stages “which can be construed schematically as moving from left to right, and are as follows: (a) warded off, (b) unwanted thoughts, (c) vague awareness, (d) problem recognition, (e) insight/understanding, (f) application of understanding, (g) problem solution and (h) mastery” (Barkham (1992; p.255). An interesting feature of this model is that it makes use of concepts from various therapeutic approaches, including cognitive and developmental psychology (Stiles et al, 1990). Thus, it is of integrative nature, offering the opportunity to draw on different theoretical orientations, with psychodynamic and relationship-oriented approaches on the left side and more the more behavioural and problem-focused towards the right. Thus, this framework might offer an interesting approach in understanding the processes of change in therapy with
people in codependent relationships. This might perhaps provide an insight into the
development and resolution of problems presented by this client group.

The second alternative mentioned, is a model used in the context of therapeutic work
with drug and alcohol addicted clients. Therefore, I want to consider its application
to the spouses of the addicted clients, and women in particular. The ‘Model of
Change’ proposed by Prochaska and DiClemente (1984) was initially proposed in 6
stages. Conceptualised as a “wheel of change”, it is mainly developed to describe the
process through which addicted people ‘travel’ as they change from resistance to
taking action and maintaining sobriety. The model also takes into account the
possibility of ‘lapsing’ or relapsing to previous style of addicted behaviour (alcohol or
drugs). Thus, by their very nature, stages are targeted at addiction, rather than “the
diffuse presenting problems associated with, for example, depression” (Barkham,
p.255). This argument may also apply to the problem of codependency, which could
therefore limit its applicability.

However, the ‘travel’ from one stage to another is seen as happening through several
different processes of change. The authors have specified 10 superordinate systems
for processes of change (Prochaska and DiClemente, 1984; Barkham, 1992), e.g.
social re-evaluation, self-liberation and the helping relationship. In this sense, the
model transcends single therapeutic orientation, and suggests that different therapy
systems can be applied in the process of change, in the different stages of the model.

All of those processes are based on different therapeutic approaches, among those are
the Freudian-, humanistic-existential-, and behavioural approaches such as that of
Skinner. Accordingly, the cycle of change is described as a transtheoretical approach
(Prochaska and DiClemente, 1984). Important in this model would, for example, be
the process of ‘Awareness Raising’, which according to the feminist approach is well
known as Consciousness Raising. Thus, the integration of the feminist theory to this
‘Transtheoretical Model’ might make it more therapeutically feasible for women who
enter therapy in the context of being in a relationship with an alcoholic partner,
seeking help for his addictive problems. Based on health rather than sickness, this integrative model may serve as an alternative to the traditional solution of the AA-oriented model which defines codependency as a personal illness.

Integration of feminist perspectives to the model of change

As indicated above, the 'model of change' is mainly applied to addiction, however, it has been used with several clinical problems, such as difficulties in sexual relationships (Prochaska and DiClemente, 1984). Based on its superordinate processes, such as 'awareness raising and 'social or self liberation', has given me the idea to explore the model and its applicability from the feminist point of view. As a contribution to this integration, two possibilities will be mentioned.

A theoretical framework coming from the feminist perspective is the concept of 'Self-in-Relation' (Jordan et al., 1991) hypothesises that women’s ‘healthy’ development occurs in the context of relationship (Chodorow, 1978; Gilligan, 1982; Jack, 1991). This framework would give the opportunity to take social and political factors into account in the therapeutic approach with women as wives of alcoholics. It has been suggested that although this would not necessarily change the goal of treatment, however, the application of this framework would have a radical impact on how the woman experiences herself within the relationship and how those goals are achieved (Sloven, 1995). For example, this model would acknowledge that the ‘other focus’ can be of value in human relationships and to be affected by others would be seen as normal. In psychological assessment with women, as partners of alcoholics, the feminist approach would acknowledge their sense of powerlessness. Thus, the need to ‘control’ the addicted person, could be explored as originating from the unpredictability and the lack of control they suffer within the relationship. The model would also highlight, that due to societal factors coupled with the stress within the
relationship, women’s needs are often neglected, both by themselves as well as their partners, culminating in a strong sense of powerlessness.

As a second issue of concern, models of empowerment could be used as an additional tool to help women understand their situation and how to find ways of enhancing their sense of personal power. Based on Bandura’s ideas of self-efficacy (1982), a model of empowerment with ‘women of color’ emphasises how political, social and economic factors may influence the woman’s perception of herself (Gutiérrez, 1990). A sense of empowerment may be achieved by looking at factors such as self-efficacy, ‘group consciousness’, reducing self-blame and taking responsibility for self. Relevant to this model, but in contrast with the concept of codependency, having control is the essential component in empowerment; i.e. having “a sense of control over one’s life ..., ..., at the level of being able to make a difference in the world around us” (see Rappaport, 1985).

The transtheoretical model of change

Given the discussion above, the model of change, will briefly be discussed as a possible therapeutic tool in work with women in alcoholic relationships. The main aim and advantage of using this integrative approach would be to help women conceptualise their problems in terms of health rather than sickness.

Stage 1: Precontemplation: “Becoming aware of personal problems risks lowering self-esteem, a loss of sense of control and a possible loss of the values that have maintained the previous pattern of life” (Prochaska and DiClemente, 1984; p.24). Working with women of alcoholics, the initial task of therapy may often be to help them acknowledge how the drinking has created problems which are affecting the relationship and involving difficulties, not only for their partner, but also for themselves. The feminist approach might be used at this stage to raise an awareness
of how women may understand their situation in a more positive light than has been offered so far.

Stage 2: Contemplation involves the awareness that a personal problem exists. For this stage, Prochaska and DiClemente (1984) state that "contemplators are more distressed than precontemplators because they are admitting that something significant about them is not OK." Rather that conceptualising the wife as fundamentally not being "OK", the feminist model would look at its roots through a much wider lens. To this effect, application of the feminist framework, such as the Self-in-Relation theory might be a helpful tool.

Stage 3. Action: "Action is the stage in which people change their overt behaviour and the environmental conditions that affect their behaviour. Self esteem tends to be high because people are acting on their beliefs in personal self-efficacy. Also, changes in the action stage tend to be most visible to others and to receive the greatest recognition from others" (Prochaska and DiClemente, 1984, p.28). The application of this stage to the problems created within the alcoholic relationship, for the wife, as well as for the alcoholic, involves several theoretical and therapeutical implications. According to the codependency/disease model, the 'codependent' wife is encouraged to detach from the alcoholic by letting go of the controlling behaviour (Beattie, 1987). This approach is, however, quite simplistic or at least one-sided, as it is based only on the needs of the alcoholic (i.e. to help him stop drinking and maintain sobriety). In fact, both models fail to provide a theoretical understanding of problems as encountered by the wife. This failure might be complicated by the fact that in the treatment setting, the alcoholic is considered to be the main client, and not his wife. However, resolving the problem simply by detaching (Sloven, 1995) might be a difficult solution as a treatment goal for the wife, as both have a part to play in the relational problems encountered.

Stage 4. Maintenance: This stage can be difficult for people dealing with addiction as the occurrence of relapse can be a threatening issue. For codependents, the
difficulties of change may perhaps be rather at the earlier stages involving insight and understanding of personal rights vs. responsibility to others. Thus, a model that explains more explicitly this process, e.g. Stiles et al’s (1990) model might be more effective as a framework for changes within the relational context.

In conclusion: The therapeutic effects of treatment models with women as wives of alcoholics may be undermined by the fact that, by definition, addiction centres offer treatment to the addicted individual who accordingly is seen as the main recipient of therapy. Therefore, the model is liable to defining the wife as a ‘concomitant’ and ultimately the therapeutic goals of her treatment would be to help the alcoholic partner maintain sobriety.

Possible Implications of Therapy with ‘Codependent’ Women

It has been reported that psychological and/or physiological symptoms observed in wives of alcoholics were most often reactions to the trauma resulting from their attempts at coping with their alcoholic husband (Asher and Brissett, 1988). However, women in those relationships may have difficulties in understanding the concept of detachment from the addicted person, and accepting the ‘prescribed goal’ of thinking more about own personal needs, and thus experience confusion of how that may happen.

This dilemma might be understood better through Lerner’s (1983) theorisation of female dependency. She states that “passive-dependent behaviour serves a protective function in the maintenance of primary relationships” (p.697) and claims that “therapists frequently encourage their women patients to be more assertive or independent without first analysing the adaptive function” (p.702) of their behaviour. Lerner emphasises the need to explore what might be gained by “the patient’s dependent stance”. This warning may also be applicable to the ‘codependent’ woman.
The failure to explore why she behaves in the way she does, may therefore elicit resistance on her behalf and create a confusion of where to go and what is the gain of making a change at all.

**Conclusion**

It is not my intention to explain away the problems described by the concept of codependency. Instead, I would like to highlight that the model of codependency can be seen as a 'simplistic' extension of the addiction model, used more for the benefit of the alcoholic, rather than having the well-being of his (her) spouse in mind. The concept of codependency is originated within the AA-model which defines alcoholism as a disease. The implications of encouraging women to accept this label is that it perpetuates powerlessness and the sense of being 'secondary' to the other. However, women's willingness to accept this label might lie in the fact of how closely it resembles the typical socialisation of women.

The integration of feminist perspectives to the treatment of 'the codependent spouse' would not necessarily change the goal of treatment. But it would change the ways in which the problem is conceptualised. However, resolving the problem simply by detaching might be an unrealistic solution as a treatment goal for the wife, as both have a part to play in the relational problems encountered (Sloven, 1995). A different model of explaining the problem would change the process of treatment and the ways in which agreed goals are attained.
References


Therapeutic Practice Dossier
Therapeutic Practice Dossier

This dossier represents and addresses issues relevant to my therapeutic training over the years. It contains two papers. The first describes placements and their context as well as addressing educational opportunities and supervision involved.

The second paper is an exploration of how I see myself working as a Counselling Psychologist. This essay is of integrative nature. It starts with exploring how I see a personal knowledge and value base as necessary to be able to work as an integrative therapist. The essay further explores and illustrates and how I see myself integrate theory and research to therapeutic practice.
Description of Placements

This section includes description of the four placements I have engaged in for the fulfilment of my PsychD training.
First Year Placement: A Private In-Patient Clinic for Alcohol and Drug Addicts

October 1995 - August 1996

This placement was based in private clinic for alcohol and drug-addicts. Treatment and therapy groups were mainly according to the Minnesota (or AA-) model. However, some group work was based on cognitive theories. I had opportunity to observe and take part in co-therapy with counsellors specialised in treatment with addicted clients. My main individual work was assessing clients.

Clinical assessments of chemically dependant individuals applying for treatment were presented every week. Evaluation and decision on the acceptability of the applicants of the addiction treatment were made by the clinical team. Main criteria for clinical acceptance: motivation, no history of mental illness, availability of funding. I took part in those meetings and presented assessments of my clients and participates in the discussion assessment presentations of other members of counselling staff.

Besides this, participation in group work with the employed counsellors and making presentations was included in the opportunities offered.
Second Year Placement: A Community Mental Health Team Service within the NHS

September 1996 - August 1997

The Placement was based in a Community Mental Health Team service (CMHT) where I saw clients from different social backgrounds. Presenting problems mainly comprised depression and anxiety. The CMHT offered community mental health services such as: community nursing, outpatient services, day care and the service of psychiatrists and a psychologist. Besides this occupational therapist offered art and craft therapy. There was an emphasis on moving activity from the hospitals to the community, with more emphasis on prevention and to shorten patients' stay in hospital.

Psychology services were offered to clients on a weekly basis and most often the contract was open-ended. Supervision was given by a clinical psychologist with training as based on the psychodynamic approach, which was the basis of my theoretical and therapeutical orientation in this given placement. However, interventions with clients would vary depending on individual needs.

The placement offered further opportunities through staff meetings and seminars on psychoanalysis.
Second Year Placement: An NHS Psychoanalytic Psychotherapy Department for Out-Patients

September 1997 - August 1998

For this placement I was based in a Mental Health Unit, in a general hospital serving a big area. The department employed psychotherapists and clinical psychologists, thus offering individual therapy, couple therapy, family therapy and group therapy, a focus clients experiencing relationship difficulties, depression and anxiety, victims of sexual abuse or have difficulty managing anger and aggression. Special teams dealt with patients who have eating disorders and those who have experienced traumatic life events (PTSD).

Presenting problems included depression, child abuse with underlying suicidal ideation. Length of therapy with clients could vary, with some on a 'long-term' basis. In this placement I had a weekly supervision with my main supervisor. However, other therapists also offered supervision when appropriate. I felt that this offered a wider perspective. Thus I gained insight from various therapists, who were actively participating in psychoanalytic or psychodynamic orientations
Third Year Placement: An NHS Community Drug and Alcohol Service

September 1998 - August 1999

This placement was of cognitive-behavioural orientation within a community drug and alcohol service within the NHS. The centre employs clinical and counselling psychologists a number of CPN’s (Community Psychiatric Nurses), as well as Clinical Nurse Specialist and Social Workers.

I worked with alcohol- and drug-clients who were at different stages in their motivation and effort to change. Some clients presented with depression or had some other form of dual diagnosis. Other work opportunities provided were assessments, and participating as a co-therapist in family and group treatment programmes. Weekly meetings were mainly in form of peer-group supervision.

I saw participation in Solution Focused Brief Therapy (SFBT) as proved useful, in terms of participating in and observing the therapeutic process within this setting. Supervision was provided by two members of staff, a clinical psychologist and a clinical nurse specialist. The main orientation and models used were according to the cognitive-behavioural approach, with a holistic and empowering orientation to the client.
My personal integration of theories and research into practice with my clients

Introduction

In this essay I want to discuss and illustrate how I integrate theory research in my current practice as a counselling psychologist. I will start with an overview of what I see as the philosophical foundation of this integration. I will use the metaphor of ‘voice’ (see Gilligan, 1982) and the notion of ‘listening’ (Belenky, 1986) to illustrate ways in which I see integration between different sources (i.e. different theoretical ideas, data from research, personal experiences and observations of my client) that inform my practice. Then, I will illustrate the reality of my therapeutic work by use of two examples. In particular, I will explore and describe how I think about, understand and formulate, my work with clients. Finally, I will conclude with a brief evaluation of my practice.

Epistemology and value-base

When thinking about what integration means, I have come to the conclusion that a theoretically consistent epistemology is one of the cornerstones for the counselling psychologist to be able to integrate theory, research and practice in a sound and coherent way. Epistemology is the branch of philosophy that deals with ways of knowing the world around us. Philosophy can also inform us and give directions about underlying value systems and philosophical orientation of a given discipline. I
will now discuss those two aspects of philosophy as I see them in relation to my practice.

I have been informed by my recent readings on feminist epistemology (Harding and Hintikka, 1983; Belenky et al, 1986; Alcoff and Potter, 1993) which draws attention to that value-free, objective observation, highly regarded in empirical sciences, ignores social context and encourages 'perception at a distance' (Code, 1993). This position can be contrasted with listening through accepting, understanding and being in relation - necessary in therapeutic practice (and in qualitative research as I know it). These two positions can be seen as the 'two epistemological opposites' on which counselling psychology is based. The bridge between research, theory and practice, would depend on the ability to listen in a coherent way to the qualitatively different scientific/analytical and relational voices. In my thinking about the importance of a 'clinical theoretical bridge', I have been informed by Alford and Beck (1997) who have proposed that learning is based on both relationship and cognition. The 'gap' between research and practice as a human encounter has also been raised by van Duerzen-Smith (1990). This gap might perhaps best be bridged by a therapeutic encounter based on reciprocity and collaboration to construct knowledge (Belenky et al. 1986) which is meaningful for the 'human inquiry' and co-operative research (see Rowan, 1998) created between client and therapist.

Secondly, I have come to see a coherent philosophy as highly important in the ethos of integrating different theoretical approaches and a basis to meet the needs of the client in a consistent way. As a value base for my practice, I have from the very start adopted the humanistic approach (see Rogers, 1951; Woolfe, 1996). Thus, in my orientation I have chosen to focus on and assume health rather than disease and well-being rather than sickness. In humanistic terms this includes 'development of potential' and seeing the client in a holistic way rather than having exclusive focus on his presenting problems.
As I have progressed through my studies in Counselling Psychology, I have gradually adopted values highlighted by the feminist approach, which on further thought are in many ways consistent with the humanistic ones (Chaplin, 1998; Waterhouse, 1993), but also provide emphasis on other issues such as social context, personal development, identity-formation and morality (Chodorow, 1978, Gilligan, 1982). In other words, I started with the humanistic assumption that each person is unique and I am now adopting the view which is informed by theories within the feminist approach helping me clarify and conceptualise how this uniqueness may have been brought about.

My attention has also been drawn to the fact that there is more than one ‘voice’ in the world (i.e. the white male, middle-class, powerful) (see Gilligan, 1982) that can be listened to and used to illustrate psychological issues such as development, moral thinking and different ways of separating and relating. The feminist insight and philosophy to see opposites as interconnected (such as ‘feminine and masculine’, ‘independence and dependence’, ‘isolation and intimacy’) and ‘equal valuing of difference’ (Chaplin, 1998) has given me the epistemological orientation that people can manifest different qualities in diverse ways. This position is consistent with the underlying humanistic value base that ‘each person is unique’.

Finally, equality between therapist and client and the relationship between them is an important aspect of feminist thinking as well as the client-centred approach to feel valued and empowered (Rogers, 1952; Chaplin, 1998) and the importance of being in relationships (especially for women) is highlighted by many feminist theorists (Gilligan, 1982; Jack 1991).
The relationship as an ‘integrative bridge’

In my work and training, I have gradually been learning and understanding the importance of the relationship between therapist and client. Whatever the given theoretical orientation in my training, I have adopted a collaborative and an egalitarian approach as much as possible. I am aware that this can be difficult to put into practice within a psychodynamic approach, which is based on a model of transferential model of parent-childhood experiences. Within this model, it may be argued that ‘too’ an egalitarian relationship can be a hindrance to the therapeutic process (Chaplin, 1988).

Research has extensively shown that it is the ‘helping’ or therapeutic relationship, rather than any particular theoretical approach, that determines the efficacy of approach taken. Several theorists have made this point a central theme of their thinking and others have discussed its importance (Miller and Rollnick, 1991; Clarkson, 1995; Woolfe, 1996; Alford and Beck, 1997; Wills and Sanders, 1997). Drawing on this, I have come to see the therapeutic relationship as a medium of highly integrative nature, and the ‘bridge’ (Alford and Beck, 1997), through and over which all change is made. It is through its different modalities (see Clarkson, 1995) that the therapist has the opportunity to integrate and convey to the client the different approaches which would be ethically, theoretically and personally beneficial for the person at that given moment.

For me as a therapist in practice, the integration of listening to my inner thinking, or ‘voices’ (see Belenky et al, 1986), both theoretical and personal, whilst also observing and being with the client, has been a gradual process, that has not been straightforward or easy. I have noticed that I have tended to stay in the listening modality whilst staying with the client, with the theoretical and analytical observations only coming to me as soon as I am ‘isolated’ at home thinking about my client and the session. (I have come to see this as qualitatively similar to, and representative of the
‘gap’ that has been illustrated between practice and theory/science (Woolfe, 1996; Alford and Beck, 1997)). It is only with increased experience that I have been able to integrate those ‘voices’ (as useful sources of information) in the context of being with my client.

The process of change

In the context of working with alcohol and drug addicted clients, I am informed by a model of therapeutic change proposed by Prochaska and DiClimente (1984). Based on research, it suggests that change occurs through several stages: ‘Precontemplation’ is the stage when need to change is denied or not thought about; ‘contemplation’ involves an awareness that a personal problem exists (this stage is often felt as distressing); ‘action’ is the stage when the person changes the overt behaviour; and the ‘maintenance stage’ involves work on the gain attained through the ‘action stage’. ‘Relapse’ is seen as a stage that can occur at any time. When maintenance strategies fail, relapse is ‘the rule rather than the exception’ (Prochaska and DiClimente 1984, Miller and Rollnick, 1991).

It is important to be aware of the particular stage at which the individual is placed as each stage requires different interventions and techniques. For example, clients in the ‘contemplation stage’ know they have a problem but they have not yet worked out how they want to solve the ‘crisis’ they are in. Work with those clients requires exploration of therapeutic goals and to clarify which changes are possible for them at the given time. This work may also involve an understanding of factors maintaining the problem and how it was brought about. Clients in the ‘action stage’, however, “tend to become impatient if too much time is spent on trying to understand the origins of their problem” (Prochaska and DiClimente, 1984; p.28). Therapeutic work with those clients is mainly problem- and solution-focused and it is relevant to maintain and/or increase their motivation for change. Thus, the main focus in my
work with those clients tends to be mainly cognitive-behavioural, with an emphasis on current functioning and high awareness of the obstacles and advantages associated with reaching the desired goal, and preparing for a successful maintenance. Interventions are directed at negative automatic thoughts that can undermine the clients' self-efficacy (see Bandura, 1982), as well as highlighting and drawing attention to factors that may raise self-esteem, and so increase belief in the ability to reach the desired goal (i.e. stop using drugs or alcohol). Thus, the therapeutic ‘lens’ is directed at the near future and how effective change can be brought about as soon as possible.

I find ongoing assessment relevant with clients who are in the stage of contemplation or have reached the maintenance stage. Exploration of the past and interventions that increase awareness and insight become more important to the understanding of how clients perceive themselves and their situation. Exploration of ‘high risk situations’ (Marlatt and Gordon, 1985), i.e. defining concerns that might lead to a relapse, is always an important part of therapy with clients in the maintenance stage. Thus, I find Prochaska and DiClemente’s (1984) model of change a useful framework and tool to help me find a direction in my work.

The value of this model is that it is transtheoretical and suggests “components which are amenable to empirical testing” (Barkham, 1992; p.254) and gives an opportunity for an increased understanding of the therapeutic process. The model is transtheoretical because it offers a framework for the processes involved and suggests various therapy systems that may facilitate change. Research has identified 10 different processes of change (Prochaska and DiClemente, 1984). Additionally, based on research from various directions, Motivational Interviewing (Miller et al, 1988; Miller and Rollnick, 1991) offers various therapeutic techniques to work with ambivalence and motivation to change.
Context and Practice

As a counselling psychologist I work in a community drug and alcohol service located within community mental health care. In this outpatient unit, my work mainly involves assessments and therapy; secondly I work as a co-therapist in group work and Solution Focused Brief Therapy (SFBT). This has offered me the opportunity to participate in clinical work with experienced therapists and observe how various models are put into practice.

Assessments are usually made by two therapists, seen as important to give in-depth quality. The main focus is on obtaining relevant family history, current life problems (Beck et al, 1993), history of addiction and current use. Last but not least is an insight into future goals and aims in therapy. Length of therapy varies with each client according to individual needs.

I will now illustrate my thinking and practice with my clients. For the sake of anonymity I will refer to them as Mr AL and Mr DN. When Mr AL came for an assessment he was in the ‘contemplation stage’, subsequently he moved towards the action stage through his determination to stop his excessive drinking. Mr DN had already stopped drinking and was struggling with maintaining his new lifestyle (‘maintenance stage’).

Example 1: In my work with Mr AL, I mainly used cognitive-behavioural interventions according to models within the field of addiction. However, in my understanding of his problems, I was also informed by the psychodynamic approach and the feminist orientation of working towards personal empowerment; defined as “a process of increasing personal, interpersonal, or political power so that individuals can improve their life situations” (Gutierrez, 1990; p.149). Drawing on a feminist understanding of the ‘sense of self’ (see Gilligan, 1982; Jack, 1991) I felt that Mr AL learned to include ‘the other’ into his world-view. This was manifest by his apparent
appreciation of the support of others and that he had a good network of family and 
friends who were willing to help him if only he allowed them to.

Mr AL was assessed by myself and a colleague of mine. I noted that although Mr AL 
saw his drinking as problematic, he did not have any notion of an alcohol free life; 
furthermore, he did not accept an offer of being placed on a waiting list for managed 
alcohol withdrawal. This ambivalence is known as a feature of addiction (Miller and 
Rollnick, 1991) and is best addressed directly “as a part of the early process of 
establishing therapeutic goals (Beck et al, 1993; p.131). I accomplished this by means 
of a feedback letter to Mr AL, where main aspects of the assessment were 
summarised and future aims stated. This is to clarify and feedback current situation 
in a way that highlights strengths as well as clarifying the damaging nature of current 
lifestyle, with the aim of increasing awareness and ‘cognitive dissonance’ (Festinger, 

I was able to take Mr AL on as a client 6-7 weeks after his initial assessment. In the 
meanwhile, he had doubled the amount of his alcohol intake and had started selling his 
belongings to support his drinking. However, the ‘cognitive dissonance’ had changed 
in a therapeutically helpful way, in that the discrepancy between present state and a 
desired future goal had increased. In other words, Mr AL was desperate to be 
admitted for an inpatient detoxification. Now he learned he would have to wait for 
another 8 weeks before being admitted to hospital. He then expressed a lot of anger 
and frustration.

At first, I felt this intolerance was quite unfair as he had not accepted our offer and 
did not see ‘detox’ as a personal goal less than 2 months ago. However, it seemed 
counter-therapeutic to use that as a defence, and likely to elicit further defence and 
ensuing anger in my client. In my mind, I related this process to Miller et al’s notion 
of denial, which they consider as “not inherent in the alcoholic individual, but rather is 
the product of the way in which counsellors have chosen to interact with problem 
drinkers” (Miller et al, 1988, p.253). Instead I saw his upset mood as a desire for
'instant gratification'. This can perhaps be further explained within the psychodynamic approach. Freud (1923) has discussed this as a feature of the id, i.e. to maximise pleasure and minimise pain (Lemma-Wright, 1995). This ‘longing’ may also be a characteristic of many alcoholics and drug addicts. Omnipotence and narcissism (Freud, 1914) is portrayed as self-centeredness to denote self-preoccupation or self-love characterising infants or those who have a limited notion of the other. People with such a sense of self-centeredness “usually do not take kindly to being in learning situations where they have to defer to someone else’s knowledge or power” (Lemma-Wright, 1995, p.107). In this situation with Mr AL, I may have thought about narcissistic elements (Symington, 1993), and the possibility that alcoholics may have a sense of self-sufficiency and not being dependent on others to fulfil their own needs; they do so themselves through their drinking. However, in my thinking, I was also informed by my readings on the relational self that includes or recognises the other (see for example Jordan et al, 1991), which in fact models the feminine sense of self. This model emphasises empowerment through relationship with others. This can be compared and contrasted with the more psychodynamic notion of recognition of the ‘not me’ (Lemma-Wright, 1995).

In my intervention with Mr AL, I portrayed two elements of my thinking: firstly, expressing feeling empathy (Burns and Auerbach, 1996); secondly providing a different perspective, or new information about the causes of distress (Frank, 1973). T. denotes therapist and C refers to the client.

T: I understand that it might be difficult for you to wait again for such a long time, and you may not be used to the idea of waiting, especially as drinking alcohol is in itself, a way of instantly satisfying one’s own needs. However, in as much as it has taken time for you to reach the point of where you are now, it will also take time for us to arrange the inpatient detox and a hospital bed to be available for you.
In this last part of my intervention I was being congruent (Rogers, 1951) to my own feelings and I wanted him to know that in as much as problem drinking was developed over time, ‘giving it up’ was a process as well.

In this first session, Mr AL expressed very little belief in his ability to change his drinking style and to prevent its further ‘down-spiralling’. Due to his heavy lifestyle, he would at times confuse days or not be able to attend, whereby I would send him reminding letters to state the boundaries of therapy. Perhaps to my surprise, Mr AL was, in fact, very vigilant to be in contact as to his absences.

In the early phase of therapy, Mr AL felt that he was a “waste of space”. He expressed his fear that he would become depressed after alcohol-withdrawal. My first response to this fear was to respect his opinion to make use of antidepressants, and I gave him information (see Beck et al, 1993) about the length of time for the medicine to work. Respect for the ‘patient’s autonomy’ has been discussed by Livingston Smith (1991) as closely linked with the ‘love of truth’. However, this may not always be the case. Later I questioned my own response and put this issue on the therapist agenda (Beck, 1995) to explore the implications of this belief, e.g. that he would not be able to maintain sobriety without the help of other substances (antidepressants). I also raised with him that I felt as if I was ‘subscribing to’ this belief myself if I would ‘continue to respect his opinion and give him advice how to bring it to action’. I felt that the above intervention served to challenge his underlying schema and negative self-concept of being helpless (see Beck at al, 1993). This exploration resulted in Mr AL concluding that he “did not want to replace one cushion (alcohol) with another (antidepressants)”. The feeling of helplessness plays an important part in depression (Seligman, 1975) and I am also aware that powerlessness has also been theorised to be at the core of depression (Gilbert, 1992).

Over the next sessions I mainly used interventions to increase his motivation (Miller and Rollnick, 1991) and in particular his self-efficacy to strengthen beliefs in the ability to perform actions needed for the desired outcome (Bandura, 1982).
highlighted what I saw as strengths, however minute they seemed. Thus I started by focusing on the importance of Mr AL ‘being able to visualise himself as a sober person in the future’. Visualisation and mental rehearsal, especially that of using techniques of NLP (Neuro-Linguistic Programming), have been explored and recommended as a way of preparing for, and changing the future (Alder, 1997). No doubt, a simple visualisation of a positive future goal will also be of help in changing one’s lifestyle and to encourage replacement of ‘disempowering belief’ with more ‘empowering beliefs’. This line of reasoning is similar to the process of developing control beliefs whereby “patients examine their dysfunctional beliefs and replace them with more constructive, alternative beliefs” (Beck et al, 1993, p.178). Methods such as the ‘Advantages-Disadvantages (A-D) analysis’ or ‘guided discovery’ help the client to activate and strengthen such ‘control beliefs’.

My last ‘vignette’ of therapy with Mr AL is a short example from our last session before he went for in-patient detoxification. We explored his strengths and the social support he appreciated having when coming back. Suddenly he stated:

C: I still feel a bit of a “waste of space”.

I was a bit shocked and alarmed to hear this as if he, at the end of the day, was lacking self-efficacy needed, and I felt that he was devaluing himself in a way I did not like. I tried to do some positive rephrasing, when I suddenly realised that this was a helpful attitude in changing behaviour: It underlined the perceived inconsistency between an unpleasant internal state (Festinger, 1957) in the present and the more valued ‘future membership’ as a sober person with his family and friends.

T: I can see what you are saying and I think you are right.

C: (relieved) Thank you. (He laughed).

T: I can see your point. As you are still drinking you cannot yet be happy about yourself. I expect it is only when you have stopped drinking that you feel able to be proud of yourself.
This reasoning of my client can be seen as similar to the notion of 'retrospective justification of effort'. Aronson and Mills (1959) found that according to the cognitive dissonance theory, people who make considerable sacrifices or are put to a difficult test, place a higher value on their new membership or status.

*Example 2: I use assessments and formulations from myself and others (if available) to guide my work. I also see an ongoing assessment as an important and necessary aspect of therapy, which allows for the use of "theoretical frameworks to develop hypothesis about clients and their concerns and make tentative plans for the counselling work" (Culley, 1996, p.136).

This ongoing process can perhaps best be seen in my work with Mr DN. Aged about 40, he had already stopped drinking for several months when he came to see me. He stated that he was in a mutually 'supportive relationship', however, he felt that his tendency to "bury his problems in concrete" might constitute a crisis for him, leading to a relapse and previous drinking style.

In my initial assessment of Mr DN was the hypothesis that he had been brought up by a 'good-enough' mother (Winnicott, 1988; Jacobs, 1995) for the first years of his life, after which he had to endure an abusive upbringing with a stepmother and passive/absent father. The literature shows that domestic violence is condoned to a 'certain point' and is only condemned when 'violence exceeds the limits' (Smith, 1989; quoted in Lloyd, 1998). This happened in Mr DN's case, which has left him confused as to whether his experience was true or not (see Brown and Wiener, 1998).

My formulation of a 'good' biological mother was based on how well he was doing in his recently established relationship with his girlfriend and his emphasis on its 'supportive quality' seemed to support that he had some underlying schemas about positive relationships.
Drawing on Cognitive-Analytic Therapy (CAT; Ryle, 1990), I planned to share my formulation with him. Before doing so I explored with him his memories of his biological mother. The few memories he had tended to be blurred whilst the vivid memories of her were his resentments of meeting her in later life, when he experienced her feelings of guilt (for having abandoned him). This made me change my plans (I did not want to ‘make excuses’ for his mother). However, my attention was brought to the relevance of exploring and strengthening the existence of positive internal schemas. I was aware of schema-focused therapy, which extends Beck’s (et al, 1979) model of cognitive therapy to “address the needs of patients with long-standing characterological disorder” (McGinn and Young, 1996, p.182). I felt that underneath a maladaptive schema was an earlier ‘schema of security and self-worth’ which could only activated when being in a supportive relationship. If that failed, the more ‘overpowering isolation and abandonment schema’ would become overwhelming. I developed this formulation through therapeutic work when he felt his current relationship was in danger. His homework sheets reflected this as well. The homework sheets, which I developed from CAT (see: Keeping a Diary of Your Mood and Behaviour; Ryle, 1990), give a focus on emotions rather than cognitions (see Beck et al. 1993). Mr DN particularly liked this and made good use of the form.

At this point, brief lapses to alcohol and crisis in his relationship indicated how threatening it was for him to explore the very experiences which he saw as ‘buried in concrete’ and had specified as a therapeutic goal, for us to explore.

Informed by the usefulness of Gestalt Therapy and the empty chair technique (Perls et al, 1969) with abused clients (Bannister, 1992 quoted in Lloyd, 1998; Perry, 1993; Wolf, 1998), I discussed the issue with my supervisor who recommended the ‘two chair technique’. It is found particularly valuable for those who have experienced trauma and responded to that by dissociating parts of the self. In her book Counselling for Women, Perry (1993) describes the technique in this way: “The client is asked to move back and forth between two chairs. The chairs can represent...
conflict or unresolved situation between herself and another, or they may represent
different parts of herself” (p.51). Drawing on this, I started by introducing an idea to
my client of exploring the past (i.e. his vulnerable self) as contrasted with a preferred
future (i.e. visualising his inner strengths). This choice was based on my formulation
that he would need to be aware of his inner strength to be able to tolerate increased
awareness of threatening issues in the past. Mr DN accepted doing this as an
experiment. Through the technique he explored a childhood event of being afraid and
isolated; he was able to do this knowing that he could ‘escape’ to a better place in the
‘chair of a preferred future’. I felt enabled to put this into practice through personal
experiences in a psychodrama group, where past roles are seen to play an important
part in the personality (Moreno, 1964; Davies, 1988). Besides this I have been in
therapy where the ‘empty chair’ technique was used to give voice to problems.

In my work with Mr DN, it has come apparent that direct work with his ‘maladaptive
schemas’ (as related to his step-mother) is too threatening, subsequently leading to
old ‘useful defence mechanisms’ such as dissociation and detachment of feelings
(Brown and Wiener, 1998). This has directed my focus onto developments of the
‘two-chair technique’ (see Greenberg, 1979) which I am using in my current work
with Mr DN.

Through my reading on depression (Gilbert, 1992) I was informed that the ‘two-
chair’ technique, has been used in a situation of conflict or split (Greenberg, 1979) by
making polarities within the person explicit. This method has “been found to facilitate
an increase in the Depth of Experiencing, an index of productive psycho-therapy”
(Klein et al, 1969; quoted in Greenberg, 1979). Emphasis is on therapist
interventions that pay attention to content and process of the client’s ‘dialogue’ in the
two different chairs, with the aim of increasing awareness of ‘moment to moment
experiencing’ (Greenberg, 1979).

My work with Mr DN has been complicated by his needs to be in a ‘supportive
relationship’. This has apparently created a conflict, whereby his wish to work on his
own personal issues may put his present relationship at risk. His need to be in relationship, has brought attention to the dynamics in his past relationships. In this work I have been drawing on my own research, through which I am informed about power-imbalances and how oppressive relationships, like that with his step-mother, may instil feelings of powerlessness and inadequacy in asserting self in other relationships.

Conclusions: Evaluating own practice

In this essay, I have illustrated and described my understanding and development as a counselling psychologist and how I attempt to incorporate theory and research within my current practice. The description of the therapeutic process and ongoing assessment with the above clients provide examples of how I attempt to gain an understanding from various sources.

Whilst I appreciate working within the cognitive-behavioural approach, I am also informed by other approaches to increase my understanding and insight into how I may enhance my therapeutic skills. Furthermore, I feel that I have been developing a good sense of being with the client in that I am more confident in integrating my inner theoretical and personal voices to that of the client. Through my cognitive-behavioural training, I feel as if I have been developing and integrating more ‘openness and honesty’ in the therapeutic relationship and towards myself as an inclusive factor in that process. Thus, I have developed an awareness to my own emotional reactions as valid information in the therapeutic process, but sometimes tend to remain quite ‘other-focused’ when it comes to the conceptualisation of my own feelings and how they may impact on the therapeutic process. Thus, the ‘voice’ I have been the most reluctant about is that of ‘integrating myself as a person of ‘equal value’ in the relationship’. However, work in this direction is where I see myself going.
References


Research
Dossier
Research Dossier

This dossier contains three research reports, one for each of the three academic years. All of them embrace the same line of thought as developed through the years. The initial research paper is a literature review exploring the concept of codependency. The concept is reviewed from a feminist perspective and the implications of this concept are discussed and critiqued in the light of feminist theories on female development within society.

My research was aimed at exploring women's sense of self and how they perceive their heterosexual relationships. In my second year, this theme was explored with Icelandic women taken from the general population. The research also examined a relatively unknown methodology and its application in this area. The final research was on developments made through previous research findings aimed at examining women from the clinical population. This study had a methodological and theoretical focus and attention was directed at the usefulness of the card sorting technique as a way of obtaining in-depth qualitative data and a method of collaborative enquiry.
Critically considering codependency: definitions, women’s relationships and therapeutic implications

This article looks critically at the concept of codependency and its origin within the disease model of alcoholism. Its popularity among women is addressed and why women identify with this conceptualisation. Several definitions of codependency are critically examined in light of feminist psychology. It argues that the socialisation of women is an important factor that contributes to and maintains the characteristics described by the concept of codependency. It is suggested that the problems of relating implicit in the codependency model are more originated in the oppressive, culturally prescribed caregiving role rather than in women’s ‘preoccupation with focusing on the needs of others’. It is argued that the codependency model is based on a model of ‘deficits’ which needs to be replaced by an approach based on relational strengths of women and the need to care for self as well as for others.
Introduction

The concept of codependency has become increasingly popular in modern society. Books on codependency can be found in the self-help sections in many bookstores. These books are frequently bought by women who have found an answer to their pain and their problems in these books. Many can easily identify with the message postulated and accordingly label themselves as codependent, or even just dependent on others. It is both interesting and yet surprising to notice the fact that many of the books written within popular psychology are by female authors who describe women’s tendency to depend on men and how they seek fulfilment by ‘loving too much’ (Norwood, 1986). Others describe women’s fear of independence (Dowling, 1981), or demonstrate how women disguise their dependence by using the ‘favourite trick’ of codependents, caretaking (Beattie, 1981).

But what is codependency? Why is it so popular and well known among many in society? Some claim that codependency is a disease (Wegscheider-Cruse, 1989), or a personality disorder that should be included in DSM-IV-R like “narcissism personality disorder” or “post-traumatic stress disorder” (Cermak, 1986). Others identify with some characteristics of the concept and “diagnose” themselves as codependent. Some claim that codependency has become so widespread in North American society, that 96%-100% of the population is considered to be codependent (Troise, 1995). How can a disorder that should be included in the DSM be so common? Or is codependency something that reflects traits or learned behaviour that is normally found within societies like that of North-America?
Alcoholism as the background of codependency

In the last century excessive drinking was considered as a moral vice, or an illegal activity. Later the concept of alcoholism as a disease was developed. Many theorists have, however, doubted the validity of this conceptualisation. Robinson (1972) has pointed to how the disease concept of alcoholism has increasingly become more global. As a consequence the meaning of the concept can be interpreted in different ways. However, the debate about whether alcoholism is a disease or not has still not been resolved. But the disease concept has proved to be useful as a model for alcoholics in treatment, because it eliminates guilt, shame and the stigma connected to excessive drinking. Alcoholic Anonymous (AA), established in 1935, is a substantial part of alcoholic treatment and is based on the idea that the alcoholic has a disease over which he/she has no control. Only by admitting his powerlessness and unmanageability, he/she may recover from this disease. When treating alcoholics, workers in the field realised that the alcoholic was not the only one affected by chemical addiction. The non-alcoholic partner, usually the wives of alcoholic men, were considered to 'enable' the partner's drinking. They were seen to be 'enablers' by taking over all or most of the responsibilities of the alcoholic and trying to control him and his drinking. Later the word 'co-alcoholic' was used to describe the role of the non-alcoholic spouse, who accordingly was seen to be a participant in the alcoholic disease.
Workers in the field state that AA-philosophy with its Twelve Step program works for codependents (Beattie, 1987, Stafford & Hodgkinson, 1991). Thus the model of alcoholism has been extended to include the alcoholic’s partner and consequently codependents are considered to have a disease, which can be treated in the same way as alcoholism. This extension seems to be a matter of ‘parsimony’ and a ‘bonus’ for the alcoholic and his treatment. The use of the same philosophy and the same concepts enables the codependent to understand the language used in AA meetings. The spouse of the alcoholic is thus encouraged to explain and define her or his distress in the same way as the alcoholic. This ‘mutuality’ is meant to help the codependent, as well as to look at and understand problems from the alcoholic’s point of view. In that sense, participation in self-help groups can be considered another form of ‘enabling’ as the codependent is encouraged to define own problems in the light of the other.

**Codependency as a ‘disease’ or an ‘addiction’ to relationships**

Recently, many life activities have been included in the addiction model, not only drugs and gambling, but also work, physical fitness, eating, sex and relationships (Myer, Peterson & Stoffel-Rosales, 1991) in the form of codependency or ‘love-addiction’. O’Brien and Gaborit (1992) have reported that codependency is found in non-alcoholic relationships. They found that ‘caretaking’ and ‘centering one’s life on the needs of others, rather than one’s own’ were the two main factors in their study, measured on The Codependent Inventory (CDI).
Codependency has been described by many authors as perceived from their own experience and intuition. In his book, *Painful Affairs*, Dr. Cruse (1989) maintains that codependency develops in the same manner as alcoholism and states that both result from the direct effects of "toxic" behaviours (or chemicals) on the brain. Mellody (1989) sees codependency as an emotional damage resulting from traumatic experiences in childhood. Wegscheider-Cruse (1989) emphasises codependency as a disease within every family member of an alcoholic family.

One of the best known books on codependency is Melody Beattie’s (1987) successful best-seller, "Codependent No More: How to Stop Controlling Others and Start Caring for Yourself". This book describes how codependents are over-involved in caretaking and think and feel they are responsible for other people. Over-committed to the relationship, codependents try to control the other, whether a child, an adult, a lover, a spouse and so on. Her definition of codependency is among the most frequently quoted: "A codependent person is one who has let another person’s behavior affect him or her, and who is obsessed with controlling that person’s behavior" (Beattie, 1987; p.36). Caretaking and responsibility for the needs of others is seen as the need to control others. Beattie suggests that through detachment and being ‘undependent’, codependents need to learn how to care for themselves.

Other workers in the alcoholic field have gone so far as to define codependency as "ill health, maladaptive or problematic behaviour that is associated with living with,
working with or otherwise being close to a person with alcoholism (other chemical
dependence or other chronic impairment). It affects not only individuals, but families,
communities, businesses, and other institutions, and even whole societies” (Whitfield,
1989; p.20). According to this definition the ‘disorder’ is ubiquitous and the concept
so global that everyone seems to be codependent.

This tendency to include more and more in the definitions of codependency has
encouraged some to study this emerging concept carefully. Still based on the ideas of
pathology, the psychiatrist Cermak (1986) has suggested the solution that
codependency is a mixed personality disorder which should be included in
classification systems like DSM. He offers several diagnostic criteria for codependent
personality disorder which are supposed to differentiate codependency from other
disorders (Morgan, 1992). Cermak’s suggestion to find a solution to the problem of
global definitions is laudable. However, the question remains whether the problem of
definition can be solved by diagnostic criteria and the inclusion of codependency in a
classification system as a disease or a personality disorder.

As introduced by the codependency movement, it is not clear whether the concept
should only be used in relation to dysfunctional families such as alcoholic families or
whether it exists on a continuum from ‘healthier’ families to the other extreme of
dysfunctional and addictive families. At the one extreme, there are many theorists
who try to explain codependency as a pathological disease or addiction like the
disease of alcoholism. At the other end, there are ‘normal’ individuals who find
codependency as a useful label for themselves. Certainly, aspects of codependency are encouraged in society and praised in popular music. Songs like “You are the sunshine of my life”, “Stand by your man” and “Make someone happy and you will be happy too” show that intimate relationships with others are highly valued. At the same time, dependence is seen as immature while independence is valued and considered necessary for adult mental health (Broverman et al., 1970).

An alternative to the ‘disease model’

The feminist perspective has highly criticised the concept of codependency and how cultural and societal influences on the individual are neglected. Many feminists have challenged the conceptualisation on the grounds that the model pathologises behaviour and characteristics associated with women (van Wormer, 1989; Anderson, 1994). Instead of seeing caretaking and responsibility as a normal behaviour, gone awry in the context of being in an alcoholic relationship, these qualities are labelled as ‘sick’ (Haaken, 1990; Anderson, 1994). This pathologising of female behaviour is a method of blaming the victim and another form of oppression (van Wormer, 1990; Bepko & Krestan, 1991). Secondly, feminists emphasise that the model blurs the power imbalances between the sexes. Women are socialised to be dependent on men (Miller, 1979), depend upon others for approval and not to take care of herself (Walters, 1990). In the alcoholic relationship, this imbalance of power is augmented, as the codependent is extremely powerless against the ‘powerful’ addiction, so strong that not only individuals but even whole societies become codependent (Whitfield, 1988).
The central focus of feminism is the recognition of the inferior status of women. Feminist scholars challenge and study how the socialisation of women maintains oppression and perpetuates the 'feminine' image of women as dependent and subordinate to men (Miller, 1979). Additionally, feminist psychologists emphasise the research and study of the ways in which women may not fit within the existing theories on human development, which almost exclusively are drawn from research on men (Gilligan, 1982).

The aim of the present paper is to critically examine the concept of codependency from a feminist perspective. One can ask why codependency has become so acceptable for so many, and why many women are willing to go to therapists with the self-diagnosis of codependency. Certainly it seems as if many can identify with the characteristics and problems described in books on codependency. Hands and Dear (1994) point out that "these books undoubtedly offer comfort and hope to many individuals who share a common experience" (p.444) and if the popularity of self-help books on the subject is to be taken seriously, there must be a great need for help for these individuals. But do these women, and men, have to explain their problems in terms of 'love-addiction' or 'disease' over which they have no power, as recommended by the codependency movement? Or, is there another way of looking at the problems addressed in the codependency paradigm? In what ways can counselling psychology contribute to the understanding of these problems that are so easily explained by this 'mushrooming' concept called codependency.
Seen in a different light, what are the therapeutic interventions that can be offered by counselling psychology as an alternative to the paradigm offered by self-help books and the codependency model?

**Codependency vs. Dependence - Independence:** Codependency is in many ways similar to dependence. While these two concepts may have some similarities, there are some important differences. As an example dependence can be seen as 'learned helplessness' (Seligman, 1974) denoting 'to have things done for oneself'. In contrast, codependents are more likely to be engaged in doing things for others. Morgan (1991) has reported that codependents believe they have the 'willpower to change the feelings and behaviour of others', and this is often coupled with 'confusion of identities'. The outcome of this combination then results in the control that is seen to characterise codependents: "if their partner is not happy, codependents feel responsible for making their partner happy" (p. 725).

Denial is another important characteristic of codependents, needed to sustain the belief that things will change, despite evidence to the contrary. These characteristics, reported by Morgan, have been discussed by Zelvin (1989). She argued that dependence in women and denial of alcoholism in general is demanded by society. This socialisation makes the 'co-alcoholic' wife especially vulnerable. Social demands encourage the wife to hide the problem of alcoholism; at the same time she is
expected to depend on her husband. Her pretending that the alcoholic problem is non-existent leaves the wife even more dependent upon the husband’s behaviour. Zelvin suggests that relationships where the codependent is female and the alcoholic male represent an exaggerated pattern of the ‘normal’ male-female roles.

In our society, independence is highly valued as a goal, and dependence is often pathologised. Women are expected to be dependent in many ways while autonomy and self-sufficiency is encouraged in men. However, independence may not necessarily be the optimal goal in human development (Miller, 1979). If that goal is attained ‘too successfully’, the end result may be isolation which may be difficult to bear and is by no means healthy for anyone. Frank Pittman (1985) has discussed the Myth of Male Power which “requires an uninterrupted display of authority” but The Myth of Female Delicacy consists of “pleasing men by acting delicate and vulnerable, and thereby making men look more Masculine” (p.26). He states that most people have learned their gender role so well that it is assumed to be inherent and innate. Thus, dependence is seen as feminine and pathological whereas independence is masculine and healthy. However, men’s dependence is masked by women’s dependability and their willingness to be there for men (Siegel, 1988).

_Dependence and Interdependence:_ For children, development is said to be based on ‘healthy’ dependence but adulthood is ideally said to be characterised by autonomy and separation (Stiver, 1991). Miller (1979) was the one of the first to cast doubt on this androcentric value system (Siegel, 1988), which formulates adult health solely in
terms of independence and autonomy. Instead, feminists have argued the necessity of
an androgynous system that values both male and female characteristics (Jiminez and
Rice, 1991). In that model dependence is not necessarily seen as pathological but as a
normal part of human existence (Siegel, 1988). Recently, Jordan et al. (1991) have
suggested that the most adaptive ‘outcome’ in human development is the ability to
perceive oneself both as a separate individual (i.e. capable of independence) and able
to depend on others. Accordingly, Stiver (1991) has proposed a new view of
dependence which she defines as: “A process of counting on other people to provide
help in coping physically and emotionally with the experiences and tasks encountered
in the world when one has not sufficient skill, confidence, energy, and/or time “
(p.160). Thus, Stiver sees dependence as a process through which “one can count on
others and be heard, understood, and validated” (p.160) leading to stronger sense of
self-worth and a more solid sense of self. This is a form of ‘healthy’ dependence, that
offers an opportunity for growth and development, “and for experiencing one’s self as
being enhanced and empowered through the very process of counting on others for
help” (p.160). In contrast, Stiver (1991) highlights that pathological dependence may
occur when “turning to others for help” is “in a more static place, or worse, pulls one
back to a position in which one feels awful about oneself” (p. 160) which may happen
when that person is for some reason subordinate to the other or in a relationship that
reactivates histories of early deprivation and abuse (Stiver, 1991). Thus, when a
person is for some reason not able to have one’s needs met, the opportunity for
growth and developing a strong sense of self and a feeling of self-worth is
undermined. This type of dependence where needs go unmet seems to be the case in
codependent relationships. According to Stiver’s formulation, codependents are then bound to suffer from low self-esteem and low self-worth.

Based on the idea of dependence as a ‘healthy’ form of relating in relationships, the concept of interdependence has been introduced in a ‘androgynic’ model that underlines the development of relational skills in mutual and egalitarian interactions (Siegel, 1988; Jordan et al., 1991). Accordingly the combination of dependence and independence is seen as the appropriate goal for adult development. Based on Jordan et al’s (1991) ideas, Siegel (1988) has defined a fully functioning mature person “as an individual whose independence encompasses the ability to be interdependent, that is, to depend on others and to be depended upon in a manner that is equally respectful of the needs of self and others, as well as appropriate to the situation” (p.114). This process of interdependence may be a very difficult one, which requires respect both for oneself and others. In a ‘hostile’ environment, it may be difficult to receive mutual respect and equality. Siegel (1988) has argued that “when we cherish our ability to meet the needs of others, our dependability, we are better able to express our own needs, our dependence, and to take care of ourselves, to be independent” (p.122). This statement, that suggests we appreciate our ability to be responsible for others, is in stark contrast with the codependency model which defines responsibility as a weakness.
On definitions

Most of the definitions of codependency are extremely global and most of them are offered in self-help books. All of them are formulated without prior research to support the existing definition. However, psychology has been very slow to take the opportunity created by the codependency movement to explore symptoms and dynamics that might contribute to the concept (Morgan, 1991). It might therefore be interesting to explore what constructs are commonly found in some of these definitions. An exploration of following definitions from a broader perspective like that of feminist theory is likely to explain and illustrate codependency in a way that includes other aspects than are taken into account by the current paradigm based on a model of 'addiction'.

Interpersonal aspects

Focus on the needs of others: Most workers in the field of codependency highlight how codependents tend to focus on the needs of others rather than on their own needs (Beattie, 1987; Wegscheider-Cruse, 1989; Stafford & Hodgkinson, 1991). In this tradition, Whitfield (1989) has defined codependency as: “any suffering and/or dysfunction that is associated with or results from focusing on the needs and behaviors of others” (p.19).

A focus on the needs of others has been characteristic of the role of women and they are socially expected and ‘trained’ to be there for others (Miller, 1979; Siegel, 1988). In their research, Brown and Gilligan (1993) found that due to societal influences,
adolescent girls tend to focus more on the needs of others, rather than listening to their own ‘voice’. These findings support previous views stating that “women are taught to hide the self, and to stifle self-expression” (Siegel, 1988; p.116). Thus, the focus on the needs of others is strongly ingrained in the socialisation of women. Whether this socially expected quality results in suffering and/or dysfunction, can depend on many factors characterising and contributing to the codependent relationship.

Preoccupation with others: In some definitions the need to focus on the needs of others becomes a preoccupation. Wegscheider-Cruse (1989) sees codependency as preoccupation and Mendenhall (1987) defines codependency as “…a stress-induced preoccupation with another’s life, leading to maladaptive behaviour”.

The extreme stress of living with an alcoholic has been well documented. In their study of spouses of alcoholics and matched controls, Moos et al (1982) reported that psychological and/or physiological symptoms observed in wives of alcoholics were most often reactions to the trauma of being married to an alcoholic; and most of their problems resulted from their attempts at coping with their alcoholic husband (Asher and Brissett, 1988). The ‘Stress Reaction Theory’ has defined this coping as a “mechanism developed to maintain family functioning and stability” and the theory described “the wives of alcoholics … as dependent, self-righteous, enabling, controlling, and in denial” (Collins, 1993, p.471). It has already been discussed how the denial of alcoholism by society coupled with the socialisation of dependence in
women (Zelvin, 1989) can create a great pressure for wives of alcoholics to pretend as if nothing is wrong. These demands amalgamated with the unpredictability of being close to an alcoholic may result in extreme stress and preoccupation with the source of the traumatic experiences.

_Control_: Beattie’s (1987) definition of codependency is one of the most frequently quoted in the literature that tries to define the concept. It is followed by a nine-page non-‘all-inclusive’ list of all the ‘symptoms’ that characterise the codependent person. Beattie has been criticised for her extensive and general list which seems to define almost anyone as codependent (Myer et al., 1991). Her definition is as follows: “A codependent person is one who has let another person’s behavior affect him or her, and who is obsessed with controlling that person’s behavior” (p.36).

The first part of Beattie’s definition applies to everyone and dismisses the fact that the very nature of relationships involves being affected by others. It also reflects the view that health is represented by the autonomous and separate self (Miller, 1979; Collins, 1993) - a notion that some writers have deconstructed and problematised anyway - (see Kitzinger, 1992). Furthermore, it devalues the human need to be in relationship with others. From a feminist perspective, this part of definition can be critiqued on the grounds that, for women, identity and the sense of a separate self does not occur through “an increasing sense of separation” (Miller 1988, p.2) but in mutual relationship with others (Chodorow, 1978; Gilligan, 1982).
In the second part of her definition, Beattie emphasises the ‘obsessed’ nature of codependents to control others, which lies “in the ways we try to affect them: the obsessing, the controlling, the obsessive ‘helping’, caretaking ..., (and) other-centeredness that results in abandonment of self“ (p.36). Obsession has been defined as “a persistent preoccupation with a certain mental content, typically an idea or a feeling” (Carson and Butcher, 1992; p.189). What is this obsession about and why is the ‘codependent’ so obsessed with controlling the other?

It seems as if the codependent has no ways in which to affect the other person in a ‘natural’ manner. Being able to give the other person what she or he needs usually gives a sense of gratification and pleasure (Stiver, 1991). Being unable to please the other or affect him in any way, is then likely to be dissatisfying and contribute to a breach in the relationship. This disconnection (Miller, 1988) may result when one is prevented from participating in ‘mutually responsive and enhancing relationships’. Thus, codependents may experience disconnection. Collins (1993) has listed consequences like “depression, anger, isolation, confusion, increased striving for connection, a diminished sense of well-being”, as necessary to adapt or feel connected in a non-accepting relationship (p.473). Seen from Miller’s perspective, the struggle for connection in a relationship with an emotionally unavailable person (Zelvin, 1989) may then encourage what Beattie (1987) calls “obsessive helping” and “other-centeredness that results in abandonment of self”.

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Rules in the family: Family systems therapy looks at interaction within the family whereby every member contributes to communication and behaviours within the system. According to this view, it is the relation between members that matters rather than the individual itself (Jones, 1993). Within this systems approach, Subby (1984) has defined codependency as “an emotional, psychological, and behavioral condition that develops as a result of an individual’s prolonged exposure to, and practice of, a set of oppressive rules - rules which prevent the open expression of feeling as well as the direct discussion of personal and interpersonal problems” (p.26). According to Subby’s definition, adherence to ‘a set of oppressive rules’ is seen as the origin of codependency.

One of the major strands of the feminist critique is the general oppression of women. Feminists have pointed out that the codependency model has overlooked the role of oppressive forces within society and how these shape the personalities of women (van Wormer, 1990; Anderson, 1994). They also maintain that the ‘codependent’ identity, based on caretaking and excessive responsibility for others, is virtually describing the emotional condition of the oppressed, involving an identity of powerlessness (Haaken, 1990). Thus, Subby describes the effects of oppression, although its source is not clarified in his definition.

Caretaking and responsibility: Few definitions mention the caretaking role of codependents, or their extreme sense of responsibility. One exception is Beattie’s (1987) additional list in which she describes the characteristics of codependency. On
caretaking, Beattie says: “Codependents may: • think and feel responsible for other people - for other people’s feelings, thoughts, actions, choices, wants, needs, well-being, lack of well-being, and ultimate destiny” (p.42). This caretaking role has been considered a good quality of women. It has been their role for ages to take care of others and be responsible for home and children. Carol Gilligan (1982) has found how women’s morality is based on taking the needs of others into account, which may at times be at the cost of self (see discussion below).

In the codependency model, the traditional female role of caretaking and responsibility for others has been pathologised and explained as control and preoccupation with others. Bepko and Krestan (1991) have argued that the traditional role of women is virtually ‘codependent’; thus, in a relationship with an alcoholic these ‘codependent’ characteristics “are essentially exaggerations of women’s prescribed cultural role” (van Wormer, 1989; p.55). Additionally, Haaken (1990) has maintained that “the co-dependent’s identity is formed out of the experience of powerlessness” (p.397) coupled with the necessity to compromise, make peace and to manipulate. Thus, caretaking and being responsible for others fused with powerlessness serves to create a negative identity for women, both in the model of codependency and in the historical oppression of women.

**Intrapersonal aspects**

*Dependence - Loss of identity:* The common thread in many definitions of codependency is a dependence on someone or something else for emotional
fulfilment, to the point of losing one's own identity. Wegscheider-Cruse (1989) says codependency is: "a specific condition characterised by preoccupation and extreme dependence on another person, activity, group, idea, or substance. This dependence is emotional, social, and sometimes physical. It is used, unsuccessfully, to help the codependent person feel connected and worthwhile. Eventually, this lifestyle becomes a serious pathological condition that affects the codependent person in social and occupational functioning, physical health and all other aspects of life" (p.243).

Thus, Wegscheider-Cruse sees codependency as a pathological condition. What initially is dependence on something has become a progressive disease. However, the definition does not clarify what might contribute to this dependence. Zelvin (1989) has defined codependency as: "an exaggerated dependence upon a significant other, in which the self is neglected, identity lost, and self-esteem at minimum. Implicit in the term is the idea that the beloved other is emotionally unavailable due to addiction or some other cause" (p.101). In her discussion on "Dependence’ as a Female Style of Relating” Stiver (1991; p.155) has suggested that pathological expressions of dependence might be caused by underlying rage about unmet needs and difficulties of expressing them rather than about dependence itself. Krestan and Bepko (1991) have observed that loss of identity is at the core of many definitions of codependency and in Zelvin's (1989) definition dependence seems to be at the cost of self-identity. Feminists have highlighted that women need to be in relationships that are mutual, in which empathy for self and others can flourish, thereby, unlike the codependency model, stressing the need for a dual focus.
Feminist perspectives

The feminist perspective has challenged the concept of codependency and argued that it has more complications than are taken into account. In theory, both men and women can become codependent, but more women are labelled codependent; men may behave in a codependent way, but women are codependent. Furthermore, the concept describes feminine behaviour. As theories in feminist research seem to be very relevant to the concept of codependency, a few of them will be discussed below.

Some feminists emphasise, that there are important developmental differences between men and women. According to Chodorow (1978) these differences are not biological but are acquired through early childhood development. She argues that as children are primarily raised by their mothers, their development is asymmetrical. Being of a different sex, boys are taught to leave their mothers and develop identity based on separation and individuation. Girls develop their identity through same-sex identification in continued attachment with their mothers. Thus, men value independence while women value intimacy and connectedness. Furthermore, empathy is intertwined into the identity of women in a different way than for men. Chodorow states: "Girls emerge with a stronger basis for experiencing another’s needs or feelings as one’s own (or of thinking that one is so experiencing another’s needs and feelings)” (p.167). Thus, girls experience themselves as less differentiated than boys. Based on Chodorow’s theory, Gilligan (1982) points out that “male gender identity is threatened by intimacy while female gender identity is threatened by separation” (p.8), claiming that women and men experience issues of dependence in a different manner.
Relevant to the codependency model is Gilligan’s (1982) gender-specific theory of moral development which challenged Kohlberg’s theory on the ethics of rights and justice. She proposed a theory based on the ideas of ‘a self defined through separation and a self defined through connection’. In agreement with Kohlberg, she found that men’s morality is based on a sense of individual rights. However, Gilligan’s research showed that women develop a morality based on care and responsibility, rather than individual rights. Thus, women take the well-being of others into account, as equal to or stronger than that of self. Gilligan maintains that focus on others needs and empathy is ingrained in the female identity. She argued that caretaking and responsibility are women’s strengths rather than weaknesses.

Gilligan’s research on women’s ethics of care has received a great deal of attention. Jiminez and Rice (1990) have questioned whether Gilligan’s claim is “a step backward or a step forward for feminism” (p.15) and for women in general. They point out that these characteristics assigned to women are the result of differences in socialisation and the ‘long-standing oppression of women’ and they caution that any theories that represent differences between men and women may be used to perpetuate that oppression. Jiminez and Rice (1990) substantiate their claim by quoting self-help books that have used Gilligan’s findings to support their ‘psychological paradigm’ based on a deficit model of women’s personalities (see Grant, 1988). Others state that Gilligan is ‘liberating’ women from their ‘weaknesses’, and in fact she is describing women’s coping styles and how they react to domination and
powerlessness (Puka, 1993). Friedman (1993) argues that Gilligan's 'care-justice dichotomy' deserves attention as it describes 'the nature of relationship to other selves' as opposed to 'adherence to rules'. She states that these two orientations of morality do not exclude each other and can be applied by both sexes, but the 'ethic of care' seems to be 'the stereotypic moral norm' for women. Thus, care for others may be a strength of both sexes, but historically it has been exploited to oppress women. Moreover, due to their socialisation, women's 'strengths' as caretakers tend to be over-emphasised at the cost of taking care of self.
In Conclusion

The codependency movement defines and explains codependency through the lens of the addiction model and how this syndrome affects the behaviour of the alcoholic. Thus, codependency is seen as a ‘disease’ or an ‘addiction’ to other people, this involves that codependents need to recover from their disease. The traditional ‘prescribed’ role of women as caretakers is seen as a deficit and the main medium by which women control other people. By focusing on the needs of others, codependents neglect their own needs, “that results in the abandonment of self” (Beattie, 1987, p.36). According to the codependency model the fault lies within women (codependents) themselves, and the model “tells the woman reader that femininity is pathology, and for this she cannot blame society or power relationships but only herself” (Collins, 1993; p.472). Thus, female characteristics are taken out of context and explained within the narrow focus of codependency theory. The socialisation of dependence in women is not considered and the social expectation of the female role to care for husband and home becomes invisible in this model. Feminists have strongly criticised this “failure to address the social and political context” (van Wormer, 1989; p.62) and argue that, at worst, caretaking and femininity itself have been labelled as pathology (Collins 1993; Anderson, 1994). In sum, the concept of codependency is based on a deficit model which illustrates women’s weaknesses and highlights the need to define oneself as powerless in relationship with others.
Feminist theory has offered a new understanding of the concept of codependency which shows how developmental and societal factors perpetuate the characteristics that underpin the concept. They argue that the stereotypical role of women in society is in fact codependent. However, the effects of this role may be heavily augmented in relationships characterised by relational disconnection, such as in alcoholic relationships (Miller, 1988; Zelvin, 1989; Haaken, 1990; Bepko and Krestan, 1991). Social factors contributing to codependency can be very influential, such as lack of power, societal expectations, loss of control of one’s environment, loss of mutual relationships, all of which may increasingly result in a ‘non-healthy’ dependence. Thus, it is argued that codependency is rooted in powerlessness. Characteristics, such as ‘extreme dependence’ or ‘obsessive “helping”’ are then seen by feminist psychologists as an adaptation to an unhealthy environment and ‘normal reaction to an extreme situation’ (Haaken, 1990; van Wormer, 1989).

As the foundations of the codependency model are based on personal deficiency rather than strength this model will inevitably be ‘victim-blaming’ or highlighting the ‘blame-the-codependent’ syndrome (van Wormer, 1989) whether the codependent is a female or a male. Originating in the field of alcoholism, proposed therapeutic solutions of this ‘syndrome’ will then be based on adapting a role of ‘powerlessness’ rather than emphasising individual ‘empowerment’.
Therapeutic approaches to codependency

Feminists have challenged the codependency model and argued that it tends to oversimplify complex phenomena, stereotype clients, and deny their uniqueness (Anderson, 1994). They highlight that self-help books like “Women who love too much” (Norwood, 1985) reflect the underpinnings of the model, by rejecting the feminist ideal of equality in relationships and taking men’s personality as given (Jimenez and Rice, 1990). Taylor (1996) has highlighted some important goals of feminist therapy, such as identifying internalised sex-role messages and understanding how society oppresses women as well as ‘developing a sense of personal and social power’ (Worell & Remer, 1992). Another aspect of feminist counselling and therapy is that of addressing the issue of power within the therapeutic relationship. Equality and collaboration between therapist and client is considered to be a very important factor contributing to change (Libow et al., 1982; Taylor, 1996).

Empowerment in Relationship - Self-in Relation Theory:

A model based on empowerment has been proposed for women experiencing powerlessness in their lives. Based the importance of connection in women’s sense of self, this model replaces the notion of separation-individuation with a new construction: relationship-differentiation (Surrey, 1991). Mutual empathy is emphasised and the problem of differential power in relationships is addressed (Collins, 1993). This model, ‘self-in-relation theory’, is proposed by theorists in the Stone Center, based on ‘women’s growth in connection’ (Jordan et al. 1991). Instead of a solution of detachment, this theory is based on attachment and a process
of development through relationships (Surrey, 1991). In line with Gilligan’s theory, a continuing relationships with others is emphasised, arguing that women find power through connection rather than separation.

However, difficulties may arise in women’s lives when trying to assert their own needs whilst also maintaining connections with others. Miller (1988) has suggested that such ‘disconnection’ may disempower women. Apparently, this model explains relationships, in very different terms than the model of codependency does. Instead of pathologising female behaviour, the self-in-relation theory is based on model of competency, seeing women’s characteristics as strengths. At the same time it defines women in terms of their own needs, rather than from the needs of the alcoholic.

Based on these ideas are models that focus on issues of power imbalance. In one of these models, the process of empowerment occurs through the use of techniques like ‘increasing self-efficacy’, ‘reducing self-blame’ and ‘assuming personal responsibility for change’ (Gutiérrez, 1990). Still another approach looks at how women might need the power “to define and determine themselves ... and to act in ways that are congruent with that definition” (Rubenstein and Lawler, 1990; p.36).

The self-in-relation theory explains how internal factors may constitute problems for women, and links them with external factors, like that of oppression and lack of power in relationships. The theory challenges the disease model, by arguing that
Codependency is not 'cured' by women relinquishing the power they never had, but rather by empowering themselves in a changed environment.

*Codependency and the Family:* In the codependency model, the responsiveness and willingness to 'save' the family from disaster (Black, 1982) is pathologised and the family members are seen to interact in a way that perpetuates the family disease (Wegscheider-Cruse, 1989). Black (1982) has described the suffering of children of alcoholics and found three unspoken rules in the alcoholic family: 'Don't talk' 'Don't trust' and 'Don't feel'. She finds that these rules are used to deny certain perceptions of reality so as to make life more tolerable and to keep the family life going. Wegscheider-Cruse (1981) has discussed the inhuman, rigid and closed system in which the rules are made for the benefit of the rule-maker to keep a secret which is seen as emotionally and socially threatening. But who is the rule-maker and who or what is really threatening?

Theorists within family system therapy have based their work on the idea the family is best viewed as an open system. Family members are seen as 'elements' that contribute to the interaction, thus influencing the well-being or dysfunction of the system. Inherent in this approach is the idea that the system's main function is the maintenance of stability, as to keep the 'status quo'. Events in the system are seen as circular. Rather than talking about cause and effect, interaction is seen as a sequence of stimulus-response, in which the individual is responding to the previous stimulus.
In this sense, events are both a response to one event and giving rise to another (Jones, 1993). By using this concept of circularity, family therapists try to avoid moralism that blames the clients (Ault-Riché, 1986). The locus of change is the family interaction, and the system is targeted as a unit, rather than focusing on each individual (Libow et al., 1982).

The family systems approach is consistent with the codependency model, in the sense that it reinforces the view that every member of the family contributes to problems and dysfunction within the system. However, through this conceptualisation the woman is made co-responsible, whether the problem is wife-battering or the husband’s alcoholism. Feminists, in contrast, have highlighted the existence and right of every individual within the family and that the welfare of each person may be different from that of the family unit (Libow et al., 1982). Bepko and Krestan (1991) have argued that the unequal distribution of power in so-called ‘normal’ families is in fact ‘dysfunctional’. They also state that while the wife is assigned less power and socialised to be other-focused and responsible for relationships, the ‘normal’ family structure can be considered ‘codependent’.

This imbalance in power serves to produce rigid and inhuman rules that tend to preserve oppression of those who are allocated less power.

*Bowen’s Family Therapy:* It has been suggested that codependency is another name for the ‘undifferentiated self’ introduced by Bowen (Fagan-Pryor and Haber, 1992). Bowen is a therapist who has integrated a notion of self into his family systems theory
(see Bowen, 1978). In this framework, he classified people on a level of
differentiation determined by a ‘togetherness force’ (low end) and the degree of ‘basic
self’ (highly differentiated). The closer an individual’s scores are towards the low
end, the more she/he seeks the approval of others. According to this instrument,
codependency would be seen to match Bowen’s concept of self on a continuum
towards the lower end of the scale (Fagan-Pryor and Haber, 1992). Hare-Mustin
(1978) argues that Bowen, like many others, considers males as the only model of
mental health. She argues that Bowen’s scale is in fact a sex stereotyped masculinity-
femininity scale with femininity at the devalued end. Similarly, the differentiation scale
has been harshly criticised by other feminists for overvaluing stereotypically male
characteristics (Ault-Riche, 1986). Fagan -Pryor and Haber (1992) state that Bowen’s
theory does not take into account that women are socialised to become
undifferentiated (heavily relationship-orientated). For this and other reasons,
Bowen’s family therapy has been dismissed by many feminists. However, Frank
Pittman (1985) has pointed out that those critiques confuse differentiation and
separation and maintains that Bowen did not assume separation from family
interaction as health. His framework of multigenerational transmission processes
lends itself to explain socio-cultural forces in women’s lives. Furthermore, Bowen’s
theory focuses on how individual needs might be cared for while remaining connected
to the family. Thus, Bowen’s family therapy emphasises self-care and connections
with networks of friends and offers help in understanding the impact of socialisation
on emotional functioning in relationships within and outside the family. Therefore,
Bowen’s family system therapy seems to be the most promising of the family therapy
approaches for feminists (Ault-Riché, 1986). Bowen’s therapy is likely to be very beneficial for codependents. Besides his concept of differentiation, which includes being separate and connected, the emphasis on self-care and connections outside the family seems to offer rich opportunities for the therapy with those experiencing problems of relating which may be classed under the definitions of codependency discussed earlier.

Concluding words

The view of codependency developing within the field of addiction needs to be challenged. Like the concept of alcoholism, codependency seems to be very vague as to include more and more, depending upon the observer.

Feminist psychologists have shown how the problems presented by the codependency movement are virtually exaggerations of the socially prescribed female role in marriage, within the family, as well as in society at large. This might be one of the reasons why many women identify so easily with the experiences described by the codependency concept. However, the notion of many self-help books illustrating that the fault lies solely within the woman herself and not in the environment, is not likely to help women in the long run. Instead, an alternative paradigm based on interdependence and relational strengths of women needs to be considered in developing therapeutic approaches to problems of relating that have been construed as codependency.
It has been argued that the model of codependency, is a paradigm that pathologises women for their socially prescribed role of responsibility and caretaking. These characteristics have been explained as the 'need to control others' and according to the alcoholic model, codependents need acquire an attitude of powerlessness. In line with the feminist perspective, it is maintained that problems of relating, such as tendency to exert control over their environment, rather lie in the socialisation of women as caretakers which often results in the neglect of taking care of self. Moreover, oppression in the form of powerlessness and dependence is likely to perpetuate low self worth 'to the point of having little self-identity'. Instead of advocating 'how to stop controlling others' (Beattie, 1987), the emphasis should rather be on breaking out of the limiting, oppressive, and culturally prescribed caregiving role, and how women can focus on their own needs and stay in relationships in which care for self and others is considered as equal (Gilligan, 1982; Jordan et al., 1991). In that respect, paradigms discussed earlier with a focus on power-imbalances and personal change in a changed environment can be used as a therapeutic model for working with women who have been described as 'codependent'.

**Therapeutic Implications of Codependency**

The term "codependency" is a label that has become widely known and accepted to describe the 'extremes' of female behaviour. Its conceptualisation is grounded in the
notion of the autonomous and separate self. This framework values masculine
identity as the healthy goal of adult development.

One of the major disadvantages of the concept of codependency is its origin within
the AA-model which defines alcoholism as a disease. The implication of this is that it
conceptualises human behaviour as an addiction and 'therapeutic solutions' are
derived from its medical approach to alcohol addiction. This appears to result in a
sexist language, which favours the benefit of the alcoholic rather than the non-
drinking spouse. Thus, treatments programs based on the Twelve Step orientation
courage women to refer to themselves as sick or having the "disease of
codependency" (Wegscheider-Cruse, 1987). However, the concept comprises a
phenomenological description of female behaviours traditionally demanded in society
(Tallen, 1995). Perhaps, it is this "clarity" that enables many women to identify with
the concept and take its implications on board, such as stereotyping female behaviour
and seeing women as "sick" or addicted to relationships. Based on a medical model,
the codependency model describes presenting problems in terms of a personal deficit
proposing a cure based on prescriptions (12 step program), subordination to higher
authority (AA or AlAnon) and conformity to treatment protocols (Walters, 1995).
Accordingly, implications of treatment require willingness to accept self-blame
(Tavris, 1995) and as such exploits the 'deficits' it is meant to 'cure', such as
dependence, over-responsibility and subordination.
The codependency concept describes and devalues female behaviour, the concept is “particularly well designed for the oppression of women” (Schreiber, 1995; p.177; Haaken, 1990) and blaming the ‘victim’ for the powerlessness and subordination assigned to women within society. Thus, the framework not only can foster negative identity and self-blame, but also avoids exploring the dilemma in a wider context, such as its origins within patriarchal society. The codependency perspective teaches women to look within themselves instead of exploring oppression which colludes with a culture of dominance (Hagan, 1995). In this way, the implications of the concept are anti-female.

Codependency directs attention to personal deficits, whilst it fails to address its origin within interpersonal and social context. As a treatment solution, it recommends “detachment” (Beattie, 1978) from the problematic partner. However, the approach fails to consider that resolving the problem simply by detaching might be an unrealistic solution, as both have a part to play in any problematic relationship dynamic (Sloven, 1995). Thus, the codependency approach downplays the dyadic and interactional nature of problems encountered within relationships.

In sum, the term codependency describes female behaviours which taken to extreme can result in a condition “in which the self is neglected, identity lost and self-esteem at minimum” (Zelvin, 1989). This condition of permanent inequality in relationships (Miller, 1976) evolves around an identity “formed out of the experience of
powerlessness” (Haaken, 1990) leading to oppression of those women who “adjust too well” to the demands of society (Hagan, 1995).

The present research suggests the concept of codependency is based on an orientation that downgrades and perpetuates devaluation of women. The term should be seen as a ‘simplistic’ extension of the addiction model, used for the benefit of the alcoholic, rather than having the well-being of the female spouse/partner in mind. Here, the problems explained by the concepts of “addiction” or “progressive disease” (Wegscheider-Cruse, 1987) will be examined in a different and much broader sense.

The present research paper will focus on the development of women’s sense of self and how they construe their experience in interpersonal contexts and the dyadic nature of relationships. It will be argued that therapeutic approaches should focus on how women can increase their personal responsibility in a way that takes into account women’s need for connection (Gilligan, 1982) and affiliation (Miller, 1976).

Whilst women need be aware of how social expectations position women as ‘self-sacrificing and the emotional caretakers of men and children’ (Lodl, 1995), the emphasis of the present research is the need to find ways in which women can explore personal context and thus become more aware of how they may silence themselves and collude with the “oughts” and “shoulds” of their environment.
Focus of Further Research

Following the above critique of the concept of codependency, further research aims at examining the viability of an idiographic and qualitative method for the exploration of underlying personal meaning. Rather than looking at the deficits of the "codependent personality", the development of women within heterosexual relationships will be explored, with a special focus on the relational self (Gilligan, 1982). Secondly, the implications of the model’s more negative sides, often resulting in caring for the other at the cost of self, self-silencing (Jack, 1991) and internal oppression (Hagan, 1995; Wilkinson, 1997) will receive attention. The following study will examine how women from the general population make sense of their self in relationships with heterosexual partners, with particular focus on ‘caretaking’ and ‘expression’ and how the women perceive change over time. This study includes a theoretical examination of the term ‘codependency’. It will be followed by two studies which have methodological and theoretical foundations. The main aim of these studies is directed at exploring women’s sense of self and the viability of a relatively new and unused methodology as a tool within research as well as therapeutic context.
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AIMS AND SCOPE

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8. Book reviews will normally be commissioned by the Book Review Editor although unsolicited reviews will be considered, and the journal will also review other media and relevant fiction.

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Understanding the Development of Relational Attitudes in Women: An Evaluation from the Feminist Approach to the Perception of the Sense of Self in Intimate Relationships

The purpose of this study was to explore women's sense of self in their relationships with their partners. Nineteen interview responses were obtained. Multidimensional scalogram analysis and content analysis were used to examine the structure of the data. Analysis showed that many women perceived change over time, moving from care for the partner at the cost of self, to more openness about self, increased self-expression and mutual caring in relationships. Women's sense of self seemed to be strengthened by self-expression and respect for own opinions and needs. Dominant categories used to describe perceived change over time were: 'maturity', 'balance', 'adjustment to each other' and 'increased self-expression' used to describe mutuality in relationships. In contrast, 'increased self-awareness', 'more respect for own opinions' and 'do things for oneself' were the main categories used to describe a recent change in relationships.
Introduction

This project is developed from a theoretical examination of the concept of codependency (Haraldsdóttir, 1996). Codependency was initially seen as a concept that describes women's behaviour in response to alcoholic men. Codependents are seen as focusing on the needs of others to the degree of being preoccupied with other persons' lives, which then results in the loss of their own identity (Beattie, 1987; Zelvin, 1989). They are seen as being obsessed with controlling the behaviour of others, while they think and feel they are responsible for other people's well-being. Codependents have also been defined as being dependent on others in order to feel connected and worthwhile (Beattie, 1987).

Focus of the present research

The present study has a particular focus on caretaking and expression by women in general relationships and how they perceive change over time in relationships with their partners.

The previous paper (pp. 99-140; Haraldsdóttir, 1996) argued that the implications of codependency evolve around pathological identity, treatment approaches based on a deficit model and “step-by-step” solutions emphasising masculine identity and, implicitly, exploiting female vulnerabilities (Tavris, 1995). The study addressed how the concept perpetuates the devaluation of women and obscures power-imbalances and oppression. For those reasons the concept is not used as an organising
theoretical principle in the present study. Instead contrasting frameworks are used to explore the nature of women’s experience in a much broader and more interpersonal perspective. The main theoretical frameworks already discussed in Haraldsdóttir (1996) are Self-in-Relation (Jordan et al, 1991) and Gilligan’s (1982) theory of women’s relational self based on a morality of responsibility and caring for others. The present study will focus on empowerment and interdependence in relationships (Jordan et al., 1991) as well as theories on self-silencing, and care as self sacrifice (Gilligan, 1982; Brown and Gilligan, 1983; Jack, 1991; Jack and Dill, 1992).

**Theoretical background**

Feminists have offered a different framework for understanding of the conceptualisation of codependency. Instead of seeing this behaviour as ‘sickness’ or pathology, feminists emphasise that caretaking and responsibility are ‘normal’ behaviours that have been exaggerated within the context of the relationship.

From the feminist point of view, it is hypothesised that women are socialised to take the needs of others into account more than their own, and to suppress their feelings (Brown and Gilligan, 1993) in order to avoid being in conflict with people who are close to them. Thus, feminist theories highlight that the caretaking role is culturally prescribed in the female identity. It has been pointed out that ‘taking care of others at the cost of self’ (‘care as self-sacrifice’) can be a hindrance to women’s development (Gilligan, 1982). It has also been suggested that women develop from a focus on caring for others (and seeing caring for self as selfish) to a new understanding of the
connection between self and others, whereby responsibility to self is seen as necessary to maintain healthy relationships with others (Gilligan, 1982). However, some women continue to view their feminine role as involving care to the exclusion of taking their own needs into account. Such an attitude fosters the emergence of difficulties that are often a central focus in psychological therapy with these women, where presenting problems usually involve difficulties in the marital relationship, severe depression (Jack, 1991), or being ‘over-responsible’ (Krestan and Bepko, 1991) and ‘self-sacrificing’ in a relationship with an alcoholic, or an otherwise dominant partner.

Thus, emphasis on responsibility for others can be seen as a hindrance for women to develop an insight to the ethic that self and other are interdependent (see Gilligan, 1982; Jordan et al, 1991). Therefore many women learn to be dependent upon the needs of others, instead of engaging in interdependent relationships, in which the needs of self and others are taken into account on equal terms.

**Empowerment and Interdependence in Relationships**

Surrey (1991a) discusses empowerment and how women are strengthened by being in a relationship. Power has been defined as ‘the capacity to produce a change’ (Miller, 1991). Surrey describes this as a bi-directional relational process of “empathic relationships that facilitate psychological growth and empowerment” (p. 166). She states that the fundamental processes of mutual relationship are obtained by mutual *engagement* (attention and interest), mutual *empathy* and mutual *empowerment.*
Mutuality seems to be an important factor in interdependent relationships, where both partners have the ability to depend on each other as well as being independent (Collins, 1993; Jordan et al, 1991). Thus, the concept of mutuality is an important element in Surrey’s (1991b, p.61) working definition of relationship, which she sees as “an experience of emotional and cognitive intersubjectivity: the ongoing, intrinsic inner awareness and responsiveness to the continuous existence of the other or others and the expectation of mutuality in this regard” and she defines ‘mutuality’ as “separate but equal coexistence”. The above definitions are based on the notion of the ‘separate self’, which many women may find difficult to achieve within relationships of inequality and subordination (Gilligan, 1982; Brown and Gilligan, 1993; Jack, 1992; McLeod, 1994).

Suppression of Self

Jack (1991) has argued that women silence themselves because they value relationships. Women, who are in relationships characterised by dominance and power-imbalance tend to ‘keep the balance’ and avoid conflict by suppressing their feelings (Brown and Gilligan, 1993; Jack 1991). In the hope of saving the relationship in this way, women deprive themselves of the opportunity to enhance intimacy, and mutual interaction necessary to develop an equal relationship. Thus, the opportunity to give voice to feelings, without being subordinated, has been found to be an important experience for women (McLeod, 1994).
Relevance to counselling and therapy

Feminist therapy and counselling, with emphasis on collaborative relationships and empowerment through perceptions of control, endeavours to give women an opportunity to be in an egalitarian relationship where issues of power-imbalance can be addressed. (Taylor, 1996; Worell and Remer, 1992). Thus, psychological therapy can help these women realise how they often devalue and suppress own feelings, and to find ways in which they can “develop a balance of dependence and independence (interdependence) in relationships” (Worell and Remer, 1992, p.96). Counselling psychology and therapy could aid these women to understand the importance of acknowledging one’s own needs (Chaplin, 1988) and find new ways of exerting their own will and wishes in more fulfilling relationships, based on equality and mutuality.

Objectives and methodology

The objective of the present study is to examine how women make sense of their heterosexual relationships, in terms of caretaking and self-expression. Another objective of the study is to explore whether they perceive their relationships have changed over time and what factors are considered as important in contributing to this change. The identification of which factors women perceive as important elements in the process of strengthening their sense of self may prove helpful in enhancing the counselling psychologist’s understanding of the ways in which these women make sense of their situation. It is argued that this information facilitates the therapeutic process.
For the purposes of the present study, a standardised questionnaire involving four subscales is used (Jack and Dill, 1992; Jack, 1991) and adapted by the researcher to be used for multiple sorting technique, by using 16 items from this scale (see Appendix 1; p.254). The items of the questionnaire (see App. 4) refer to the perceived imperatives of how women should maintain relationships (Jack and Dill, 1992). The method of the multiple card sorting procedure provided a focus for interviewing the women (Canter, Brown and Groat, 1985). In addition, this method can offer an opportunity to assess women’s sense of self within close relationships in a collaborative way within feminist approach to assessment (Taylor, 1996; Worell and Remer, 1992).

The Multiple Card Sorting procedure was used as a method since it has been argued that is flexible enough to provide insight into an individual’s idiosyncratic perception of their life situation through a process of collaborative discovery with the client or respondent (Canter et al, 1985).
METHOD

Participants

The present study was conducted in Iceland. The method of snowball sampling (Krueger, 1994) was used to obtain a sample of 19 women. A letter was sent to seven individuals in Iceland, some of whom were asked to participate in the study and/or to find other participants willing to take part. As the present study is concerned with perceived changes over time, the inclusion criteria was that these women would have been in a heterosexual relationship for 10 years or more.

The Instrument

A questionnaire including questions to obtain demographic data, multiple card sorting tasks and a semi-structured interview schedule was devised. The demographic information included age, length of partnership, occupation, education, number of children, problems, (alcoholic, psychopathological or other problems) of the partner, that may have affected the relationship, and finally women’s experience of therapeutic encounters (see App. 5).

The interview schedule consisted of open questions which were designed to elicit how the women perceived their relationship having changed over time and what factors they felt may have contributed to this change (see App. 5).
The multiple sorting task schedule: The items used for the multiple sorting tasks are structured around The Silencing the Self Scale (STSS), developed by Jack (1991; Jack and Dill, 1992). This questionnaire (see App. 4) has 31 questions designed to measure how women perceive themselves in their relationships with others. The STSS scale has 4 subscales intended to measure the following:

1: • **Externalised self-perception**: judging the self by external standards.
2: • **Care as self-sacrifice**: securing attachments by putting the needs of others before the self.
3: • **Silencing the self**: inhibiting one's self-expression and action to avoid conflict and possible loss of relationship.
4: • **The divided self**: the experience of presenting an outer compliant self to live up to feminine role imperatives while the inner self grows angry and hostile.

(Jack and Dill, 1992)

Following a pilot study, all 31 questions were used and additional 9 items were included. These were selected according to Beattie's (1987) list on 'Codependence'. 16 out of the 31 questions were selected, and 5 items, out of the 9 additional items, were also included. The shortening of the questions from the STSS (see App. 1 on Development of Methodology, p.254), necessary for the design of this study, may have compromised contextual information. Through that process, some items were changed from being negatively phrased (i.e. "I don’t speak my feelings in an intimate relationship when I know they will cause disagreement.") to a positively phrased part of a sentence (i.e. “speak my feelings ... when/ although I know they will cause disagreement”).
An independent rater was asked to classify the items. For subscales 1 and 2, 80% were correctly classified. For scale 3, only the negatively phrased item (25%) (selected from the additional item pool and assigned to scale 3: “to suppress my feelings”) was correctly identified. For subscale 4, two of the three items (66.6%) placed within that category were correctly identified; two items were located elsewhere. The independent rater created a new category for the positively stated items from subscales 2 and 3, giving it the name of “Healthy” Expression.

The 21 items are intended to measure how the women perceive their behaviour and attitudes in their relationships with their partners: a) in the present, b) in the past, and finally c) how they see their emotional well-being (strength) to be increased or decreased in close relationship with others.

Procedure

Each participant was given 21 items to sort on three different tasks (see Procedure - Instructions in App. 1). After a short orientation, the items were sorted, one by one in a consecutive order (1-21). All the tasks were sorted according to 3 pre-selected categories or fixed sorts (see App. 1; Choice of Administration). In the first task the women were asked to sort the items in terms of how they saw their relationships with their partners at the present: 1) what they need to do for the relationship to work well; 2) what they avoid doing; 3) and thirdly what they feel is ‘not important’. This procedure was repeated for how they perceived their attitudes and behaviours in the
past. Finally, the women sorted the cards as to what they considered giving them well-being (strength) in relationships in general, and what would decrease or not affect this strength. The open-ended questions were introduced between sorting tasks 2 and 3. Finally, questions on demographic information were answered (see App. 5).

**Multidimensional Scalogram Analysis (MSA)** was used to examine relationships between cards (elements) sorted by participants. The MSA analysis computes relationships between elements based on how similarly and differently they were sorted by each participant. Based on how the cards were sorted, MSA examines the structure of the data, whereby the position of each card is presented as a point in a two-dimensional, geometric space (the Euclidean space). The technique identifies 'conceptual distance' between all the cards. This analysis is based on how the cards are related to each other through the different sorts performed. Differences found in the underlying sorts determine how closely or far apart the elements are in relation to each other. Secondly, these differences are displayed and show how and whether they are clearly divided into different, meaningful regions. MSA provides plots for each of the sorts performed, thus providing information on how the elements in the identified regions can be interpreted. This interpretation is derived from the meaning given to the cards in the sorting tasks (for further description see App. 1: Multidimensional Scalogram Analysis).

MSA can be used to explore relationships within the data on an individual and group level (Canter et al, 1985). In the present study, individual profiles will not be
discussed. However, relationships among the 21 elements will be analysed as to explore whether the 4 subscales of the STSS would be identified. Most importantly, the MSA was used to identify separate groupings of women and examine which elements distinguished most clearly between the different regions. This analysis was performed in three different ways: 1) how the respondents saw their relationship in the present; 2) perceived differences between this present status and the past status of relationships; and 3) between present status and how they perceived status of well-being or (‘ideal emotional strength’).

In this analysis, the MSA provides an overall plot, showing each individual as a point in the geographic space. This provided an opportunity to explore similarities and differences among respondents as well as investigating characteristics of each identified region (see App. 1; Preparing and Entering Data). The regions identified through this analysis (i.e. ‘present relationships’) was used to divide the participants into subgroupings as to better explore categories identified in the Content Analysis.

*Content Analysis* was used for the second part of the study. Content analysis is a technique of systematic and objective inquiry for investigating linguistic material, whereby inferences from the data can be made (Krippendorff, 1980). One part of this inquiry was to identify units of analysis (Millward, 1995), a segment which can be a word or a phrase that are assigned to categories. Due to the richness of material available for analysis, the units selected, a word or a phrase frequently mentioned as a factor in change over time, were be identified, coded and assigned to categories.
These categories differed in relevance. Only the categories that were considered relevant for the purpose of the present study will be discussed. In one interview, the tape-recording failed and one women did not give a consent to tape-record her interview. The remaining 17 interviews were transcribed in Icelandic and subjected to content analysis. Once categories had been selected they were translated into English, but due to time limits cross-translation was not possible. An independent coder was asked to read through these to verify the fit. Two discrepancies arose, which were resolved by excluding the items from the categories they had been assigned to, which would have resulted in an interrater reliability coefficient of $k = 0.72$.

In the process of sorting the items, some women felt an additional category denoting mutual engagement was needed. According to this comment a fourth category was created, meaning mutuality or interdependence with respect to that item.
RESULTS

Background data

A total of 19 Icelandic women, aged 25-62, from the general population, participated in the study. Most of the women were married and had been in a relationship with the same man. Two were divorced. One of these women had recently separated from a marriage of 17 years and was now in a new relationship. One was divorced following the break-up of her 17 years marriage. One of the women was a widow. Each of the women completed the interview in one and a half to two hours. Background data is summarised in Tables 1 and 2.

| TABLE 1 |
|-----------------|-----------------|-----------------|-----------------|
| Age             | Length of       | Length of       | No of           |
|                 | relationship    | education       | children        |
| 41.32           | 20.26           | 14.58           | 2.63            |
| (11.32)         | (9.92)          | (4.21)          | (0.96)          |
### TABLE 2

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>5</td>
<td>26.32%</td>
</tr>
<tr>
<td>Secretary</td>
<td>4</td>
<td>21.05%</td>
</tr>
<tr>
<td>Housewife</td>
<td>3</td>
<td>15.79%</td>
</tr>
<tr>
<td>Cashier</td>
<td>2</td>
<td>10.53%</td>
</tr>
<tr>
<td>Designer</td>
<td>2</td>
<td>10.53%</td>
</tr>
<tr>
<td>Assistant nurse</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td>Qualified nurse</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td>Nursery teacher</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>19</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

As illustrated in Table 2, five of the women were teachers and four employed as secretaries.

**Identified regions in the MSA**

The analysis of relationships between items revealed 3 main regions. These were in agreement with the subscales of the STSS, i.e. 1) Self-expression (as opposed to Silencing the Self), 2) Care for the partner (Care as self-sacrifice), and 3) Suppression of self (The divided self). 4) The items of subscale 1, Externalised Self-
Perception, were distributed among the other item groupings in differing ways. These four groupings could most clearly be detected in the analysis of how women perceived their relationships in the present. For the purpose of conciseness, these profiles will not be discussed.

**Identified groupings of women**

*Present relationships:* When this same data was entered in a reversed way, showing individuals as points in the two-dimensional space (instead of items), three main regions could be identified. The most clear factor in distinguishing between these regions was the degree to which the women expressed themselves within the relationship. Openness vs. suppression (hiding some aspects of self) was another element that divided the plot in similar ways. The three identified regions of the plot indicated that the women’s sense of self could be described in an ordered way, which was a movement from women who avoided expression to those who openly expressed themselves within the relationship (see. Figure 1; p.164). An explanation of the identified regions is as following:

*Interdependence:* This was the most clearly identified region within the plot, characterised by openness, self-expression and mutual care. Having the ability to give and receive care in their relationships, the women within this region (No.=9) seemed to have a sense of an integrated self, characterised by interdependence, the ability to give and receive (Jack, 1991).
The 'loss of self' ('divided self'): This region was characterised by avoidance of expression and openness. When the interviews of these women (no=3) were analysed, it became apparent that all of them were in dominant relationships (see Figure 1; p.164).

The less integrated self: In between of the two aforementioned regions were women who were able to express themselves but put less emphasis on being open and congruent with their own feelings (no. 7). Two of these women (no. 7 & no.17) had started a new life-style after the break-up of a long-term relationship with a dominant partner. Along with two other women (no. 1 & 4), they reported to be in a phase of transition in their lives (see Fig. 1; p.164).

Apart from the region representing mutuality (see 'interdependence' in Fig. 1), items representing 'care for the other' failed to divide the overall plot into clear regions. It was also observed that items on self-care failed to distinguish between groups. This might have been due to different response styles of the women within the regions. Almost all women in interdependent relationships said they emphasised taking care of their own needs as well as those of their partners. Other women varied in terms of whether they saw their own needs as important or not.
Analysis of how women perceive change in their relationships with their partners

When interviewing the women, the most obvious difference between the past and the present status of the relationship was how they had taken the needs of their husbands more into account in the past than they do in the present.

The most clearly identified regions in the MSA plot were characterised by elements of expression, openness and care for the other (i.e. mutual care vs. care as self-sacrifice). An ordered facet of these themes was identified (see Fig. 2; p. 165), where there is movement from: 1) lack of expression to expression beyond thought of conflict, 2) suppression of self to emphasis on openness and being oneself; 3) and from care as self-sacrifice to integration of mutual needs and opinions. This particular pattern can be seen as representing a continuum from loss of self, or the ‘divided self’ (Jack and Dill, 1992) to the integrated self or ‘self in relation’ (Surrey, 1991b). According to this, the emphasis on being open about oneself seems to be a strong factor in self-expression and most of the women, who reported mutuality in their relationships express themselves openly. These elements seem to be important factors in the development of women’s integrated self, where the needs and opinions of both are taken into account.

Women who avoided self-expression did not seem to emphasise the need to be open about their inner self as much as the interdependent women did. Being in unequal relationships, characterised by alcohol abuse and dominant attitudes, they might have
seen avoidance of open conflict as necessary for the survival of the relationship. Finding it hard to express their needs and respect their own sense of self, this might have resulted in suppression of self and being responsive to their partner's needs at the cost of their own.

On the whole this analysis appears to show that, in the past, women often tended to take their partners' needs more into account. For some women, it seemed easier to report what they did in the past, than to acknowledge the same behaviour in the present. However, the results of this analysis seems to indicate that more open self-expression facilitates the development of the more integrated attitude, and enhances a healthy and interactional 'give and take' in the relationship (Cappella, 1988; Jack, 1991), which according to Surrey (1991a) leads to personal empowerment within the relationship.

*Perceived change over time:* There was a considerable movement between identified regions, from the past to the present. Eight women moved towards more openness and appreciation of own rights (see Fig. 2; A = present relationship, R = past relationship; p.165). The main reason for this seemed to be participation in social activities, alcohol-related treatment, and open communication within the marital relationship. A few of the respondents mentioned social support as a mediating factor for these changes. Change to the negative direction was found in one case (see no: 6 A and 6R), which, according to the idiographic profile, might have resulted from lack of communication, reported flexibility and overvaluation of the partner's attitudes.

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Emotional strength and present relationship: *Analysis of differences between relationships in the present and perceived emotional strength:* In the comparison between present relationships, on one hand, and what women perceive as giving them emotional strength, on the other hand, the MSA plots appeared to indicate that openness, and respect for own opinions are the elements that distinguished best between the four identified regions (see Fig. 3; A = present relationship; S = ideal emotional strength; p.166). An ordered facet of sense of self appeared where there was movement from the 'divided self' (Jack, 1991) to a strong sense of self with respect own opinions and needs. Thus these women reported that care for the other at the cost of self would decrease their emotional strength. In between these two regions, there was a grouping of women who seemed to find strength in caring more for the other by relinquishing own needs, whilst also though reserving some sense of self. Finally, there was a grouping of women who appeared to gain strength and a sense of self in relationships by mutual respect for needs and opinions (the integrated self or interdependence, see Fig. 3; p.166).

Comparison of pairs for each of the women: There appeared to be considerable movement between groups, in what women perceived as giving them strength, on one hand, and how they perceived themselves behaving in actual relationships, on the other. The most ‘positive’ move between regions was demonstrated for the women who had a strong sense of self, and managed to integrate that strength in their present
relationship by including the other in a mutual relationship (Surrey, 1991a; Cappella, 1988; Aron and Aron, 1996). Although some women perceived their emotional strength as stemming from being mutually related to the other, these women seemed to sacrifice some aspects of themselves in favour of care for partner's needs. This might also apply to the women who appeared to remain static over time in the region of the 'divided self', (see comparison no. 1A and 1S). Being in an oppressive relationship, where caring for the other was more important than respect for own needs and opinions, might have fostered in suppression and dissociation from her own sense of self (Brown and Gilligan, 1993).

The interpretation of the overall plot regarding women's change over time which seemed to indicate a movement from dissociation of self (the 'divided self') to a strong sense of self which, however, appeared to involve some dissociation from the other (see comp. No: 12A and 12S). However, most of the women tended to move toward exhibiting an integrated sense of self in relationship with the other, ranging from more emphasis on the needs of the other (at the cost of own needs) to respect for own opinions and needs in a mutual relationship with the partner.
Figure 1: "The Present"
A = Present relationships; R = Retrospective account of relations

Figure 2: "The Past vs. Present"
Figure 3: "The Present vs. 'Ideal strength'"
CONTENT ANALYSIS

When the interviews were analysed according to the pre-specified criteria (see above; pp.153-154), it became apparent that the units of analysis assigned to categories came mainly from two different subgroupings from MSA analysis (see Fig. 1, p.164) of how women perceived their present relationships. Four categories were identified from interviews (see below) with women who according to the MSA were classified as interdependent, and three from interviews with the women, classified as 'self in transition' (see Fig. 1).

Analysis of demographic variables revealed that four out the nine women clustered in the region of interdependence had qualifications as teachers, thus leaving two teachers in other regions. Secondly, 'problem of partner' was distributed towards the upper region of the MSA plot; i.e. women who reported their partner as alcoholic or domineering were distributed in a semi-circle ranging between the west-north-east region of the plot (see Fig 1). Four of those women were seen in terms of 'self in transition' (i.e. including participant no. 4, who was in the early process of changing her past behaviour). Interviews with the six remaining women identified in terms of an 'independent', 'isolated' and 'divided self' did not elicit common categories.
What factors played a part in how women perceived change over time in their relationships?

The interdependent group: Six of the women in the 'interdependent group' explained changes over time in terms of 'Maturity', (no.=6). In addition, some of the women emphasised obtaining a 'Balance' in the relationship (no.=4), and others mentioned 'Adjustment' to each other (no.=4). 'Increased Self-expression' (no.=6) was the fourth category and two of these six women mentioned their partner as an important factor in helping them open up and share their feelings. For the purpose of conciseness and considering the aims of the study only the following two categories will be discussed.

Balance:

No. 2: I think there is more balance in our relationship. For me, there was a struggle for independence during the first years. You see, I was around twenty when we started living together, and he was twenty four; and you are so immature, you go from one authority to the other.

For further quotations: see Fig. 1-3

The concept of balance seemed to be an important aspect of interdependent relationships, where mutuality was emphasised and both partners interacted on an equal basis. Cappella (1988) discusses this in terms of the struggle to find a balance between the competing forces of interdependence and independence. He views the existence of these forces, on the one hand, as a mechanism that drives the person to seek closeness and responsiveness to the
other’s needs; on the other hand, as the strive for autonomy and responsiveness to one’s own needs.

**Increased Self-expression: Male partner’s support.**

In addition to the above categories, two women mentioned their partners as a good source of support for their self-expression, which might have contributed to the perceived changes:

No 11: (Reason for change?) It is just discussing things. (You were saying that he helped you to disclose things). Yes, he was much better in discussing things. He was much more open, although in a way he is a silent person.

No. 9: I have always had difficulties talking about my feelings. In fact all the time. But, I can say that he has in a way helped me to open up. I have learned how to talk more about feelings, ...

McLeod (1994) has argued that despite frequent accounts of the effects of male partners’ dominating behaviour on women’s’ well-being, there are also accounts of their supportive behaviour. The two above quotations seem to exemplify that. Research evidence on feminist therapy suggests that the opportunity to express emotional needs without subordination is a rare experience (McLeod, 1994) which might, however, be very important for many women in their attempt to increase their well-being.

‘Self in transition’: When the women were interviewed, it became apparent that four women were in the phase of transition and making changes in their lives. According to the
MSA results, three of them were identified as a separate grouping (see Fig. 1). The fourth woman (no. 4) sorted her items according to how she had perceived her relationship up to the present and therefore she fell in a different location in the geometric space. She reported that although she had not changed her behaviour much, she was in the phase of changing her attitudes towards herself and the relationship.

The three remaining categories identified came mainly from women within this group, who described how their opinions had changed and what factors might have contributed to such change.

*Increased self-awareness*

Five women talked about increased awareness of themselves. Four of those made up the group that described themselves as being in transition and making changes in their relationship. When asked how her opinions had changed, the first answered:

No. 1: I have become more aware of what I want for myself. I was not aware of that. It is more like that.

No. 17: There was an event that pushed me a lot to do something (about my relationship). In fact, it was that our mothers died within a period of one month. This awoke me so harshly, (and showed me) that life is not eternal and you control your life yourself. Nobody does it for you. Then, I saw that this was not a life I wanted.
Jack (1991) has described the authentic self as a voice that says: “I want, I know, I feel, I see, I think” (p.94). The increased awareness of this voice seems to be a factor mentioned by the women who felt they were in transition in their lives. It may therefore be an important element in the therapeutic process to help women to acknowledge this voice in a safe environment, free from inducing subordination and dominance (McLeod, 1994).

**More respect for own opinions**

Four women talked about increased respect for own opinions. All but one came from the group of women who felt in transition in their lives.

No. 1: Yes, my opinions have changed in the direction, that now I have opinions on what suits me. I was not thinking about myself. I just had no opinions what suited me.

No. 4: I would describe this in the way that I have started becoming more independent. I have started respecting how I feel about things.

According to the MSA results, respect for own opinions seemed to be strong element in the women’s development of sense of self. Increased awareness about own opinions also appeared to be an invaluable element for those women who felt they were in the process of perceiving themselves in a new light and finding new ways of interacting (Jack, 1991).

**Do things for oneself**

Three women mentioned doing things for oneself.
No. 1: Now it has changed and I am beginning to think about doing something for myself, and to do what I think is best.

No. 4: And, it changed more in the way that I started, for the first time in my life, to do something for myself, although it would cost conflict. Instead of: ‘Love the peace’-attitude I have started gradually doing things for myself, although it costs some noise.

In the process of changing their lives, these women seemed to be in the phase of starting to do, or, “think about doing something” for themselves. Coming from the interdependent group, the third one said:

No. 19: I have never stopped being in my sewing club in town. If something happens within my field, I go.

There seemed to be a clear difference between women in whether they emphasised doing things for themselves or not. In the analysis of the items, it could be seen that all women but two, who belonged to the grouping of ‘interdependent’ women, emphasised doing things for themselves, while there was a more variability among the others. Doing things for oneself can be seen as ‘self-reinforcement which enables the individual to nurture and empower the self’ (Worell and Remer, 1992). Feminist therapists have integrated many of the cognitive-behavioural strategies, which they have found them effective for counselling with women. Some of these strategies could be used to assist women to identify their needs and help them to understand the importance of achieving personal goals.
Discussion

The method employed proved to facilitate the process of the disclosure of sensitive and personal issues like that of a relationship with a partner. Thus, most of the women reported that the process of card sorting helped them clarify their thinking about their relationships and how they felt their position was in relation to their partner. This seemed to be especially helpful for women who found it difficult to express themselves in a difficult relationship with their partner. Additionally, the card sorting task seemed to enhance exploration of issues in a systematic way, that would otherwise be time-consuming to obtain.

The main results of this study seemed to indicate that self-expression and respect for own opinions are important factors in the development of women’s emotional strength. It was not possible to clearly show that the women cared for the other at the cost of self. However, there appeared to be clear indication of perceived change over time. The women, who reported having cared for the other at the cost of self, had ‘moved’ towards more openness and increased self-expression. However, data based on relationships in the past are retrospective and could therefore be unreliable and subject to personal memory and biases that can occur over time. This, retrospective nature of the data needs to be considered in the speculation of perceived changes in long-term relationships.

The findings of the study suggest that women in unequal relationships tend to suppress their feelings, whereas openness and self-expression are an important factor in enhancing
mutuality in relationships. Evidence for this, has been found by McLeod (1994) who asserted that the capacity for self-expression "is either nourished by comparatively egalitarian relationships, ... or undermined by hierarchical relationships" (p. 57). One of the ways in which feminist therapy can help women is increasing their understanding of how the power differentials, existing between men and women, may result in oppression and dissociation from self (Brown and Gilligan, 1993; Cowan et al, 1995; Worell and Remer, 1992). Therapeutic interventions might help women to act responsively toward self, as well as the other (Gilligan, 1992) by advancing their awareness of how they may find the resources to change their roles in life.

The women in 'comparatively' equal relationships emphasised balance and adjustment as important elements of change over time. It seems likely that the process of knowing oneself and the other would be enhanced through mutual interaction and expression in the relationship (Surrey, 1991b). This process may also facilitate the development of a caring attitude toward the self and the other.

Increased awareness of self, and respect for own opinions and needs, seemed to be important elements in the experience of women who were moving out of a relationship of dominance and subordination (McLeod, 1994) to more freedom in the relationship. According to the self-in-relation theory, this caring for oneself does not occur in isolation. Interaction with others and development of new forms of relationship would be needed for strengthening their sense of self (Surrey, 1991b). To this effect, psychological therapy can
provide women with the opportunity to identify their personal strength and value own needs within the context of an egalitarian therapeutic relationship (Worell and Remer, 1992).

It seems inherent to the findings of this study to suggest that women should be encouraged and enabled to express their opinions and to enhance their sense of self. Marital therapy might be a useful intervention, especially in unequal relationships where difficulties of expression hinder communication. It has been suggested that such therapeutic techniques as self-disclosure between partners might produce change in intimacy between the couple (Waring et al, 1994). In feminist therapy, women are also encouraged to explore their experience in relationships with other women (Surrey, 1991b). Assertiveness training is valued as a useful therapeutic approach by feminists as well (Worell and Remer, 1992), and Gestalt therapy has been accredited much importance in identifying what might block self-expression (McLeod, 1994).

**Conclusion**

It would be erroneous to generalise about women's sense of self from the outcome of this study. A sample based on the willingness to participate is likely to give an over-representation of enthusiastic women, which might have decreased sampling validity (Krippendorff, 1980) and confounded the generalisability of the results of the study. A disadvantage to the richness of the findings of this study is the limited use of the card sorting technique. For this reason, idiographic analyses of individual plots did not prove to be meaningful. Instead the MSA analysis provided group characteristics, seen as useful to support findings derived from the content analysis.
However, one of objectives of the present study was to serve as an experiment in finding new ways in the development and use of the card sorting technique. It was strongly felt that the technique was a promising method in doing research with women and providing a richness of personal information. Thus the study will serve as a basis for similar study with women from a clinical sample, where the methodological observations and findings will be taken into account.

Findings and Women’s Sense of Self: Discussion

The MCS technique is a collaborative method. It was found to encourage exploration of the personal meanings underlying the elements provided. The women reported that the card sorting procedure helped clarify their perception and understanding of their present relationships. Many of the women were enabled to report increased awareness of the quality of the relationship and how this had progressed over time. Such a finding is promising and seems to encourage use of the technique as a tool to explore personal context and - in this case - how women come to understand their behaviours and attitudes in relation to others.

The MSA and Content Analyses revealed that interdependence in relationships was characterised by open communication and mutuality in interaction with partners. Gradual change over time was characterised by maturity, balance and increased expression.
The finding that 'problem of partner' (i.e. alcohol or domineering attitude) characterised regions termed as 'self-in-transition', 'the divided self' and the 'isolated self' was noteworthy. This raises questions of causality and whether the underlying structures revealed through the MSA reflect different response styles related to being in an oppressive and problematic relationship.

**Conclusion**

The findings of the present study suggests that a strong sense of self and identity characterised by interdependence is developed within a relationship where there is an opportunity to interact in an open and mutual way. This is in agreement with Miller’s (1976) observation that “women stay with, build on and develop in a context of attachment and affiliation with others” (p.83) and supports the contention (Gilligan, 1982) that women “define their identity through relationships of intimacy and care” (p.164).

In contrast, self-silencing and/or “the divided self” (see Jack, 1991) is a condition that might arise within problematic relationships devoid of intimacy and interconnection. Miller (1976) claims that for women “affiliation is valued as highly as, or more highly than self-enhancement” (p.83). This might create a dilemma for some women and yet clarify why they choose to stay in unequal relationships. It does provide an interesting focus for research as to explore the personal meanings these women attribute to their relationships and perhaps reveal the theories they use to explain the need for continuation of their own powerlessness and subordination (Gilligan, 1982). As a focus for therapeutic progress, it
would be helpful to explore how they make sense of their 'self-silencing', explained by some as 'internalised oppression' (Hagan, 1995; Wilkinson, 1997).

**Development for the next study**

One of the questions raised by the present study was how women experience and/or gain a sense of power within relationships. This might be especially important in relation to the coping strategies used by women who fail to empower themselves through open expression. The following study will attempt to obtain answers to this question by asking women to provide elements describing the ways in which they exercise (or fail to exercise) power or control within the relationship.

Another objective of the following study is to explore the viability of the MSA technique as to whether an underlying structure exists, representing the personal meanings of women encountering difficulties in their relationships with alcoholic partners. The study will also explore the potential of the multiple card sorting procedure as a therapeutic tool for women to explore and clarify how they construe their sense of self in intimate relationships.
References


AIMS AND SCOPE

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All figures should be of a reproducible standard. Font notes should be kept to a minimum, and presented as End Notes. Papers should normally be between 5000 and 8000 words, but exceptionally up to 10,000 words for theoretical and empirical articles, research reviews and reports of practice; and between 500 and 2000 words for observations and commentaries. Please provide a word count. A variety of forms will be welcomed.

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Women's sense of self: A feminist perspective.
The implications of using idiographic approach in
the understanding of women's relational problems
with alcoholic partners

Initially based on a feminist critique of the concept of codependency, this study explores a
relatively new, structured but flexible method (Multiple Card Sorting) in exploring and
identifying relational problems of women and their sense of self in heterosexual
relationship with alcoholic partners. 16 interview responses were obtained from
participants seeking group therapy, for their relational problems, in an Icelandic
outpatient clinic for alcoholics and their relatives. Multidimensional Scalogram Analysis
and Procrustean Individual Scaling analysis were used to examine the structure of the
data. Two examples of MSA plots were discussed to illustrate interpretation and use of the
idiographic structure and implications in therapeutic context. The PINDIS analysis
revealed a common structure indicating a common structure with an overall fit of 0.73.
The results indicated that the MCS technique is a promising method for the women in
exploring their personal meanings, producing a "cognitive map" which can provide a
useful method and an insight into underlying problems as foci of therapy.
Introduction

This research paper is based on a critique of the concept of 'codependency' (Haraldsdóttir, 1996; pp.99-140) and endeavours to explore how women with the self-label of 'codependency' make sense of their self in relationships with alcoholic partners.

The present study is a methodological examination of the multiple card sorting procedure (MCS) and its utility in exploring the personal contexts and meanings created by Icelandic women who have identified difficulties in their relationships with alcoholic partners. The study builds on the findings of a previous study, which examined the usefulness of this technique in a sample of 19 women taken from the general Icelandic population (Haraldsdóttir, 1997; pp. 142-182). The technique is based on sorting elements describing behaviour and attitudes deemed to be characteristic of the socially demanded female role. The card sorting procedure was seen as useful in clarifying meanings attached to personal relationships. The present study will draw upon observations and developments from the previous research.

Previous findings, obtained through the MCS technique, revealed that open communication, respect for own opinions as well as willingness to care for the other were the main elements characterising women in mutual and interdependent relationships. Most of the women who did not emphasise mutuality had an oppressive or alcoholic partner. Content analysis showed that the interdependent women perceived that change over time was gradual and happened as a result of maturity, balance and increased expression within the relationship.
In contrast, women who had problematic partners, reported a recent change in the relationship mainly characterised by increased self-awareness and respect for own opinions, as well as starting to do things for self.

**Women's Sense of Self**

Psychology and Western society, in general, value highly the existence of the independent self whilst dependency is devalued (Sampson, 1988; Stiver, 1991). The notion of independence as a primary goal of psychological development and ideas about the individual as having a unitary and separate self have gradually emerged over the last few centuries in a society that favours competition and individuality (Sampson, 1988). Established within this paradigm, the concept of codependency is based on the orientation of an 'independent self' as necessary for healthy development (Miller, 1979; Collins, 1993). This view has been critiqued by many social psychologists who have argued for the existence of a social self and self-awareness (Chase, 1992). Feminists have raised their doubts about the 'individuated self' as a basic entity and Kitzinger (1992) maintains it to be a social construction, historically and culturally specific to Western culture.

In his theorisation on men's problems, Jukes (1993) contends that 'masculinity is based on the assumption of male superiority'. Others argue that boys acquire masculinity by rejection of female characteristics (Chodorow, 1979) and separation from others whilst femininity is defined through attachment and continued relationships (Gilligan, 1982; Belenky et al, 1986; Miller, 1991). Thus, many feminists have argued that women develop a sense of self which is relational and takes others and the context/situation into account. In her critique,
Miller (1991) states that for a woman the experience of being ‘related to another person’ is satisfying, motivating and empowering, resulting in the enhancement of self, which is seen as a goal for women, not a means to an end. It can be speculated that this relational nature can constitute both strength and/or weakness for women in close relationship with others. However, historically, gender identity formation seems to be developed through a sense of superiority in men (Jukes, 1993) and of inferiority for women (for a review see Babcock and McKay, 1995).

**Voice - Listening - Self-Silencing**

Coming from a feminist perspective, Carol Gilligan (1982) has developed her theory on women’s ‘different voice’. Her theory has been highly influential and elicited animated critiques (see for example Larrabee, 1993). Gilligan states that socialisation prepares women to care for others, which often is based on the ‘illogic of inequality between other and self’ and confusion between self-sacrifice and care (Gilligan, 1982). She introduced the notion of women’s ‘different voice’ that is inherently relational, based on responsibility and caring for others. However, through their development, girls/women often silence their own voices for the sake of avoiding conflict and staying in relationship (Brown and Gilligan, 1993). Belenky et al. (1986) have also directed their focus onto the notion of connection, intimacy and the inclusion of others in women’s sense of self. However, ‘listening to the voices of others’ (Belenky et al, 1986) may lead to subordination of the self and difficulties of taking responsibility for one’s own needs, (Jack, 1991) a process resulting in the loss of self (Jack and Dill 1992).
Power in intimate relationships

The central focus of feminism is the recognition of the inferior social status accorded to women and how the socialisation of women maintains oppression and perpetuates the ‘feminine’ image of women as dependent and subordinate in relation to men (Miller, 1976). One form of this oppression is how power is distributed between the sexes. The power of women has been confined to the home, to caretaking and responsibility for the well-being of the family, and men are assigned power in society, both outside and over the family. The ‘negative’ side of women’s power and capacity to give power-to-others is that through socialisation they learn to use this power at cost to themselves. Women learn that the only way to be valued and feel empowered and worthwhile is to be empowered vicariously through others (see Walker and Goldner, 1995).

Research on ‘power strategies’ has shown that women and those having less power in relationships tended to use ‘weak’ influence tactics, such as manipulation (Howard et al. 1986) and that men’s perception is that they have a position of relational strength, “whereas women perceived themselves to be influencing their partner from a weaker or subordinate position” (Falbo and Peplau, 1980; p.627).
Relevance to Counselling Psychology

Understanding of relational problems have been too easily explained by the ‘mushrooming’ concept of codependency (Haraldsdóttir, 1996) and the concept has been criticised as vague and meaningless (Krestan and Bepko, 1991). As a descriptive label, the concept may mean different things to both clients who ‘diagnose’ themselves as codependent, as well as therapists who work with them. Evidence shows that women are not always sure what they mean by their own self-labelling (Asher and Brishett, 1995). It is therefore important to provide a therapeutic technique through which the presenting problems of ‘codependent’ clients can be explored.

The present study suggests that a counselling interview is a valuable instrument in addressing sensitive issues in qualitative research (Coyle, 1998). Based on idiographic approach as research tool (Canter, Brown and Groat, 1985), it provides an meaningful focus in exploring behaviours and perceptions, labelled by many as ‘codependency’. Instead, women's personal and social experience should be explored in a way that allows for an understanding of conceptual systems (cognitions, emotions, assumptions) utilised by women as to make sense of their self and behaviour in problematic relationships with alcoholic partners.

The present study is based on a research using a sample of women from the general population (Haraldsdóttir, 1997). Its objective was to examine how women make sense of their heterosexual relationships, in terms of caretaking and self-expression; and to explore how the women perceived change over time and what factors in the relationship were seen
as important in contributing to this change. The study also served the purpose of exploring the multiple cards sorting (MCS) technique as a potential method in identifying personal meanings involved in relationships with others. Based on the process and outcome of this previous research, it is suggested that the MCS provides a research method of ‘collaborative inquiry’ that erodes much of the barriers between researcher and subject (Reason and Heron, 1995; Rowan, 1998). It is further proposed that the research interview in itself exemplifies an in-depth psychotherapeutic interview in that it provides a tool for the respondent/client to explore and clarify how different aspects of relational behaviour affect personal well-being without undue stress or pressure. This overlap between, or integrative nature of, qualitative research and counselling psychology/psychotherapy has been noted and explored (see Coyle, 1998).

The present study draws upon the former (Haraldsdóttir, 1997) in that the technique is elaborated and developed to obtain more in-depth personal information about the uniqueness of each respondent. Thus, the two studies present a development of a research technique. Not being identical in their use of the research method and analysis of data, comparison between samples can only be indirect. This objective is not within the scope of the present paper, and would present a focus for another study.

Thus, the present study is qualitative and partly methodological in its aim. It endeavours to collect data using Multiple Card Sorting (MCS; Canter et al, 1985) as a way of exploring idiographic and group characteristics. This choice of method is influenced by its emphasis on an idiographic model with a strong theoretical basis, arguing for individual differences.
This is particularly relevant in context of dealing with a concept like ‘codependency’, which includes a whole range of relational problems, qualitatively different from one person to another.

**Idiographic Approach**

In his emphasis on the ‘human, healthy and organised aspects of behaviour’ Allport (see Pervin, 1970) proposed a theory of personality traits which people can show in flexible ways in different situations. According to the qualitative differences within and between individuals, he maintained that idiographic research based on in-depth study was useful to explore individual uniqueness as well as giving information about people in general. Of importance here also is Kelly’s (1955) personal construct theory as an approach in understanding how people make sense of the world. He argued that people deal with anxiety, fear and threat not just by adopting constructs but by changing their pattern of construing in order to reduce confusion and make sense of events. Furthermore, and of interest for the present study, Kelly argued that in growth and development, the person could be seen as a scientist seeking expansion of the construct system (Pervin, 1970).

Finally, the Multiple Card Sorting (MCS) technique has been proposed as flexible way of exploring conceptual systems as it allows for an intensive study of individuals, in their own terms, by using their own concepts and categories (Canter et al, 1985; Groat, 1982). In the exploration of conceptual systems, the MCS technique is based on the assumption that “the ability to function in the world relates closely to the ability to form categories and to construct systems of classification [...] Thus, an understanding of the categories people use
and how they assign concepts to those categories is one of the central clues to the understanding of human behaviour” (Canter et al, 1985, p.79).

The main aim of the present study is to explore the potential of a relatively new and unused method. Mainly used so far in research, it is suggested that this method might also be promising in therapy. The focus is on its applicability to explore and understand how women seeking treatment in relation to their ‘self-diagnosis’ of codependency construe their sense of self and experience in relationship with alcoholic partners. The technique should enable us to a) identify idiographic cognitive maps specific to each woman; b) identify a ‘common’ cognitive map which would provide commonalities within the sample, as well as providing insight into the ‘specifics’ and idiographic nature of individual maps.

The method used is related to Kelly’s (1955) Repertory Grid, a well-known technique, based on his personal construct theory, to explore relationships of constructs in a mathematical space. However, the method has its own restrictions (Canter et al, 1985) as it does not allow for using categorical and ordinal variables simultaneously. This limit has been redressed by the Multidimensional Scalogram Analysis (MSA; Lingoes, 1968) which is more relaxed and flexible and gives participants opportunity to sort the cards in any way they like. The MSA analysis explores relationships between elements (cards) through rigorous statistical methods, whilst its meaning is based on interpretation of how the elements were sorted.
Based on the MSA, is the Procrustean Individual Dimensional Scaling (PINDIS; Lingoes and Borg, 1978) as a way of exploring whether the idiographic structures involve common cognitive representations, perhaps indicating a meaningful commonality within the data (Hammond, 1995). This allows for examining common characteristics presented in the individual MSA plots and gives an opportunity to how identity better how the idiographic structure differs from the common representation.

In sum, the present study aims at exploring the usefulness of MCS as an approach to identify problems presented by women in problematic relationships with their alcoholic partners. Of interest is also whether the technique might be used within therapeutic context, as a tool for the client to clarify aspects of own behaviour, a process through which she might change her pattern of construing and making sense of her sense of self and relationships with others.
METHOD

Participants and the Clinical Setting

The present study was conducted in Iceland in an outpatient clinic for alcoholics, working under the University Hospital in Reykjavik. A part of this service is a weekend course and group therapy for relatives of alcoholics (open to both men and women) who see themselves as having problems in relation to their alcoholic partner or significant other. Lists of names of those who were willing to participate in the study from groups held over the period of October 1998 to March 1999 (No=25), were given to allow each person to be contacted by the researcher. Research interviews were conducted in January and April 1999. The 20 women, who were contacted, agreed to participate and identified a place and time for the interview. Of the 18 women interviewed, 16 women met the inclusion criteria of having participated in group therapy because of their partner's alcoholism. Women who were already divorced or separated were included as they were seeking treatment in relation to their relationship with an ex-partner.

Through co-operation with the service, a short description of participation in the study was given to members in group therapy. Ethical approval was given by Data Protection Commission as to guarantee anonymity, confidentiality and deletion of personal data. Secondly, ethical approval was given by a medical Ethical Committee within the University Hospital (Landspitalinn) (See Appendix 8).
The group therapy was based on two-weekly meetings for a month, after an initial introduction to the concept of codependency in a week-end course. Being embedded within the AA-orientation (Alcoholics Anonymous, 1939, 1976; Gorski, 1989), the group therapy makes use of the Twelve-Step program (AA, 1976) which was used to challenge group members to look at themselves and their relationship with the alcoholic family member. Secondly, was 'Mirroring', involving solution-focused group work, with introduction of a personal problem and feedback from other group members to provide a different perspective of behaviour, i.e. maladaptive thought processes and emotions (Ellis, 1967).

A work booklet with exercises and examples of thoughts and emotions was given to each participant including plans of positive change. 'Recovery' is seen as an active change, based on self-respect and increased self-awareness instead of directing focus on others. Participants were encouraged to do things for themselves, participate in Al-Anon (1979) or by enhancing their own physical well-being. - Al-Anon is a self-help group with historical roots in AA. Formed in 1951 by wives of alcoholics, it adopts the AA-philosophy of the Twelve Step program (see Haaken, 1993).

The Instrument

A questionnaire in Icelandic including questions to obtain demographic data, multiple card sorting tasks and a semi-structured interview schedule was devised. The demographic information included age, length of partnership, number of children, occupation, education, problems of the partner and personal problems seen as affecting the relationship; women's
experience of therapeutic encounters; and length of time (weeks) elapsed since they participated in the group therapy. Finally, the women were asked whether they saw themselves as financially independent, codependent and/or dependent, an option they could clarify if they wanted (see App. 6). Before going on to the interview schedule, women were asked to rate on a scale from 0-10, how powerful they perceived themselves in relation to their partner, how powerful the partner was, and thirdly how they perceived the relational strength in their partnership.

The interview schedule consisted of open questions designed to elicit how the women responded to stressful situations, such as in a conflict or when they wanted to make their own way. Emphasis was on eliciting coping strategies and underlying feelings in these situations. Finally, the women were asked how group participation had changed their opinions and how or whether they coped differently as result of the group participation. The interview was tape-recorded and main points (coping strategies and feelings about self) were noted down so as to create additional sorting cards (3-5) for each woman. After those personal cards had been read and accepted, or changed slightly, those cards were added to the original sample of cards. At the end of the research interview, women were asked whether participation in the study had affected or changed their opinions in any way (see App. 6).

The multiple sorting task schedule: The items used for the multiple sorting tasks are structured around The Silencing the Self Scale (STSS), developed by Jack (1991; Jack and
Dill, 1992). This questionnaire (see App. 4) has 31 questions designed to measure how women perceive themselves in their relationships with others. The STSS scale has 4 subscales intended to measure the following:

1: • Externalised self-perception: judging the self by external standards.
2: • Care as self-sacrifice: securing attachments by putting the needs of others before the self.
3: • Silencing the self: inhibiting one's self-expression and action to avoid conflict and possible loss of relationship.
4: • The divided self: the experience of presenting an outer compliant self to live up to feminine role imperatives while the inner self grows angry and hostile. (Jack and Dill, 1992)

The 31 questions were translated by the researcher to Icelandic, and translated back to English by an Icelandic clinical psychologist. The two English versions of the questions were compared by an English speaking person, which led to a few changes of the Icelandic version. Having completed this process, a part of each question was used in a small pilot study and out of which 16 were selected (see Haraldsdóttir, 1997).

As a development, the present study aimed at including three ‘fixed sorts’ (see App. II) and three ‘free sorts’, whereby each woman was encouraged to find their own personal way of sorting the cards. Out of the 21 questions selected for the previous study (see Haraldsdóttir, 1997), 16 items from the STSS scale and three were selected as to present elements from Beattie's (1987) list on Codependency (see App. 3).

*Multidimensional Scalogram Analysis (MSA)* was used to examine relationships between cards (elements) sorted by participants. The MSA analysis computes relationships between elements based on how similarly and differently they were sorted by each participant.
Based on how the cards were sorted, MSA examines the structure of the data, whereby the position of each card is presented as a point in a two-dimensional, geometric space (the Euclidean space). The technique identifies 'conceptual distance' between all the cards. This analysis is based on how the cards are related to each other through the different sorts performed. Differences found in the underlying sorts determine how closely or far apart the elements are in relation to each other. Secondly, these differences are displayed and show how and whether they are clearly divided into different, meaningful regions. MSA provides plots for each of the sorts performed, thus providing information on how the elements in the identified regions can be interpreted. This interpretation is derived from the meaning given to the cards in the sorting tasks (for more detailed explanation, see App. 1; Multi-dimensional Scalogram Analysis).

*PINDIS Analysis* (Procrustean Individual Scaling) uses data obtained through multiple card sorting. Starting with the MSA analyses from each individual, the aim is to find commonalities (common spatial arrangement) based how the cards were sorted relative to each other. The PINDIS provides 5 increasingly complex models to ensure that the idiographic nature of the data will be taken into account (see Lingoes & Borg, 1978).

PINDIS works by identifying a common space and then fitting each woman’s MCS solution to that space. It proceeds first on the assumption that the structures are more or less identical except for a rigid rotation or translation of the idiographic space. This assumption is tested first in what is known as the Generalised Procrustean Solution (Gower, 1995) or GPA. In fact, it is unlikely that the GPA solution will manage to fit everyone into a
common space since the MSA analysis creates co-ordinates of arbitrary length. Therefore, it is likely that PINDIS will need to weight the co-ordinates of the common space in order to achieve congruence. PINDIS does this under the label of Model 2. Model 3 weights the co-ordinates for each idiographic solution separately. Model 4 applies weights which adjust the origin of the common space while model 5 weights each of the idiographic solution origins. In short, the lower the model required to fit the idiographic solutions the clearer the common underlying structure, as with each succeeding model the relative distances between the points on the 16 solutions become more dilated or contracted (for more detailed description, see App. 1; ‘Procrustean Individual Dimensional Scaling’).

A measure of fit is produced for each idiographic solution and an overall coefficient is determined by the mean of these individual fit coefficients. This may be viewed as a reliability coefficient in the same way that an internal consistency coefficient (such as Cronbach’s Alpha) describes the homogeneity of items in a test. In this case the fit index describes the homogeneity of participants in the study.
RESULTS

The results section of this paper will be divided into three discrete parts. In the first part we are concerned with descriptive statistics highlighting the demographic detail of the sample. This is a very brief analysis and simply serves to present to the reader with a broad picture of the nature of the sample we are discussing.

In the second part an idiographic treatment is provided in order to demonstrate the use of the MSA technique with individual participants. Clearly, it would be unrealistic to provide a detailed account of the MSA procedure for all 16 participants, therefore 2 cases are discussed in some detail.

Finally, a PINDIS analysis is presented in which an attempt is made to identify the commonalities of the idiographic analyses for all 16 participants.

Demographic Details

Each of the women completed the interview in 2-3 hours. Background data is summarised in Tables 1 and 2. The ages in the sample ranged between 23 and 54 and a majority of the women (N=10) were married. Three women were cohabiting with their partners and 3 were living on their own. In Table 2 the occupational status of the participants is described. It shows that the participants are relatively heterogeneous in their occupation.
### TABLE 1
Descriptive Statistics of Four Demographic variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>The Group (N=16)</th>
<th>Mean (Standard Deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38.81 (9.54)</td>
<td></td>
</tr>
<tr>
<td>Length of Relationship (Years)</td>
<td>15.03 (10.12)</td>
<td></td>
</tr>
<tr>
<td>Length of Education (Years)</td>
<td>14.81 (4.42)</td>
<td></td>
</tr>
<tr>
<td>Number of Children</td>
<td>2.81 (1.52)</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 2
Occupational Status

<table>
<thead>
<tr>
<th>Occupation</th>
<th>The Group N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Student</td>
<td>2 (12.50)</td>
</tr>
<tr>
<td>Childminder</td>
<td>2 (12.50)</td>
</tr>
<tr>
<td>Housewife</td>
<td>2 (12.50)</td>
</tr>
<tr>
<td>Teacher</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Therapist for mentally handicapped</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Secretary</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Salesperson</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Food related business</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Assistant nurse</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>School assistant teacher</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Hairdresser</td>
<td>1 (6.25)</td>
</tr>
</tbody>
</table>
Idiographic Analyses

This section is concerned with the process of obtaining an idiographic assessment of the individual respondent. This is the major aim of the Multiple Card Sorting (MCS) procedure. Data from the card sorting of each participants were analysed by means of the MSA scaling technique. Within the scope of this paper it is not possible to present a detailed account of MSA's for every participant. For this reason two cases are selected to reflect the more general findings. These cases are labelled Mrs A and Mrs B. The 19 cards (elements) that all participants had in common are presented in tables 3-4, pp. 211-212).

Mrs A

Mrs A was participant number 4. She is a professional woman in her early forties and has over 20 years in education. She has one son from her previous relationship and is now married to her present husband, whom she has known for several years.

Mrs A considered herself to be codependent, but otherwise an independent person, and she rated herself as relatively strong in comparison to her husband. This was based on the characteristics of integrity, diligence and determination. However, she also acknowledged a sense of powerlessness characterised by her tendency to 'keep the peace' and 'fear of anger'. She saw her husband as strong and efficient 'in the physical, tough world' whilst
she was 'strong on the spiritual and relational side'. A difficult situation for her was when she felt constrained by him and his pedantry.

She appeared to be an open and talkative person but found it a time-consuming and difficult process to decide to which categories each card belonged. Nevertheless, she succeeded in producing a solution based upon 6 sorts of the cards. The interview took approximately 3 hours.

Mrs A provided four cards (constructs) in addition to the 19 provided by the researcher; these related to the sense of constraint she experienced within her relationship. These cards were:- Note that 21 can be negative.

20) “feel coerced by his anger”;
21) “have freedom to be spontaneous”;
22) “use plots to make things better”;
23) “use sex to keep the peace”.

Mrs A sorted the 23 cards 6 times and the result of her card sorting analysis is presented in Figure 1. A small cluster of cards are identified in the south-west corner of the plot while the remaining cards may be seen to conform to an ordered line moving from the north-west corner down to the southern region. In order to aid in the interpretation of this space the plots for each sort are presented in figures 2 to 7 (pp.203-210). It should be noted that these plots simply represent the plot in figure 1 with the category values superimposed upon the points representing each card.

SEE FIGURES 1 – 7
<table>
<thead>
<tr>
<th>Participant 4.</th>
<th>Profile for Mrs A.</th>
<th>Jan '99</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Personal cards:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20: feel oppressed by his anger.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21: have freedom to be spontaneous.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22: use 'tricks' or plots to improve things</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23: use sex to keep the peace.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identical cards:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 = 14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 sorts</td>
</tr>
</tbody>
</table>

| Own needs | 11 (=14) |
| Self-silencing | 9 |
| PROBLEM | 15 10 3 |
| Other | 8 16 20 2 19 17 13 4 7 23 18 |

Figure 1: Mrs A - Profile
Mrs A: Sort 1.

1 = Self given fact.  
"I love myself"

2 = I need to work through this.

3 = This has changed.

4 = Relates to my son.  
"I was codependent on him”

5 = "This is finished"  
I kept silent to keep the peace.

Figure 2: Mrs A -Sort 1
Figure 3: Mrs A -Sort 2

Mrs A: Sort 2.

Relational needs: "To keep the peace."

Good relationship from my husband's point of view:

1 = I need to ...
2 = I avoid ...
3 = Not important.

Own needs

PROBLEM

-2
-1
1-2-2
-1 1
1 1 1
1 1 1
Mrs A: Sort 3.

Frequency of behaviour:

In my relationship with my husband:

1 = Often
2 = Sometimes.
3 = Happens occasionally
4 = Very seldom, never.

Figure 4: Mrs A -Sort 3
Appreciation of own behaviour:

1 = Very unhappy about this.
2 = Unhappy about this.
3 = Not important.
4 = Very happy about this.

Figure 5: Mrs A - Sort 4
Mrs A: Sort 4.

My behaviour in relation to me and my family:

1 = Applies to my husband.
2 = Applies to my son.
3 = Things I do for myself.
4 = Things I don't do in relation to my husband.

Figure 6: Mrs A -Sort 5
Mrs A: Sort 6.

1 = Increases my well-being.

2 = Decreases my well-being.

3 = Does not change my well-being.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>-3</th>
<th>-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Figure 7: Mrs A -Sort 6
TABLE 3

STSS - Subscales 1 & 2

16 items selected from the Silencing The Self Scale
(by Dana Crawley Jack, 1992)

3 of the items are selected from a list on 'codependence ' (i.e. no. 1, 11 and 12)
(see Beattie, 1987)

Scale 1: Externalised Self-perception

4. (23: scale 1)
   • take other people’s thoughts and
     opinions into account rather than
     my own thoughts and opinions.

7. (29: scale 1)
   • to agree with my partner
     when opinions are in conflict,
     rather than
     asserting my point of view.

15 (27: scale 1)
   • to feel responsible for other people’s
     feelings.

1. (According to scale 1:
   • get approval from others.

12. (According to scale 1:
   • be more interested in others
     than myself.

Scale 2: Care as self-sacrifice

3. (scale 2)
   • putting the other person’s needs
     in front of my own

9. (scale 2)
   • make the other person happy.

10. (scale 2)
    • do what the other person wants,
        even when I want to do
        something different.

18. (29: scale 2)
    • think more about the things that
      make the other person is happy.
TABLE 4

STSS - Subscales 3 & 4

Scale 3: Silencing the Self  
When the negative wording of the statements is removed:
Scale 3 becomes: Open self-expression

2. (scale 3)
   • to speak my feelings when/although I know they will cause disagreement.

8. (scale 3)
   • state my needs and feelings clearly when they conflict with my partner's.

19. (24: scale 3)
   • to express my anger at those close to me.

11. (According to scale 2:)
   • to think about my own needs.

14. (22: scale 2)
   • doing things just for myself.

5. (scale 4)
   • to be myself in a close relationship.  
   (Being positively worded items 5 & 6, and 11 & 14, belonged to the scale 3)

6. (31: scale 4)
   • to measure up to the standards I set for myself.

Scale 4: The Divided Self: presenting an outer compliant self
while the inner self grows angry and hostile.

13. (scale 4)
   • having to act in a certain way to please my partner.

16. (scale 4)
   • look happy on the outside, although inwardly I feel angry and rebellious

17. (scale 4)
   • to reveal certain things about myself, for my partner to love me.
The south-west cluster is reliably marked by sorts number one and four. The first sort identifies these as elements that need to be worked through while the fourth sort defines them as causes for unhappiness. This combination, of course, is not surprising but it does serve to identify those elements of her relationship that Mrs A finds particularly problematic. As such they may serve as the foci for therapeutic intervention. Containing 7 elements, the south-west cluster contains all the cards belonging to self-silencing and those of expression (involving avoidance of expression) in addition to her personal card no 20 adding the element of feeling oppressed by his anger.

The structure of the remaining elements is less easily interpreted. However, sort 2 indicates that the southern part of the ordered line reflects Mrs A’s perceived need, while the Northern section is more related to avoidance (of her need to ‘keep the peace’ with her husband). It is interesting to note that the south-west cluster is evenly split containing elements both needed and to be avoided. This sort identifies self-silencing towards her husband: thus, avoiding expression and needing to ‘present an outer compliant self’; it would be a therapeutic issue to explore whether her ‘inner self has grown angry’ (see subscale 4; Jack and Dill, 1992). Sort number 3 also imposes a clear order on the elements with those to the north occurring often while those to the south occurring seldom. Two elements do not conform to this order (23 and 12), indicating that whilst she very seldom manifests care as self-sacrifice in relation to her husband, she sometimes ‘uses sex to keep the peace’. With card no 12, she seldom finds herself to be more interested in the other person. Again the south-west cluster is not discriminated by this sort.
Perhaps the clearest sort in relation to the linear structure is sort number 6 in which elements north of the centre are deemed to increase well-being while those to the south either decrease well-being or are irrelevant. It is worth noting that the south-west cluster is made up of such elements.

Mrs A presented as someone who was open and honest but there was some suggestion at a deeper level that she was keen to make things look better, with some lack of insight into how she felt about issues in her relationship. This was mainly apparent through her uncertainty as to how she could best distinguish between the cards and to decide to which categories they could be assigned.

However, there is a clear superficial identification of the troublesome elements in Mrs A’s relationship and these are identified in the plot in the south-west corner, apparently characterised by oppression and self-silencing.

Mrs B

Mrs B was participant no 8. She is in her late twenties and has had about 10 years in education. She works now as a childminder. She has one child with her husband, whom she has been married to for 6 years.
Coming from an alcoholic family, she has herself abstained from alcohol for 6 years, with her husband having abstained for 3 years. She mentioned that alcohol in her parental family and her problems of anxiety might have affected her marital relationship. She saw herself as codependent and specified that she gained self-respect through being able to please others. She described her sense of power and powerlessness in different ways. Mrs B distinguished between 'codependent strength' (through control), 'codependent powerlessness' (i.e. when realistic); finally a sense of 'balanced power'. She saw her husband's love as a strength for both of them. Situation of conflict for her was when she wanted him to stop drinking and when she wanted her husband to do things her way.

Mrs B appeared as very committed in the sorting task. She produced a solution based on 7 sorts of five cards in addition to the 19 provided by the researcher (see tables 3 - 4, pp. 211-212). She sorted the cards as she perceived the situation before and after treatment. Her cards reflected a process of control, anger, fear, and increased acceptance. These cards were:-

20) “I control the other person: “I know better than you”
I feel as if I know better how things should be”;
21) “Underneath I am scared and feel as if I am threatened”;
22) “It gives me strength to be angry”;
23) “I have learned to listen more openly to him”.
24) “I feel now as if I have the right to exist”

SEE FIGURES 8 – 15
Figure 8: Mrs B - Profile
Mrs B: Sort 1

Relational needs before group therapy:
1 = I needed to ...
2 = I avoided to ...
3 = Not important.

Figure 9: Mrs B - Sort 1
Mrs B: Sort 2

My relational needs after group therapy:

1 = I need to ...
2 = I avoid to ...

Figure 10: Mrs B -Sort 2
Figure 11: Mrs B - Sort 3

My behaviour at the present:
1 = Seldom.
2 = Sometimes.
3 = Often.
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<th>4</th>
<th>5</th>
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</tbody>
</table>

My behaviour in relation to:

1 = My husband.

2 = My family and husband

3 = Friends + fear of rejection'

4 = This behaviour is always applicable.

Figure 12: Mrs B -Sort 4
Figure 13: Mrs B - Sort 5

Changes in behaviour:

1 = Was

2 = Was and is

3 = Change for the better

Mrs B: Sort 5

Changes in behaviour:

1 = Was

2 = Was and is

3 = Change for the better
Mrs B: Sort 6

1 1 2
-1 -1 2 4

Mutuality

Obligation

1

1

Freedom to let go of

2

-3

Freedom to be

-3

-3

-2

Mutuality

3

1

4

"RIGHT TO EXIST"

1 = Freedom to let go of

2 = Mutuality, equality

3 = Freedom to be

4 = Should be towards others

Figure 14: Mrs B -Sort 6
Figure 15: Mrs B -Sort 7

Emotional well-being:

1 = Increases my well-being
2 = Decreases my well-being
3 = Does not change my well-being.
The result of her card sorting analysis is presented in Figure 8 (p.216). In order to aid in the interpretation plots for each sort are presented in figures 9 to 15 (p.217-223). As with Mrs A, these plots represent the category values with the points representing each card in figure 8. It needs to be mentioned that Mrs B sorted some of the cards in an identical way, in which case only the card with the lowest number is presented, yet referring to the other cards as well. As an example Mrs B did not distinguish between cards 20 and 22. This implies that both cards were seen as having the same quality in respect to all the sorts she performed.

A cluster of cards is identified in the northern region of the plot, while the remaining cards can be seen as forming half a circle around one card placed in the middle. The structure seems very clear and easily interpreted. Elements of ‘self-expression’ and ‘positive relations to the other’ are located in the south-west, while ‘sacrificing’ and ‘self-silencing’ behaviour form the north-cluster. The west-middle region, however, involves elements of fear/anger/control.

The three different clusters are reliably marked in sort 5 as behaviours that “were” in the north, “were and are” located in the west-middle part and “change for the better”, evenly distributed in the south-east region. Thus, the plot provided by Mrs B, is characterised by the middle position of her card no 21. Belonging to the cards in the west, this region describes behaviour “that was” but has not changed for the better. Its middle position, however, implies a relationship with elements in the other region as well.
This relationship is partly demonstrated in sort 4 (p.220). Being reliably marked by all four sorts, the middle card (underlying fear) is related to one of the cards in the north, which otherwise is defined in terms of ‘belonging to friends’ and ‘fear of rejection’. This suggests that the north-west region could involve areas that are problematic for Mrs B, which is further explained in sort 6 as she would like to have the ‘freedom to let go of’ most of those element.

The relationship of the middle card to the south is demonstrated by its quality of ‘not being important’, as perceived before group participation (see sort 1, p.217), and it still belongs to her relational needs (sort 2, 218). As such, an analysis of how the middle card relates to the other regions in the plot seems to provide the foci for therapeutic intervention.

Showing an apparent confusion in her past personal needs (sort 1), her perception of her “Right to exist” demonstrates an apparent confusion as well (see sort 6). However, it is interesting to note that while the west region is marked by “freedom to be and let go” and “freedom to be”, elements in the eastern region of the plot apparently link the north-south clusters through values 2 and 4, defined as ‘mutuality and obligations’ in relationship with the other.

This conceptualisation of needs in the relationship, can perhaps be seen as an indication of a ‘longing for a mutual recognition’, characterising both women and men (Heenan, 1998).
Benjamin has described this quality as “not possible in a subjectivity developed in the context of refuting dependence” (1988, p.53). It is interesting to note that two cards (1 and 9), seen as representing the ‘healthy give and take’ (Jack, 1982), are ‘refuted’ by Mrs B as an option of mutuality. Yet, they seem to contribute to the connecting line between north and south (sort 6 in figure 14). This ‘refusal’ (of getting approval and making the other happy) is perhaps deemed as necessary at the present time. However, the meaning of this could be raised in therapy, as to explore whether those elements are illustrative of her past dependence on others to gain self-respect.

It is worth mentioning that the notion of mutuality, was only mentioned by 3 women, as a feasible option, with one participant including this in her sorts as a quality already existing in her relationship (see participant no 9, figures 16a and b, pp.230-1).
**Common Structure Analysis (PINDIS)**

In order to explore the presence of an underlying structure common to all 16 women in the patient sample, the idiographic solution of each was entered into a PINDIS Analysis. This procedure attempts to fit each woman’s MSA solution into a common space. In order to do this only the 19 common elements or cards are used.

The results of the PINDIS provided a common structure (commonality), as well as a ‘subject configuration’ plotting relationships between idiographic profiles. These are presented in figures 16 and 17. The resulting common structure based on the 16 profiles can be seen in figure 17a, showing number of items whilst figure 17b illustrates their meaning in words. Below is interpretation of figures 16a and b pp.230-1) starting with explanation of the two PINDIS solutions performed.

In table 5 we can see that the Generalised Procrustean Analysis (GPA) solution does not provide us with a reasonable fit. This is entirely expected for reasons stated above. The criterion set for this study is to accept the lowest model with an overall fit exceeding 0.70. This is in accordance with the notion that a reliability coefficient must exceed this value before any confidence can be placed on a measurement device (Nunnally 1978). For this analysis, therefore, Model 2 was accepted and the plots represent findings determined by that model  (see App. 1; for further clarification).  

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# TABLE 5

**PINDIS Summary Table of the Commonalties for PINDIS Transformations**

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<thead>
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<th>Participant Code number</th>
<th>GPA</th>
<th>MODEL 2</th>
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<td>0.74</td>
</tr>
<tr>
<td>2</td>
<td>0.48</td>
<td>0.60</td>
</tr>
<tr>
<td>3</td>
<td>0.61</td>
<td>0.74</td>
</tr>
<tr>
<td>4</td>
<td>0.39</td>
<td>0.61</td>
</tr>
<tr>
<td>5</td>
<td>0.68</td>
<td>0.82</td>
</tr>
<tr>
<td>6</td>
<td>0.70</td>
<td>0.63</td>
</tr>
<tr>
<td>7</td>
<td>0.62</td>
<td>0.72</td>
</tr>
<tr>
<td>8</td>
<td>0.71</td>
<td>0.83</td>
</tr>
<tr>
<td>9</td>
<td>0.75</td>
<td>0.87</td>
</tr>
<tr>
<td>10</td>
<td>0.48</td>
<td>0.63</td>
</tr>
<tr>
<td>11</td>
<td>0.69</td>
<td>0.82</td>
</tr>
<tr>
<td>12</td>
<td>0.80</td>
<td>0.86</td>
</tr>
<tr>
<td>13</td>
<td>0.70</td>
<td>0.83</td>
</tr>
<tr>
<td>14</td>
<td>0.69</td>
<td>0.71</td>
</tr>
<tr>
<td>15</td>
<td>0.65</td>
<td>0.62</td>
</tr>
<tr>
<td>16</td>
<td>0.50</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Mean GPA = 0.63, Model 2 GPA = 0.73

**GPA** = Generalised Procrustean Analysis

** denotes the highest coefficient within each model

* denotes the second highest coefficient within the model.

This table summarises the coefficients of the participants according to the PINDIS transformations performed in the two models needed to achieve an overall coefficient exceeding coefficient of 0.70. The first column shows the number of participants. The two following columns represent the coefficients for each of the participants, and how similar each configuration is to the hypothetical common structure found within the data according to those 2 models.

**Figure 16a: PINDIS Subject Space Configuration:** PINDIS provides a ‘Subject Space Configuration’ (see figure 16a, p.230) illustrating how participants are positioned in relation to each other. The figure shows that participants, represented by the numbers 1 to 16, are all positioned on a single line, demonstrating that participants are ordered on a single continuum, presenting a uni-dimensionality within the data.
Figure 16b: Individual differences within the sample: It is not within the scope of the present study to discuss individual differences found within the sample. However, it is interesting to offer some ideas as to what the continuum shown in figure 16a, p.230, might represent. In order to clarify difference among respondents, categories and elements commonly provided by the women on the continuum were explored. Some of the personal elements (not included in the PINDIS analysis of the 19 common cards) and categories showed an interesting ‘order’ (see figure 16b, p.231).

These elements represented a continuum from ‘focus on care for the other’ (‘Care as self-sacrifice’), to emphasis on negative emotions as a response to conflict situations, e.g., ‘feelings of rejection’, ‘self-pity’, ‘powerlessness’ and ‘a sense of feeling a victim’ (see the upper/northern part of figure 16b). From the middle part to the lower/southern part of the continuum was a transition, identified by insight into one’s ‘right to exist’, towards ‘increased insight into myself’. On this end of the continuum was an increased notion of accepting the other. Similarly, categories provided to sort the cards had a continuum from emphasis on ‘Control or care for the other’, through a common emphasis on ‘being silent’ and ‘not to rock the boat’ in the ‘north’, towards ‘coping by using expression of anger’ which was found in the southern part. Otherwise ‘open expression’ was not common as a coping strategy and was in fact found in three instances evenly distributed over the ‘scale’.

In general, elements and categories were seen to present a continuum from ‘Care-as self-sacrifice’ towards increasing ‘awareness of own rights’ and ‘openness towards increasing ‘awareness of own rights’ and ‘openness towards the other’ (see figure 16b, p.231).
This figure shows that the participants are ordered on a single continuum.

See figure 16b for possible interpretation of this continuum as seen in the light of additional elements and categories provided by the participants in the group.

Figure 16a: Participants - Continuum
**PINDIS Subject Configuration**

<table>
<thead>
<tr>
<th>'CARE AS SELF-SACRIFICE'</th>
<th>Main categories provided through cards sorting:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Control or care for the other&quot;</td>
</tr>
</tbody>
</table>

**Main Elements provided by the women**

| 6° | Focus on care for the other + the home |
| 15° | Underlying feelings of: |
| 14 Divorced * | self-pity, sorrow, rejection |
| 2 Abs. husb. | |

Lack of consideration from the other

| 1 Divorced | powerless in marriage, feeling a victim, sorrow |
| 10 Divorced | |
| 16 Absent husband | |

'Not to rock the boat'

"Keeping peace and quiet"

Coping through being silent

Increased awareness of interdependence and mutuality

| 3 Oppressive husband | |
| 12 Acceptance and not letting him control my life | |

| 4 Feeling oppressed by husband | |
| 11 Lack of consideration | |
| 13 | |

Coping by using expression of anger

| 5 8 Listen more | |
| Women with alcoholic or oppressive background | |

Spontaneous emotional response

| 9 INTERDEPENDENCE | |

**Figure 16b: 'Sacrifice to Self-Insight'**
Figure 17a, The Model, demonstrates a typical horse-shoe pattern which is known in multidimensional scaling as a unidimensional continuous structure presented in two-dimensions (Shephard 1962). This is also borne out when we look at figure 16a (p.230) where it is apparent that the women were distributed on a single dimension.

The ‘horse shoe’ structure of these 19 cards may be metaphorically described as a ‘magnet’ with a ‘positive’ and a ‘negative’ pole (to the south). To illustrate further, on the ‘positive pole’ were the items demonstrating ‘positive’ behaviours of asserting self, (taken from subscales 3, 2 and 4). On the other extreme end of the horse-shoe we find cards of an opposite nature. These include concealing and not expressing parts of self and acting in certain ways to please the partner; in other words, items taken from subscale 4 (‘Divided Self’) of the STSS. Also at this end was an item taken from Subscale 1 (Externalised Self-Perception), describing lack of self-assertion. The extreme item on the ‘negative pole’, item no 17, was seen as the most negative item in the overall pattern.

On this ‘negative’ side but more to the middle of the horse-shoe were items taken from subscales 1 and 2 of the STSS, most of which describe the attitude of taking the needs of the other (scale 2) or opinions (scale 1) into account at the cost of self. Grouped with those was item 16 (subscale 4) “look happy on the outside, although inwardly I feel angry and rebellious”. This indicates that this card had similar relational meaning as did the items of “care as self-sacrifice” and “opinions of the other”. In other words, the women were more able to identify with this element of ‘self-silencing’ than they did with other elements from that subscale.
### PINDIS Subject Solution for Elements

#### The Centroid Configuration (Z) Coordinate 1 (Vertical) against coordinate 2 (Horizontal)

<table>
<thead>
<tr>
<th>Coordinate 1</th>
<th>Coordinate 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The positive pole&quot;</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td>&quot;The negative pole&quot;</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Self-assertion</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Self-expression</td>
<td>19</td>
</tr>
<tr>
<td>&quot;The healthy give and take&quot;</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Interpersonal relations&quot;</td>
<td>9</td>
</tr>
<tr>
<td>&quot;Self-silencing&quot;</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

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Figure 17a: The Model
PINDIS Subject Solution for Elements

<table>
<thead>
<tr>
<th>The Centroid Configuration (Z)</th>
<th>Coordinate 1 (Vertical) against coordinate 2 (Horizontal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>'own needs'</td>
<td>'own standards'</td>
</tr>
<tr>
<td>'do things for self'</td>
<td>'be myself'</td>
</tr>
<tr>
<td>'state my needs + feelings</td>
<td>when in conflict'</td>
</tr>
<tr>
<td>'speak my feeling despite</td>
<td>disagreement'</td>
</tr>
<tr>
<td>'express my anger'</td>
<td></td>
</tr>
<tr>
<td>'get approval'</td>
<td>from others'</td>
</tr>
<tr>
<td>'make the other person happy'</td>
<td></td>
</tr>
<tr>
<td>'be more interested in the</td>
<td>'opinions of others'</td>
</tr>
<tr>
<td>other'</td>
<td>'responsibility'</td>
</tr>
<tr>
<td>'wants of the other person's</td>
<td>'happy on other'</td>
</tr>
<tr>
<td>'other's happiness'</td>
<td>'the other's needs first'</td>
</tr>
<tr>
<td>'reveal certain things'</td>
<td></td>
</tr>
<tr>
<td>'for my partner to</td>
<td></td>
</tr>
<tr>
<td>'love me'</td>
<td>'act in a certain way'</td>
</tr>
<tr>
<td>'agree my with partner'</td>
<td></td>
</tr>
</tbody>
</table>

Figure 17b: 'Model of Interaction'
In short, we are in the position to make a simple one-dimensional interpretation of the common space. The upper end of the scale includes women who expressed wish to care for others, whilst not taking care for self as an option. An example of this is participant no. 6, who is found at the upper end of the dimension. In contrast, woman no. 9 is placed on the other extreme of the subject configuration. She was the only participant who used the notion of “mutuality” as an option in the card sorting. Thus we can tentatively define the dimension as ranging from ‘care as self-sacrifice’ towards an increased notion of mutuality and interdependence in relationships. Participant no. 9 has the highest degree of fit, or 0.87, whilst no. 6 has the quite a low fit, or 0.63 (see figure 16a, p.230).

It may be interesting to note that Mrs A is participant no 4 and Mrs B is participant number 8. In terms of their relative position, both are located at the lower end of the subject configuration. Given the above definition of the ‘scale’ it is tempting to suggest that both Mrs A and Mrs B manifest similar level of the ways in which they construe their ideas towards mutuality and their sense of self in relationships with their partners. However, such a simple interpretation may be questioned when we consider that Mrs A manifests very low fit of 0.61 while participant no 8, Mrs B, shows a high degree of fit, or 0.83 (for comparison see table 5, p.228 and figure 16a, p.230). This is equivalent to suggesting that for Mrs A there is an elevated degree of error on Mrs A’s position on the scale in comparison to Mrs B.
As we can see in the two examples illustrate, Mrs B was able to distinguish between elements of expression and self-silencing, whereas Mrs A was not. This is reflected by the low fit of her plot, whilst the plot produced by Mrs B conforms better to the model. Thus, the common structure gives insight into how the idiographic plot varies from the general model described above. This can provide a further understanding in the interpretation of the idiosyncracies represented by each individual plot. Both Mrs A and Mrs B provide examples of that.

**Comments about participation in the study**

Most women felt that it was interesting to participate and that it was ‘fun’. Many mentioned that the participation served to clarify their situation and even point towards the direction they wanted to take in the future. However, it would depend on their actions whether that would translate into a behavioural change. A few noted that sorting into certain categories (usually in relation to significant others) made them realise the nature of the relationship better. Others found it striking to read own personal cards and to realise how different cards had consistently been assigned to the same categories to realise that ‘this was the problem’. Only one woman stated that the participation had changed her opinions and raised questions in relation to the effect of self-help groups.
DISCUSSION

The card sorting task (MCS) was found to give rich information in terms of categories, concepts and constructs used. Although apparently giving valuable information about the conceptual systems of women going through an important change in their lives, an analysis of this information is not within the scope of this paper.

The main results of the study appear to show that the analysis of idiographic structure provided by the individual participant has potential for eliciting a comprehensive understanding of the complexity of problems embedded in relationships in the context of having an alcoholic partner. As demonstrated in case examples, personal cards provided seem to conform to the structure of the 19 common cards in that they ‘participate’ in the relationship between elements and seem to provide richer understanding and insight into personal behaviours and feelings, not included in the common cards. It needs to be borne in mind that the cards were sorted in Icelandic. Therefore their meaning in both languages is subject to translation and cross-translation. However, it is also important that participants sorted the cards in their own language, thus would effect meaning of cards rather than the relationship between elements.
The research interview was seen as an interactive process of co-operation between researcher and participant. The card sorting seen was seen as highly personal. Touching on emotions as well as cognitions, it appeared to be a process of clarification, and awareness raising about own behaviour in relationship with others, giving the participant an idea where on a personal continuum, she finds herself at the moment.

The multiple card sorting is an interesting technique, which gives a therapeutic focus, as well as having the capacity to provide an insight into important issues of concern. Thus, the method is an idiographic approach that offers a tool for the researcher/therapist to explore individual experiences.

This procedure has been discussed and suggested as a method of idiographic assessment providing in-depth qualitative information (Kavatha, 1998). Whilst the MCS technique can be used as a part of an ‘in-depth’ assessment with women who seek therapy because of their relationship problems, it is felt that its potential lies also in its advantage as a method of ‘collaborative inquiry’ (Rowan, 1998). To clarify further, the sorting task itself seems to involve a process of exploration for the respondent, and as such be of therapeutic value.

The sorting procedure has a significant strength as it does not require the use of pre-specified concepts or impose the researcher’s preconceptions or judgements on the respondent (Groat, 1982). This is an essential quality in exploratory research, which
may also prove to be highly important in therapy with women in difficult relationships (such as those of an oppressive nature). This is based on the notion that whilst the participant is providing information to the researcher, the method itself is providing the participant with a tool which gives opportunity to access one’s own opinions, values and different meanings. This has proved to be a difficult process for many of the women participating in the present study, yet providing an exploration of issues on a very personal and emotional level. Therefore, it is highly important that the interaction between researcher and participant is based on co-operation and equality of power in the task of providing a ‘solution’ to the card sorting. This aspect can be described by the notion of seeing the participation as ‘playing’; an important aspect of therapy. As an act of ‘two people playing together’ (Winnicott, 1971), this can provide an atmosphere of equality, containment and non-judgmental attitude.

Another quality of the MCS technique is that it offers opportunity for exploration of conceptual systems. This personal exploration, ‘not contaminated’ by the researcher (Groat, 1982) may be important in two ways: it allows the participant to come up with concepts and ideas based on ‘research’ based on their own inner experience; secondly, the ‘outcome’ has not been affected by the researcher’s pre-conceptions or value-judgements, as the participant has found her own solutions to the sorting task. Thus, one of the implications of this research method is that it seems to invite a therapeutic advantage for the respondent, as the process of adopting constructs may
reduce confusion and contribute to one’s growth and development (Kelly, 1955; Pervin, 1970).

It needs to be kept in mind, that the nature of the present sample is highly specific. All the women were self-selected, which might mean that they were motivated and perhaps more articulate than the women who did not give their consent for participation. Secondly, the recent participation in a demanding group work, might have enabled them to make use of the sorting task. The language and concepts used might be affected by the AA-related nature of the group therapy. Finally, the sample was small. Those factors might affect the quality and homogeneity of the common structure produced by the PINDIS analysis.

This does not necessarily undermine the usefulness of the method to identify and explore personal meanings and conceptual systems of women who have not participated in group therapy. However, it might change the way in which they would assign elements to categories, perhaps using fewer and simpler concepts. Due to the flexibility of the MCS technique, this would not pose a threat to its quality of providing an opportunity for personal exploration and ‘collaborative inquiry’ to produce a meaningful idiographic structure of cognitive representations for that particular respondent. Importantly, for the sake of this study, the structure given by the PINDIS was accepted at a low level, with elements forming a horse-shoe, implying that they are on a continuum. This may perhaps be explained by the
homogeneity of the items as being derived from a standardised questionnaire (Jack and Dill, 1983).

In general, individual plots had a relatively high fit with the centroid or common structure. Women who had the highest fits appeared to be the those who were the most able to distinguish between categories (i.e. the sub-scales of the STSS). This can be interpreted as a conceptualisation of Allport’s ‘healthy and organised behaviour’ (Pervin, 1970), and suggests that the PINDIS solution may represent a ‘model of health’ and/or a prototype of women’s ‘sense of self’.

Thus, the PINDIS analysis demonstrated important commonalities within the sample, indicating a pattern of dynamic relationships between the elements. However, those dynamics are represented in different ways in each plot, with high sensitivity to individual differences, which can be examined and interpreted according to relationships between elements in the idiographic plot. The two examples used in the present study illustrate the richness of personal information elicited by the card sorting technique.
PINDIS analysis and women’s sense of self

The PINDIS analysis showed that the women were ordered on a unidimensional line. This dimension could be interpreted as ‘codependency’. However, an alternative interpretation is preferred for reasons already discussed in this study (see pp. 129-132).

Instead it is suggested that the dimension identified by the PINDIS analysis can be seen as representing development of the female identity ranging from “Care as self-sacrifice” (Jack, 1991) towards increased awareness of interconnection and mutuality. Gilligan (1982) has theorised that this development starts by an initial phase/transition where caring for self is criticised as selfish and the connection between self and others is understood in terms of responsibility and “fusion with maternal morality”. Being good is seen as caring for others which, however, results in the exclusion of caring for own needs. This “illogic of the inequality between other and self” (Gilligan, 1982, p.74) can be seen as characterising the upper third of the PINDIS dimension.

Gilligan (1982) maintains that the tension of realising this inequality leads to confusion and an increasing need to understand and distinguish between self-sacrifice and care for others. Women placed around the middle part of the dimension may have been entering this second transition. Themes of oppression, sacrifice and inequality were apparent in their dialogue (see figure 16: where this characterises participants no. 3 and 12 and no. 16 to some degree). This seemed to be linked with
the insight into one’s right to care and do things for oneself. According to Gilligan, this is based on an increasing differentiation between self and other, as well as understanding the interconnection between both.

This increased awareness of self was reflected by the women towards the ‘lower’ end of the continuum where the women articulated their own desires and opinions, as well as expressing the need to be connected to their partner. Those women spoke about a wish for spontaneity and reported spontaneous expression of feelings and emotions, e.g. anger or fear.

The final phase of Gilligan’s theorisation of the female development is the growing understanding and insight that self and other are interdependent. This notion of interdependence was represented only by one woman, whose configuration is placed at the lower extreme of the continuum (see participant no 9).

It was observed that the MSA structure provided by this participant had the highest degree of fit to the ‘common structure’ determined by the PINDIS analysis (see figures 17a and b). It can be speculated whether the group as a whole presented a “cumulative knowledge of human relationships” (Gilligan, 1982; p.74) evolving around increased insight into the self and the wish to achieve a goal of interdependence in relationships.
Conclusion

It is suggested that women in general strive for interconnection, interdependence and equality within relationships. However, given the stereotypical female-male roles within society, this may prove difficult for many women. This might especially be so within relationships of unequal power, such as where power imbalances are exaggerated in a relationship with an alcoholic or otherwise domineering partner.

The concept of codependency is at best seen as insufficient to describe problems developed within the interpersonal context. At worst it is seen as downgrading label for women that identifies and apportions blame to women, instead of looking at the interpersonal context in a more holistic way.

The present study has drawn attention to the multiple card sorting procedure as a technique that might provide a promising tool for exploration within both research and therapeutic contexts. Furthermore, the use of the technique as developed here might help women explore and clarify the context within which their problems have been created.

The study brings attention to several ideas. The first and most obvious potential is to explore the process of change in women’s conceptual systems over time. It is likely that women who have not received therapy have a different language to describe their experiences, or they may perhaps have difficulties of how to voice their own
underlying assumptions and opinions. This might also apply in other areas, where the focus is on different relationship difficulties. Also a possibility of this research technique is to give the idiographic plot to the participant for feedback and further clarification of its structure as well as examining the ‘long-term’ effects of the card sorting task itself.

Thirdly, inclusion of personal elements describing how the participant/client responds in a positive situation might add to the richness of the data obtained through the card sorting procedure. This might be an interesting research area and have a therapeutic value in directing the participant’s or client’s attention towards a real or perceived strength. In terms of Kelly’s Personal Construct Theory (see Pervin, 1970; Feshbach, Weiner and Bohart, 1991) this might clarify and strengthen how women perceive their own personal value as well as help them construe and interpret events in a more positive light. By providing elements from both negative and positive context provides an opportunity for exploration of differences between situations of ‘strength’ vs. ‘conflict’. This might direct attention to how women develop their sense of self towards feelings of vulnerability or empowerment.

On the grounds of the results of the present study, it is concluded that MCS might be an invaluable tool in providing a collaborative and interpersonal process of exploration and self-enhancement for women with relationship difficulties. The technique seems to enable women to explore and clarify personal meaning and confusion.
Finally, this research on women’s sense of self has explored a theoretical framework explaining women’s relational difficulties from a developmental, social and political context and proposed a methodology that is sensitive to the personal context whilst it also provides a structured analysis of the underlying meanings found within the data. Both methodology and the theoretical orientation offer a holistic approach within which women’s relational difficulties can be explored.

Thus, an important aspect of this study is that it encompasses research and ‘practice’ in a holistic way. It establishes equality, by minimising ‘neutral detachment’ and providing collaborative inquiry between researcher and participant. This is an essential aspect, that lies at the heart of Counselling Psychology as a scientist-practitioner model. Thus, this method may efficiently offer the counselling therapist a methodological tool that combines therapy and research. Its collaborative nature may be essential in exploring problems developed within oppressive relationships, i.e. that of unequal power.
References


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Sense of Self in Intimate Relationships. Work submitted at the University of Surrey.


Appendix 1

Development of Methodology

used in Studies II and III*

*For the sake of referring to the three studies they have been termed as

Study I: pp: 98 - 141
Study II: pp: 143 - 182
Study III: pp: 184 - 253
Choice of Method: Multiple Card Sorting and Multidimensional Scalogram Analysis

An important rationale for using Multiple Card Sorting (MCS) is that the method is idiographic and, as such, is sensitive to context and background. It provides a ready interpretation of individual differences giving the participant the initiative to explore personal context as well as providing a structure for collective meanings. The card sorting procedure gives the participant the initiative to explore personal context in a structured way that allow her or him to impose own categories. An attractive aspect of the technique is its co-operative nature, allowing the participant to be an active agent in the assessment process. This serves to empower the participant/client and provide an atmosphere of equality and collaboration.

On a methodological level the technique is useful as it looks at relationships in a way that enables the collection of information in a structured and objective form which allows systematic exploration of the data. This is done through the Multidimensional Scalogram Analysis (MSA), whereby individual data can be analysed on a personal or group level (Canter, Brown and Groat, 1985).

For the purpose of this research, Study I on women from the general Icelandic population makes use of the MSA on the group level, whilst Study II examines the
utility of MSA for exploring conceptual systems on an idiographic (personal) level with women who experience difficulties in their relationships with alcoholic husbands.

MCS permits exploration of relationships in a structured way. The card sorting technique is done through a number of cards, thus providing as a visual representation and an external focus, which can be an advantage in research with women who (by definition) are used to directing their focus of attention onto others rather than self, allowing the women to explore sensitive and personal issues in a relatively contained, and non-threatening way.

The use of MCS is an intrinsically collaborative technique that encourages the participant to explore personal meaning. This may be especially relevant in research with women who may experience confusion in relation to difficulties in relationships as the card sorting technique allows self-exploration by using one's own categories and constructs, without undue constraint or feeling judged by the other (researcher/therapist). Additionally, the elements (cards) themselves provide a sample of behaviours/attitudes ranging from self-assertive behaviour to the more negative self-silencing. This may serve as a 'yardstick' and encourage individual women to explore where she is on this 'behavioural and relational measurement'. This aspect increases awareness of one's own situation and as such may provide focus or motivation for therapeutic change.
Choice of elements: The STSS scale

This research attempts to explore women's sense of self in relationships with their heterosexual partners from a feminist perspective. This approach is chosen as an alternative framework to the concept of 'codependency' which uses a disease model to explain behaviours in "alcoholic" and otherwise "unhealthy" relationships. In contrast a feminist perspective argues that this is an over-simplification when describing relational difficulties, which in fact have interpersonal, social, developmental and political origin.

The advantage of choosing The Silencing the Self Scale (STSS) is that it includes traditional female behaviours and attitudes, such as focus on others, helping, caretaking, and loss of self and is based on research from a feminist developmental perspective (e.g., Gilligan 1982; Brown and Gilligan, 1983; Jordan et al, 1991). The 31 statements of the STSS include the social and cultural imperatives of the female role (Jack, 1991; Jack and Dill, 1992). The STSS is based on research with depressed women. However, it is in fact aimed at exploring 'images of self in intimate relationships' (Jack, 1991).

Some of the cards are selected from the 'codependence' orientation. It was seen as theoretically interesting to include some aspects from this framework as to examine their relationships with elements from the STSS, and most importantly whether and
how they could be explained from a feminist perspective. Therefore items were derived from Beattie’s (1987) definition and list on codependency. For example her definition starting with: “A codependent is a person that has let another person affect him or her ...” as well as the statement that ‘codependents want approval from others’, were used to produce the element “get acknowledgement from others” (card no 1). Importantly, this element showed strong relationship with card no 9 “to make the other person happy”, and has been interpreted as demonstrating mutuality and the “give and take of the relationship” (Jack, 1991). In sum, the choice to select items from the codependency framework was to explore those elements within a feminist perspective.

**Deriving elements from the Silencing The Self Scale**

A decision was taken to use the Silencing The Self Scale (STSS) scale as it reflects behaviours and attitudes representative of the female role behaviour. After deciding on using the STSS, all the 31 items were shortened. The part of the sentence which was seen as a ‘core element’ of behaviour or attitude was taken out of its social and cultural context (see Jack, 1991), to be able to stand on its own and put into a context chosen by each of the participants. This means that value judgements were eliminated. An example is statement no 9: “In a close relationship, my responsibility is to make the other person happy” which becomes element no 9 ‘to make the other person happy’ and statement no 27: I often feel responsible for other people’s feelings” becomes element no 15 ‘to feel responsible for other people’s feelings’. This allows the participants to create and select their own context for the item.
Similarly, statement no 13 "I feel I have to act in a certain way to please my partner" was changed to element no 13: 'to act in a certain way to please my partner'. In other statements two segments were extracted, such as statement no 5: "I find it harder to be myself when I am in a close relationship, than when I am on my own" was changed to element no 5 'be myself in a close relationship'. Lastly, sentences with a negative statement were changed into a positive element, e.g. statement 24: "I rarely express anger at those close to me" was changed to element 19: 'to express anger at those close to me'.

**Choice of elements for card sorting**

Following a pilot study, all 31 questions were used and additional 9 items were included. The latter were selected according to Beattie's (1987) list on 'Codependence'. The 31 items of the STSS scale were cross-translated by an Icelandic independent translator. A small sample of women (no = 4) were asked to sort these 40 items. The items that distinguished best between the women, were selected. Some items of the STSS did not lend themselves to the format of the fixed card sorting. Those elements were excluded for that reason. Thus, 16 out of the 31 questions were selected, and 5 items, out of the 9 additional items, were also included. Thus, 21 cards were used for the card sorting in Study II (see App. 2). Cards/elements selected for Study III were more or less the same as in Study II, with 17 being the same. Three cards were omitted from elements derived from Beattie's (1987) (See App. 2 and 3).
**Choice of Administration: Fixed vs. free sorting of elements**

One of the aims of Study I was partly to explore the technique and its usefulness in the given context. At the start of this process it was decided to use only fixed sorts. This restriction does not utilise fully the potential of the method. However, as fixed sorts are simpler to administer, they were chosen as a method for this first study. Of course, this choice limited the use of the technique on an individual level but increased its efficiency in comparing individuals on a group level, as well as perceived changes over time, i.e. the "past", "present" and "ideal self". The women were asked to sort the cards according to given options in relation to how they valued their behaviour. Many women felt that the option of mutuality was lacking, therefore the this category was added.

Study III made use of the free sorting. Fixed sorts were used to introduce the sorting task to the women.

**Procedure - Instructions: Study II**

The participant was contacted by telephone and time and place of the interview was decided. All the women chose to be in their own home, or in a friend’s home if both participated in the study. A table was required for the sorting task. The tasks of the participation were introduced and permission for tape-recording was asked. The three sorting tasks were introduced with a short interview after the second task.
When the overall task had been introduced the participant was given the cards and she was asked to acquaint themselves with the cards. Instructions were as follows:

"I would like to ask you to sort the following cards according to the three different sorts. I will inform you about those as we go along. First, I would like you to flip through the cards to acquaint yourself with them. - Now I want to show you the first sorting task (showing the card sorting instructions; (see Interview Schedule, App. 5) "In order to be in a relationship with my partner: I need to/I avoid/ etc. ....") I would like you to sort each of the cards according to the option which is right for you"

In this study the cards were sorted from in an order from 1 to 21, and each card was assigned to one of the above categories. This procedure was used for the three sorts performed in the study. Finally, the women were asked to give evaluative comments about the participating in the study and finally information about demographic variables was obtained.

**Procedure -Instructions**

**Study III**

Like in the previous study, participants were contacted by telephone and time and place was of the interview decided. Most of the women chose to participate in their own homes. The women were invited to read the introductory sheet which contained short information on the study and requirements about confidentiality, after which they signed the form. The questionnaire was answered in the order it is
presented, which was explained to the participant at the start of the interview, starting with demographic information. Permission for tape-recording was asked. Questions about perceived power and power differences in the relationship were asked, followed by four questions as to obtain information about how the women coped in stressful situations. The questions were aimed at producing additional cards describing power strategies, emotional response and what they had learned from group therapy. These were written on a prepared form in the questionnaire to ensure information on which elements each participant had created. These were written on cards after which the participant was asked to read them and clarify whether they agreed with the wording. Finally, the personal cards were added to the 19 card sample (selected from the STSS), and given numbers from 20 - 23. Thus, the sorting task included 23 cards.

Instructions given to introduce the card sorting were as follows:

“I want to ask you to sort the cards approximately 6 times. I will give you instructions for three of the sorts, and for the other three I would like you to sort the cards in your own way, where you find your own ideas about how to sort them.

First I would like to have a short interview with you in order to produce additional cards which are relevant to your own experience, describing how you respond in a stressful situation (see App. 6).”
Instructions at the beginning of the card sorting:

"Now, I would like you to read all the cards. I would like you to tell me if any ideas come to mind when reading them, you may choose to sort the cards according to this initial idea. Otherwise, when you have sorted the cards twice according to my instructions I will ask you to sort the cards two or three times and find categories which are meaningful to you. We will finish the card sorting in a way which I will inform you about (increased vs. decreased well-being or ‘ideal emotional strength’”).

The participant was asked to go through all the cards, and notice whether she had an initial reaction to them. If so, she was asked to sort the elements according to that idea. The next step was to ask the woman to perform the first fixed sort which was identical to the first sort in the previous study (I need to.../avoid to... ); the second fixed sort was ‘frequency of behaviour’: “How often does each card (element) apply?”. Following this the women were encouraged to produce 2-3 free sorts whereby they would sort the cards in any way they liked.

At this point in the process, the women had been introduced to the idea of card sorting. If the participant had difficulties producing own ideas (constructs or categories), two main strategies were used to prompt her:

1. The researcher suggested ideas identified through the interview process.
2. A prepared list of ideas, included in each interview schedule (see App. 6) was introduced. Ideas presented on this list had been obtained through a pilot study.

When the free sorts had been obtained, the last fixed sort was introduced ('increases or decreases my well-being' or 'ideal strength'). This sort was identical to the third (and last) sort in previous study. Finally, like in previous study, the women were asked for feedback as to whether the participation had changed their opinions in any way.

As the women performed the card sorting task, the outcome of each sort was entered into a vertical column, according to the numbers given to each pile of cards (categories). Participants could sort the cards in as many piles as they wanted. Usually the women did not sort the cards with one overall idea (construct) in mind. Rather, they started with a 'bipolar construct' or two ideas, e.g. 'keep the peace' - 'selfishness' and they created new categories in this context for the elements that did not belong to the two initial ideas.

**Preparing and entering data: Study II and III**

The individual data sheets present horizontal lines for each of the cards, showing the number of the category assigned it on each of the sorts. Each row contains one sort showing how the cards were assigned to categories on the values from 1 - N.
The values given to each category are clearly arbitrary and have no meaning except for their relationship to each other. Thus by changing the values given to each category gives the same end result, except that the plot might be rotated or reversed in the Euclidean space (the two-dimensional space).

**Analysis on an individual level:** The data matrix obtained through the card sorting (MCS) from each participant was entered into a program designed for Multiple Scalogram Analysis (MSA; see Hammond, 1990). This program analyses the data and displays relationships between elements, whereby the first plot presented shows the number of each element and its position in the Euclidean space; following this are plots for each of the sorts performed, where the number of category assigned to that card is superimposed. Given the meaning of values given to each card, the plots indicate how the relationships between elements can be interpreted and what is the meaning of each of the regions found in the overall plot.

**Analysis on group level** is done by entering the data in a reversed way (i.e. individuals in a horizontal line instead of items) showing each individual as a point in the geographic space. This provides the opportunity to explore how respondents are positioned in relation to each other. By investigating the item plots, the characteristics of each identified region can be inferred and how clearly the items distinguish between them.
Multidimensional Scalogram Analysis

The Multidimensional Scalogram Analysis (MSA) structures multivariate data in a geometric space. The structure is based on comparison between profiles, where each card (element) has a profile that shows how the element was sorted on each of the sorts. The MSA computes how similar and different the profiles are in comparison to each other. This analysis results in co-ordinates being assigned to each of the elements that accounts for their relative distance between them. The assumption is that the more often cards are assigned to the same categories, the closer they are in the geometric space and the more similar is the meaning attributed to those cards. Similarly, cards that are repeatedly assigned to different categories can be seen as having different meaning and the MSA identifies a relative conceptual distance between cards that have different profiles.

A 'relative conceptual distance' can be clarified by giving an example. When one or more profiles (cards) that are very different from all the other cards are added to the analysis, this has the effect of reducing the conceptual distance between the pre-existing and more similar cards. In general, the MSA structure presents the relationships and conceptual distance between all the cards. This relationship can be seen as fluid and dynamic in the sense that the structure is sensitive to the different cards (profiles) entered into the analysis and the absence or presence of a few elements can change the structure depending on their effect on the remaining profiles and the overall 'robustness' (degree of reliability) of the data. However, this quality also clarifies the sensitivity of the technique, and how efficient the method can be in
detecting individual differences and the personal context contributed by each participant.

Thus, the MSA analysis calculates co-ordinates for each of the cards depending on the profiles given by the participant through the card sorting procedure. According to the inter-card distances (due to differences and similarities), the technique produces a spatial representation in the smallest possible Euclidean space (usually two-dimensional). Dividing this space into four parts, the centre is determined as 0.0, with increasing values to left and right, up and down, where the left and lower (south-west) part has negative values and the right and upper (north-east) part has positive values, up to - or +100. Thus, an element placed closed to the lower, left corner has high negative co-ordinates such as 

\[-86.960, -100.000\]  whilst an element in the higher, left corner would have high positive/negative co-ordinates: 

\[+86.960, -100.000\]

The centre of the Euclidean space is referred to as ‘origin’. The closer to the origin, the lower are the co-ordinates of that item. The mathematical details of technique are explained in Lingoes (1968).

The MSA analysis provides a configuration showing the relative positions of all the cards. Additionally, it represents separate plots where the categories of each sort are displayed. This provides information on how the identified regions can be interpreted, and what the elements have in common in each of the plots. This allows for interpretation of the meaning and often clarifies the dynamics between elements located in the different regions of the plot. Thus, the identified regions within the
geometric space can be interpreted by the elements within that region and the
meaning assigned (by categories) to those elements. Finally, it is the overall pattern
rather than distances between elements that are seen as meaningful for interpretation
of the plot.

MSA analysis can be applied on both individual and group level. Study III with a
sample of "codependent" women makes use of the MSA on the individual level and
explores its utility in examining personal meaning assigned to the 19 common and 4
personal cards. In contrast, Study II, with women from the general Icelandic
population examines how the participants are structured in the geometrical space and
thus explores what may distinguish and characterise individuals found in the different
identified regions of the space. To explain further, analysis on a group level can be
done by the MSA by entering one 'identical' sort from each individual in the
horizontal lines, with the columns representing how each of the cards were sorted.
This group analysis compares relative distances between individuals on one construct
(see Study II, figure 1; p.164). Also possible is to enter each individual twice for
two different sorts. This provides an overall analysis of relationships among
individuals on the two sorts and allows comparisons between the two different sort
of each individual (see Study II, figures 2-3; p.165-166).

Procrustean Individual Dimensional Scaling
or PINDIS Analysis
The Centroid Configuration or PINDIS Solution for Elements

PINDIS (Procrustean INdividual DImensional Scaling) analysis (Lingoes and Borg, 1978) is a complex, algebraic procedure that is aimed at finding a common structure (centroid) in individual configurations by using five increasingly complex models to assess and represent individual differences within multivariate data. The item configuration describes the structure of an individual’s response space. In other words the plots derived from the MSA may be said to be two-dimensional configurations. The technique determines the degree of commonality between individuals by using increasingly complex transformations.

PINDIS starts with a set of individual configurations, such as those produced by MSA. These are used to determine the existence of ‘common group space’. The first and simplest model that PINDIS utilises is know as General Procrustean Analysis (GPA). In this model the transformations made are: 1) ‘rigid’ rotations of the individual structures; and/or 2) translation of the geometric space. Thus, the individual configurations are manipulated to be as close to each other as possible. The transformations applied at this point are known as numerically ‘admissable’ because they maintain the exact distances between points in each individual’s n-dimensional space (i.e. hypothetically there can be two or more dimensions to account for the data provided by the individual).

The Centroid Configuration (Z) refers to a ‘common group space’ or ‘communality’ found within the MSA data. It is computed as the average of all the individual
configurations, and the fit of each to the centroid is found. These fit indices are presented in Table 5, p.228. They can be seen in the column labelled GPA. This model is extremely rigid and rarely provides a common structure with good overall fit with real data. The overall fit is evaluated as the mean of individual measures of fit. It is standard practice to consider this index as analogous to an index of reliability. For this reason we take the value of 0.70 as representing a minimal coefficient of reasonable fit. In the present study, the fit for the GPA model (0.63) is clearly suboptimal therefore the PINDIS analysis proceeded to the second model.

The second model in the PINDIS program applied weights to the dimensions or the centroid configuration in such a way that agreement is maximised between individuals. This transformation does affect the relative distances between the elements in the centroid plot by stretching or shrinking the dimensions (vertical and horizontal in a two-dimensional solution). However in the case of the MSA, the dimensions are largely irrelevant as it is typically the overall pattern or shape which is interpreted. Thus the dimensional weightings of this PINDIS model should have little real effect upon interpretability. This is true because the dimensions deriving from the MSA are arbitrarily standardised and stretched for output. In the present study, this model improved the fit of the data such that the index exceeded our criterion of 0.70 by reaching 0.73. Thus, the aim of PINDIS is to find a common space by using as parsimonious a model as possible.
The subsequent models of the PINDIS approach add increasing complexity. However, since fit was achieved at model two, it was unnecessary to proceed with the more complex transformations. Suffice it to say that model 3 performs dimension weights on each of the individual configurations rather than the centroid. Model 4 applies weights to the vectors of the centroid space (i.e. differentially weighting the distance of each element from the origin, or the centre of the space). Model 5 applies these vector weights to each individual configuration.

The transformations of data mentioned so far are made according to one of two principal models applied by the PINDIS technique, the ‘dimensional salience model’ which assesses communalities found within the data. Thus, the first 3 models mentioned above involve transformations to estimate the similarities in the data. To summarise, this is done averaging conceptual distances in the individual plots to determine the respective points in an average common structure.

The second principal model transforms the data in more flexible and idiosyncratic ways to assess individual differences. This is called the ‘perspective model’ as the individual is treated as a point of perspective (see table 1, below). This model is mainly based on ‘vector-weighting’ transformations and deals with idiosyncratic differences or the individual context, which the ‘salience model’ is able to detect. Table 1 summarises the transformations made by each of the two hierarchical models contained in the PINDIS analysis (see Lingoes and Borg, 1978).
### TABLE 1
Summary of PINDIS Transformations

<table>
<thead>
<tr>
<th>Model</th>
<th>Number of inadmissible fitting parameters</th>
<th>Fit index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similarity transformation</td>
<td>0</td>
<td>$r^2(\tilde{X}_i, Z)$</td>
</tr>
<tr>
<td>(unit weighting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Dimensional salience</td>
<td>nd</td>
<td>$r^2(\tilde{X}_i, Z'W_i)$</td>
</tr>
<tr>
<td>(dimensional weighting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimensional salience</td>
<td>nd x ns</td>
<td>$r^2(\tilde{X}_i, Z'_iW'_i)$</td>
</tr>
<tr>
<td>with idiosyncratic orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Perspective Model</td>
<td>ne</td>
<td>$r^2(\tilde{X}_i, V_iZ'_i)$</td>
</tr>
<tr>
<td>with fixed origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vector weighting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perspective model with</td>
<td>ne * ns</td>
<td>$r^2(\tilde{X}_i, V'_iZ'_i)$</td>
</tr>
<tr>
<td>idiosyncratic origin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$nd = \text{number of dimensions}$

$ns = \text{number of people}$

$ne = \text{number of elements}$

Admissible Transformations: no change of the property of the data.

Inadmissible Transformations: manipulations towards increasingly idiographic representations of the data.

Lingoes and Borg (1978)

These two hierarchical models produce transformations presented under the five sequential and increasingly complex models, mentioned above. The coefficients produced by the first two models are shown in table 5 (p.228). These show the
coefficients for each individual, i.e. how similar each MSA-plot is to the common space determined by each of the two respective models.

Use of PINDIS in the present study

The PINDIS was used to compare the MSA configurations from the 16 participants. For the sake of this comparison only the profiles from the 19 cards (elements) provided by the researcher were entered into the analysis.

For clarification of group comparisons in Study II and III, the comparison of the general sample in Study II was performed by MSA analysis of how the women sorted the elements on one sort only. In contrast, the PINDIS analysis is based on the individual MSA structures provided by the multiple card sorting. In this study each individual MSA structure was usually based on 6 sorts. This technique was used to analyse the data obtained from the “codependent” sample in Study III.

The PINDIS analysis, like the MSA explores differences and similarities found within the data. The MSA explores conceptual distances between elements, and provides underlying plots clarifying how each of the elements was sorted. PINDIS, on the other hand, uses individual MSA plots to compare similarities of the conceptual distances and structure within all the individual plots, and secondly it provides an analysis of how the individual configurations differ from each other, i.e. individuals with similar inter-card responses are close together while those who differ in some important ways are farther apart.
In sum, while PINDIS provides a common structure based on how participants have sorted the elements (termed commonality or Centroid Configuration), it also shows that participants are different from each other, demonstrating which participants have similar response patterns and whose configurations are different in some important ways.
References


Appendix 2

The four subscales of the Silencing the Self Scale:

Subscale 1: Externalised self-perception
" 2: Care as self-sacrifice
" 3: Silencing the self
" 4: Divided self

The subscales are intended to measure:
1: Externalised self-perception: judging the self by external standards.
2: Care as self-sacrifice: securing attachments by putting the needs of others before the self.
3: Silencing the self: inhibiting one’s self-expression and action to avoid conflict and possible loss of relationship.
4: The divided self: the experience of presenting an outer compliant self to live up to feminine role imperatives while the inner self grows angry and hostile.

(Jack, D.C. & Dill, D., 1992)

Elements from the STSS: selected and shortened

The numbers in brackets refer to the numbering of the STSS scale. When lacking the element had the same number as question:

2. (scale 3)
• to speak my feelings when/although I know they will cause disagreement.

3. (scale 2)
• putting the other person’s needs in front of my own

21. (5. scale 4)
• to be myself in a close relationship.

6. (scale 1)
• judge myself by how I think other people see me.

7. (scale 1)
• be able to do all the things people are able to do these days.

8. (scale 3)
• state my needs and feelings clearly when they conflict with my partner’s
9. (scale 2)  
• make the other person happy.

10. (scale 2)  
• do what the other person wants, even when I want to do something different.

13. (scale 4)  
• I feel I have to act in a certain way to please my partner.

16. (scale 4)  
• look happy on the outside, although inwardly I feel angry and rebellious.

14. (scale 2)  
• doing things just for myself.

19. (24. scale 3)  
• to express my anger at those close to me.

5. (23. scale 1)  
• take other people’s thoughts and opinions into account rather than my own thoughts and opinions.

15. (27. scale 1)  
• often to feel responsible for my partner’s feelings.

18. (29. scale 2)  
• think more about the things that make the other person is happy.

Additional items:  
(These items are selected as characterising ‘codependent’ women (see Beattie, 1987).)

According to scale 1:

• 20. get approval from others  
• 12. be more interested in others than myself.

According to scale 2:

• 1. give my partner, although/when it is at the expense of my own well-being.  
• 11. (not) to think about my own needs.

According to scale 3:

• 4. to suppress my feelings
Appendix 3

Elements in Study III

16 items selected from the Silencing The Self Scale
In brackets: number of question and number of subscale.
3 of the items are selected from a list on codependence: termed: (according to ...)
(Beattie, 1987)

Scale 1: Externalised Self-perception

4. (23: scale 1)
   • take other people's thoughts and opinions into account rather than my own thoughts and opinions.

7. (29: scale 1)
   • to agree with my partner when opinions are in conflict, rather than asserting my point of view.

15 (27: scale 1)
   • to feel responsible for other people's feelings.

1. (According to scale 1:)
   • get approval from others.

12. (According to scale 1:)
   • be more interested in others than myself.

Scale 2: Care as self-sacrifice

3. (scale 2)
   • putting the other person's needs in front of my own

9. (scale 2)
   • make the other person happy.

10. (scale 2)
    • do what the other person wants, even when I want to do something different.

18. (29: scale 2)
    • think more about the things that make the other person is happy.
Scale 3: Silencing the Self  When the negative wording of the statements is removed:
Scale 3 becomes: Open self-expression

2. (scale 3)  
• to speak my feelings when/although I know they will cause disagreement.

8. (scale 3)  
• state my needs and feelings clearly when they conflict with my partner’s.

19. (24: scale 3)  
• to express my anger at those close to me.

11. (According to scale 2:)  
• to think about my own needs.

14. (22: scale 2)  
• doing things just for myself.

5. (scale 4)  
• to be myself in a close relationship.  
  (Being positively worded items 5 & 6, and 11 & 14, belonged to the scale 3)

6. (31: scale 4)  
• to measure up to the standards I set for myself.

Scale 4: The Divided Self: presenting an outer compliant self
while the inner self grows angry and hostile.

13. (scale 4)  
• having to act in a certain way to please my partner.

16. (scale 4)  
• look happy on the outside, although inwardly I feel angry and rebellious

17. (scale 4)  
• to reveal certain things about myself, for my partner to love me.
Appendix 4

The Silencing The Self Scale
(by Dana Crawley Jack, 1992)

Please circle the number that best describes how you feel about each of the statements listed below.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Neither agree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I think it is best to put myself first because no one else will look out for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I don’t speak my feelings in an intimate relationship when I know they will cause disagreement.</td>
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<td></td>
<td></td>
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<tr>
<td>3. Caring means putting the other person’s needs in front of my own.</td>
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<td></td>
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<tr>
<td>4. Considering my needs to be as important as those of the people love is selfish.</td>
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<tr>
<td>5. I find it is harder to be myself when I am in a close relationship then when I am on my own.</td>
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<tr>
<td>6. I tend to judge myself by how I think other people see me.</td>
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<tr>
<td>7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.</td>
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</tr>
<tr>
<td>8. When my partner’s needs and feelings conflict with my own, I always state mine clearly.</td>
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<tr>
<td>9. In a close relationship, my responsibility is to make the other person happy.</td>
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<tr>
<td>10. Caring means choosing to do what the other person wants, even when I want to do something different.</td>
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<tr>
<td>11. In order to feel good about myself, I need to feel independent and self-sufficient.</td>
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<tr>
<td>12. One of the worst things I can do is to be selfish.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>13. I feel I have to act in a certain way to please my partner.</td>
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</tr>
<tr>
<td>14. Instead of risking confrontations in close relationships, I would rather not rock the boat.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I speak my feelings with my partner, even when it leads to problems or disagreements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

280
16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.

18. When my partner’s needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.

19. When I am in a close relationship I lose my sense of who I am.

20. When it looks as though certain of my needs can’t be met in a relationship, I usually realise that they weren’t important anyway.

21. My partner loves and appreciates me for who I am.

22. Doing things just for myself is selfish.

23. When I make decisions, other people’s thoughts and opinions influence me more than my own thoughts and opinions.

24. I rarely express my anger at those close to me.

25. I feel that my partner does not know my real self.

26. I think it’s better to keep my feelings to myself when they do conflict with my partner’s.

27. I often feel responsible for other people’s feelings.

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.

29. In a close relationship I don’t usually care what we do, as long as the other person is happy.

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

31. I never seem to measure up to the standards I set for myself.

If you answered the last question with a 4 or 5, please list up to three of the standards you feel you don’t measure up to:

Appendix 5

Study on:
Women's sense of self
in close relationships

The aim of this study is to look at how women make sense of their close relationships.

It is divided into parts: First, I would like to ask you to look at how you would respond in your relationship with your partner by sorting cards according to how you see yourself in the relationship.

Secondly, I want to ask you to answer questions on how your relationship with your partner might have changed over time and what would you see as the main factors contributing to that change.

Confidentiality and anonymity is promised as a requirement for participation. And participation in the study can be withdrawn if found necessary for some reason.

With compliments,

Jóhanna Haraldsdóttir,
22 Hamilton Drive
Guildford GU2 6PL
Surrey, England.
Demographic Variables:

1) Age: ______

2) Relationship status
   - Co-habituating: ______ for ______ years
   - Married: ______ for ______ years
   - Divorced: ______ for ______ years
   - Widow: ______ for ______ years

3) Time in years:
   - ______ years
   - ______ years
   - ______ years
   - ______ years

4) Occupation: ___________________

5) Highest educational qualification: ___________________
   Education: For: ______ years.

6) No of children: ______

7) Have you received therapy of some kind related to problems in your close relationships
   - Yes: ______
   - No: ______

Towards the end of the interview, following information will be asked as to clarify whether any mental or physical problems have affected how the woman responds to the partner.

Problems of the partner that may have affected the relationship:

- ______ Physical Disease
- ______ Mental Problem (i.e. depression etc.)
- ______ Alcohol Problem
- ______ Other
Semi-structured interview schedule:

If any changes have occurred in your relationship with your partner, what would you see as the main factors contributing to that change? If so, how or why have these changes come about?

1) In what ways, if any, have you, and your views on your relationship, changed over time?

2) What was it that brought these changes about? Was there any particular event or factor that contributed to this change?

3) How did this change occur?

4) How did it change your views on relationships
   a) in terms of how you see your role in the relationship
   b) and how you respond to your partner
      (or how you want him/her to respond to you)?
A Survey on: Women's sense of self
in their relationship
with their partners

Task 1
Relationship in the present

Here, I want to ask you to sort the cards according to what you feel you have to do
or how you feel you have to behave for your relationship with your partner to work
well.

In order to be in a relationship with my partner:

1) I need to ..... 
2) I avoid to ...... 
3) I don't have to ..... 

Please, explain what is the meaning of these sorts for you:

Sort 1.

Sort 2.

Sort 3.
Task 2.

**Relationship in the past**

Looking back, do you feel as if things have changed over time?

In this context, I would like to ask you to sort the cards according to how you have tended to respond or behave in the relationship with your partner.

In relation to my partner:

1) I often tended to ..... / I often used to ...
2) I did not want to ..... / I usually did not ....
3) I did not need to ..... 

Please, explain what is the meaning of these sorts for you:

Sort 1.

Sort 2.

Sort 3.

The semi-structured interview schedule was presented here and the interview was recorded.
Task 3.
**Emotional strength**

Here I would like to ask you to sort the cards according to what increases your well-being or what you like to avoid in your close relationships.

Changes in well-being are seen in terms of what you see as changing your emotional strength in close relationships with others.

Personally, in terms of my well-being:
1) It increases my well-being to ....
2) It decreases my well-being to ......
3) It does not change my well-being to ...

Please, explain what is the meaning of these sorts for you:

Sort 1.

........................................................................................................................................................................

Sort 2.

........................................................................................................................................................................

Sort 3.

........................................................................................................................................................................

When you have carried out the sorting, please, explain to me how you see the reasons for your sorting.

What are the factors that affect your well-being in the relationship?
How would you explain these in your own words?

Finally,
How did it feel to take part in this study?
Has your participation changed your views about relationships in any way?
(If no: do you think your participation will change your views in any way?)
Appendix 6

Study on:

Women’s sense of self
and their sense of power or powerlessness
in relationships with alcoholic partners

Dear participant

I am carrying out research as partial fulfilment of the PsychD course in Psychotherapeutic and Counselling Psychology at the University of Surrey, and my work is under the supervision of the Department of Psychology.

The aim of this study is to look at how women make sense of their close relationships and their sense of power or powerlessness in a relationship with an alcoholic partner.

It will involve two parts: First, I would like to ask you to look at how you would respond in your relationship with your partner by sorting cards according to how you see yourself in the relationship.

Secondly, I want to ask you to answer questions on how you may respond in certain situations in relationship with your partner. The participation is likely to take 1.5 - 2 hours. Your co-operation in this project would be greatly appreciated and valued.

Confidentiality and anonymity is promised as a requirement for participation.

Participation in the study can be withdrawn at any time if you find that necessary for any reason.

Signature: ___________________________________________ Date: _______________________

Thank you very much for your willingness to participate.

With compliments,

Jóhanna Haraldsdóttir,
University of Surrey
Women's sense of self
and their sense of power or powerlessness
in relationship with their partners

Demographic Variables:

1) Age: ______

2) Relationship status
   Co-habitating: ______ for ______ years
   Married: ______ for ______ years
   Divorced: ______ for ______ years

3) Occupation: ______________________________

4) Highest educational qualification: ______________________________
   Education: For: ________ years.

5) No of children: ______

Towards the end of the interview, following information will be asked as to
clarify whether any mental or physical problems have affected how the
woman responds to the partner.

6) Problems of the partner that may have affected the relationship:
   _____ Physical Disease
   _____ Mental Problem (i.e. depression etc.)
   _____ Alcohol Problem
   _____ Other

7) Have you received therapy of some kind related to problems in your close
   relationships before the group treatment at the out-patient clinic?
   Yes: ☐  No: ☐

9) Do you consider yourself financially independent?  Yes: ☐  No: ☐

10) Do you consider yourself 'co-dependent (meðvirk) as any of the following:
     " (meðsjúk)  Yes: ☐  No: ☐
     dependent (håd óðrum) Yes: ☐  No: ☐
The aim of following questions is to explore how you see yourself in relationship with your partner.

*Please, estimate how you would answer following questions by crossing the line below as you feel most appropriate:*

1. How powerful or powerless do you feel you are in relation to your partner?

<table>
<thead>
<tr>
<th>Very powerful</th>
<th>Very powerless</th>
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2. How powerful or powerless do you feel your partner is in relation to you?

<table>
<thead>
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<th>Very powerful</th>
<th>Very powerless</th>
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3. In your opinion, how would you see the relational strength between the two of you? How would you estimate this balance?

<table>
<thead>
<tr>
<th>He is relatively very strong</th>
<th>I am relatively very strong</th>
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<tr>
<td></td>
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<tr>
<td>Equal strength</td>
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</table>
4. What, in your opinion, would explain those differences and your power or powerlessness in your relationship with your partner?

Your Strength:


and / or

Your Weakness/Powerlessness:


5. What, in your opinion, would mainly make your partner strong/powerful, or powerless/weak in relation to you?

His power/strength: and / or Lack of power/Weakness:


6. How would you explain the relational balance or imbalance between you and you and your partner.


Semi-structured Interview and Additional Cards:
for measuring
women’s sense of power or powerlessness
and what power strategies, if any, they use to make their way.

Stage 1:

**Interview and Additional sorting cards**

Please, start by going through the 16 items provided for card sorting. Of course you may respond in many other different ways. To increase the likelihood that the card sorting you are about to perform is reflecting the ways in which you see yourself and your relationship with your partner, I would like you to consider and go with my help through the procedure below to create additional cards of your own as to answer the following question:

*How do I respond to difficulties, challenges, and disagreements in my relationship?*

**Semi-structured Interview**

*In your opinion:*

*How do you respond to challenges, difficulties or disagreements that may arise in your relationship with your partner.*

1. Please, identify and describe one or more situations that come to your mind.

2. What are your feelings and immediate response to those situations?

3. How do you react, act or otherwise behave as a way of dealing with those situations?
   • What do you do to deal with the situation
   • What strategies, if any, do you use to make your way.

4. Are you usually happy with how the situation is solved?
   In other words, as a result:
   • do you see yourself as a stronger (more powerful) person
   • or does the outcome make you feel more powerless.

5. Finally, how do you think your participation in group therapy has changed the ways in which you see yourself and respond to different situations in your life?
If I think about such a situation, it would most likely be (when):

**Situation 1:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Perhaps, you feel there other different situations you also consider relevant.

**Situation 2:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Situation 3:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Additional cards:**

1. ___________________________________________________________________

2. ___________________________________________________________________

3. ___________________________________________________________________

4. ___________________________________________________________________

5. ___________________________________________________________________

6. ___________________________________________________________________
CARD SORTING:

Guidelines for sorting the cards:

Step 1.
Please read through the card to acquaint yourself with the statements. As you go through them please make notice of what is your first response. If necessary, it might be helpful to write those reactions down on a piece of paper. This might give ideas in the later stages as to how to sort the cards.

Step 2. Additional cards.
A short discussion to identify one or two situations and how you respond to them. From this discussion, several additional cards are made, as to describe how you respond to, and deal with those situations.

Step 3: Card Sorting.

Please, sort the cards according to following guidelines. Remember that your own response and opinions are the most important ones. The aim is to sort the cards ca 6-7 times, with 3-4 sort that are free to you to choose:

1. Please, sort the cards according to your first response, if any, to the cards.

2a. Now, sort the cards according to what 1) you need to do ..., 2) avoid to do and 3) don't have to do .... in your relationship with your partner. Please, explain what this means to you.

2b. Now, please, find a description that is meaningful for you, such as:
   > I like / dislike this behaviour or > I value /devalue ....
   > I find it selfish to behave like this .... etc.

3. Frequency of behaviour: how often do you perform each of the statements.

4. Behaviour in different circumstances, or in relation to significant others:
   Ideas:
   > I behave like this in relation to ..(partner, mother, father, sister, friends, etc.)
   > Expectations of significant others: (partner, parents, siblings, society, etc.)
   > I find it useful/necessary (etc.) to behave like this in relation to ......
   or when things are like this ...;
   difficult vs. easier situations.

Finally:

5. Sort the cards according to what increases and decreases your well-being.

Thank you very much to the contribution and your co-operation in this study. Your contribution is highly valued. I hope you will be able to find some value through being a participant in the study.

Finally,
How did it feel to take part in this study?
Has your participation changed your views about relationships in any way?
(If no: do you think your participation will change your views in any way?)

294
<table>
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<th>Card:</th>
<th>Sort 1</th>
<th>Sort 2</th>
<th>Sort 3</th>
<th>Sort 4</th>
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Appendix 7

Permission for using the STSS-scale:
from
Professor Dana Crowley Jack
January 23, 1997

Johanna Haraldsdottir
22 Hamilton Drive
Guildford, Surrey
GU2 6PL
England

Dear Johanna,

I'm enclosing a letter of permission for you to use the Silencing the Self scale, and a partial listing of research that has used the scale. The scale norms are in the Psychology of Women Quarterly article, which I am also including in case you have difficulty finding it.

I will contact you by email also, but wanted to get this in the mail to you. I will be very interested in staying in touch with you to find out some of your results.

Thank you for your interest in the scale.

Sincerely,

[Signature]

Dana Crowley Jack, Professor
You have permission to use the Silencing the Self Scale (STSS) for your research. Please do not remove the copyright information on the bottom of the scale.

Scoring on the STSS is straightforward and instructions are contained in the article in the Psychology of Women Quarterly, Spring, 1992 which you will find included in the package. I want to call your attention to two issues.

- First, you will notice that the last question in the scale can not be analyzed statistically along with the rest of the scale, and is intended for descriptive and explanatory purposes, for example, to determine whether a sample of women may employ standards different from those hypothesized as critical by the scale.

- Second, as indicated in the article on the scale, items #1, 8, 11, 15, and 21 are reverse scored before summing all the items. So, for example, if item #1 is answered with a 2, it becomes a 4 before being added, or a 1 becomes a 5, or vice versa.

- Third, items #1 & #11 have zero to negative item-total correlation in a number of studies. I suggest that you check item-total correlation of these two items for your sample, and leave them out of analysis if they do not approach significant item-total correlation. Be sure to state you have done so, since subscale and total means will look different.

Instructions to respondents are as follows: "Please circle the number which best describes how you feel about each of the statements listed in the scale." Normally, I then ask people to answer regarding their feelings and behavior in relation to an intimate partner. I instruct that if they are not currently in an intimate relationship, to answer according to how they felt and behaved in their last intimate relationship.


If you have any questions, you are welcome to call me at 206-650-4913. I wish you the best in your work and look forward to hearing about your results. Please see the accompanying form for instructions on updating me with your results.

Thank you,

Dana Crowley Jack, Ed.D.
Professor
Email: djack@henson.cc.wwu.edu
Appendix 8

Ethical Approvals
from

Ethical Committee
Landspítalinn
(Icelandic University Hospital)

and

The Icelandic Data Protection Commission

Both are in English and Icelandic
Date
12.1.1999

Jóhanna Haraldsdóttir
22 Hamilton Drive
Guilford  GU 6PL
Surrey  England

Members of committee
Leifur Bárðarson M.D. chairman
Axel Kristjánsson lawyer
Rev. Bragi Skúlason
Guðjón Vilbergsson M.D.
Hrund Sch. Thorsteinsson R.N. B.Sc.
Porsteinn Blöndal M.D.

Address:
Sidanefnd
Ethics Committee
Landspítalinn
101 Reykjavik
Iceland

Subject
Women's sense of self and their sense of power or powerlessness in relationships with alcoholic partners. A study on women seeking treatment in relation to their "codependence" in an Icelandic out-patient clinic: A feminist Perspective.

Conclusion
The Ethics Committee has discussed your application for research in Iceland.

The Committee has no objections to your methodology in your research plan. All criteria needed for this kind of research are fulfilled.

The Ethics Committee gives its approval for your research and wishes you all the best.

Leifur Bardarson
chairman
Umsækjandi

Jóhanna Haraldsdóttir sálfræðingur
22 Hamilton Drive
Guilford GU 6PL
Surrey England

Nafn Rannsóknar / Efni bréfís
Meðvirkni. Hvernig konur líta á sjálfa sig og samskipti sín við maka: (hluti af doktorsnámi í "ráðgefandi og meðferðalegri sálarfræði" við háskólan í Surrey í Englandi).

Niðurstöða
Hér er um hluta af doktorsnámi að ræða. Öll sú uppbygging er mjög nákvæmlega uppbyggð undir umsjón og stjórn háskólans í Surrey í Englandi og gerir Siðanefnd ekki athugasemdir við þá þætti.
Nú þegar liggja fyrir heimildir viðkomandi yfirlæknis og sérfræðings og raunar einnig sambykki þátttakenda og tölvunefndar.
Siðanefnd sambykkir því þessa rannsóknaráætlun.

Axel Kristjánsson
Bragi Skúlason
Guðjón Vilbergsson
Hrund Sch. Thorsteinsson
Leifur Bárðarson formaður
Porsteinn Blöndal

Dagsetning
12.1.1999

301
Authorization to gather and record personal data under paragraph 3 of Article 4 of the Act No. 121/1989.

The Data Protection Commission refers to your application of 22nd of last month for permission to record personal data in connection with a study of co-dependency. The purpose of the study is, i.a., to investigate whether the phenomenon can be accounted for in terms of theories of the development and socialization of women that have been formulated within feminist psychology and to examine new ideas regarding methods of treating co-dependent women. It is understood that this study is part of your research project for a doctoral degree in consultative and clinical psychology at the University of Surrey, which you are working at under the supervision of Dr Adrian Coyle.

According to your application, those participating in the study would be 10-15 women who have completed a course of group therapy in the out-patients’ department of Teigur in connection with their spouses’ alcoholism. You state that preparation for the study has already begun, and that a member of staff at Teigur has given you assistance in contacting the women referred to above and has, amongst other things, given them a letter outlining the study. It appears that in that letter, no mention was made of how personal data would be handled, and you therefore intend, before any actual gathering of data begins, to explain to each of the participants how the data will be handled, including how it will be marked, preserved and deleted. Your application states that data will be gathered by means of interviews, which will be recorded, and that all recordings will be destroyed in June 1999, and that other personal data will be destroyed in September 1999.

Your application has been discussed, and the materials submitted with it have been examined. The data you intend to gather and record in the proposed study are of a personal nature (cf. paragraph 1 of Article 4 of the Data Protection Act, No. 121/1989). With reference to paragraph 3 of Article 4 of the same act, it has been
agreed to permit you to gather personal data for this project. This permission is subject to the following general conditions:

1. Complete anonymity and confidentiality must be observed.

2. Unauthorized persons may not be given access to the data recorded.

3. Personal data recorded may not be used for a purpose other than that of the study.

4. The names of the participants, or other personal identification features, may not appear.

5. The findings of the study may be only published in such a way that it is not possible to trace them back to specific individuals.

6. All original data used in the study shall be deleted after processing, and the Data Protection Commission shall be notified of the deletion of the data.

7. The Data Protection Commission may at any time set further conditions regarding this study if this is demanded in the interests of legal persons or individuals.

On behalf of the Data Protection Commission

Sigrún Jóhannesdóttir (sign.)
Manager
Heimild samkvæmt 3. mgr. 4. gr. laga nr. 121/1989 til að safna og skrá persónuupplýsingar.

Tölùnefnd visar til umsóknar yðar, dags. 22. f.m., um leyfi til að skrá persónuupplýsingar vegna könnunar á meðvirkni. Er tilgangurinn m.a. sá að kanna hvort skýra megi hugtakið út frá kenningum um þróska og félagsmóður kvenna sem mótaðar hafa verið innan feminískrar sólarfræði og skoða nýjar hugmyndir til að vinnu að meðferð með meðvirkum konum. Mun könnun þessi vera líður í rannsókanverkefni yðar til doktorsprófs í ræðugafandi og meðferðarlægri sólarfræði við háskóli í Surry sem unnin er undir leiðsögu Dr. Adrian Coyje.

Í umsókn yðar kemur fram að þátttakendur í rannsókninni verða 10-15 konur sem hafa lokio höpmódeferð á göngudeildinni að Teigi í tengslum við alkohlólima makans. Fram kemur að undirbúningur að verkefniu er þegar hafinn. Mun starfsmaður á Teigi hafa veitt yður líðsíni við að nálgið umræðar konur og kanna við þíra til þátttaku og m.a. æfint þeim kynningarbréf um rannsóknina. Mun í því kynningarbréfi hafa laðist að útskrá hvormeðferð persónuupplýsinga verði hagað og því húggist þér, aður en nokkur eiginleg gagnaðöfnun hefst, útskrá fyrir hverjum þátttakanda hvormeðferð þíra verði hagað m.a. auðkenningu gagna, varðveiðslu og eýdingu. Í umsókn yðar kemurfram að gagna verður afluð með viðtöllum, sem verða hljóðrituð en öllum upptökum eytt í juni 1999. Óðrum persónuupplýsingum verður eytt í september 1999.

Fjallað hefur verið um erindi yðar og meðfylgjandi gögn verið skoðuð. Upplýsingar þær sem þer húggist safna og skrá í fyrirhuggaði könnun varða einkalífsatriði, sbr. 1. mgr. 4. gr. laga nr. 121/1989 um skráningu og meðferð persónuupplýsinga. Hefur verið samþykkt, með visin til 3. mgr. 4. gr. sömu laga, að heimila yður söfnun persónuupplýsinga vegna verkefns þessa Heimild þessi er bundin eftirfarandi almennum skilyrðum:

1. Að fullkominnar nafnleyndar og trúnaðar verði gætt.
2. Að óheimilt er að veita óviðkomandi aðilum aðgang að upplýsingum þeim sem
skrádar hafa verið.

3. Að öheimilt er að nota skrádar persónuupplýsingar til annars en þess sem var tilgangur könnunarinnar.

4. Að nöfn þátttakenda eða önnur persónuauðkenni komi hvergi fram.

5. Að einungis má birta niðurstöður úr könnuninni á þann hátt að ekki megi rekja þær til ákveðinna einstaklinga.

6. Að öll frumgögn könnunarinnar verði eyðilögð að lokinni úrvinnslu og Tölvenefnd tilkynnt um eyðingu gagna.

7. Að Tölvenefnd getur hvenær sem er sett frekari skilyrði varðandi könnun þessa ef hagsmunir lögaðila eða einstaklinga krefjast þess.

F.h. Tölvenefndar
e.u.

[Signature]
Sigrún Jóhannesdóttir,
frankvæmdastj.