A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation into gay men’s experiences of living without children of their own

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Introduction to portfolio

The work presented in this portfolio is divided into three dossiers, reflecting three core components of counselling psychology training: academic work, therapeutic practice and research. The portfolio is intended to demonstrate my development across these areas throughout my training and to offer insight into personal experiences that I feel are relevant to my training. Awareness and the use of self is another core component of training as a counselling psychologist and it is hoped that this is reflected throughout the portfolio. In this section, I will explain my motivations for training as a counselling psychologist and I will also discuss personal and professional experiences, from before and during the course, which influenced my academic development. An aim of this portfolio as a whole is to offer the reader an insight into how my personal experiences have shaped my professional training and how my professional experiences have influenced my personal development in order to present a picture of myself in relation to counselling psychology.

At school, I found that I was drawn towards reading books that discussed aspects of human nature and I developed an ambition to study psychology at university. During my teenage years, however, some family difficulties took my concentration away from school and meant that I left with disappointing A’level results. This experience gave me an understanding of how life events can change our perception of ourselves including our self-esteem and our sense of identity. In place of university, I trained as a veterinary nurse. I chose this career because I had spent much of my childhood with animals and felt excited about working in a caring profession. During my time as a veterinary nurse, I found enjoyment out of a growing understanding of how to communicate with sick, injured and frightened animals. Looking back now, I see a similarity between this non-verbal communication and understanding the processes between client and therapist. I explore this link further in the ‘final clinical paper’ in the therapeutic practice dossier. After qualifying as a veterinary nurse, I worked for the Blue Cross Animal Welfare Charity, which offers free veterinary care to animal owners who are on state benefits. During my time there, I became interested in the pets’ owners and their stories. I became aware of my own social and cultural position as I met some people from different backgrounds and lifestyles to my own. I also
became aware that these differences need not impede good, caring relationships and that I was able to help people through difficult times (bereavement for a pet or a pet’s long illness) in part by using the same non-verbal communication skills that I used with animals. My interest in psychology and human nature was revived, and by this time my self-esteem was somewhat restored, and I decided to apply for an access course and consequently a psychology degree.

Having completed my undergraduate degree, I worked as a volunteer at MIND both on the help-line and as a co-facilitator of a support group for people with addictions to minor tranquillisers. Again, I became aware of diversities in ethnic, socio-economic and cultural backgrounds both in myself on relation to service users and between group members. As my own sense of identity was strengthening, I began to develop ways of thinking about how I might be coming across to others and how this might affect our relationship. During this time, I focused on counselling psychology as a career as I felt that it met my desire to work in the therapeutic relationship and to continue to develop a sense of self in relation to others with a view to using this in the therapeutic context.

At the start of my training at Surrey University, I felt that the difficult experiences I had encountered during school were still affecting my self-confidence in an academic setting. As the year progressed and with the support of the course team, fellow trainees, personal therapy and an encouraging supervisor at my work placement, my confidence and enjoyment of the course grew. However, I was looking for feelings of security and this is reflected in my choice of first year essay (“How do you understand the term ‘therapeutic frame’? Why is it important to maintain the frame?). Writing this essay influenced my practice because it resonated both personally, in that I was looking for a “frame” to contain my anxieties, and academically as I was becoming interested in evolutionary psychology, including attachment theory, and I felt that the therapeutic frame was a start towards offering clients a “secure base” from which they could explore. This idea is further explored in the ‘final clinical paper’ in the therapeutic practice dossier. My experience as a veterinary nurse, and my view of people as an animal species (with added adaptations) led me to explore evolutionary
psychology and its possible relevance to counselling psychology in my first year literature review.

At the start of my second year of training, I fell pregnant with twins. While this was a joyous event, I was faced with some difficult decisions concerning the course. I became ill throughout my pregnancy and quickly realised I was not fit to practice. I decided to withdraw from my work placement and after consultation with the course team, decided to complete the second year over two years. During my pregnancy, I continued with the academic work, which included the second essay offered in the academic dossier ("Discuss an aspect of the therapeutic relationship in relation to psychoanalytic ideas"). I decided to think about how a therapist’s pregnancy might affect her practice including transferential issues.

After my girls were born, I began a new work placement and started my second year research. The effect of becoming a mother on my clinical practice and academic reading is discussed in the ‘final clinical paper’ in the therapeutic practice dossier. My choice of research topic, in the second year, was influenced by two things. Firstly, during my literature review, I noticed that evolutionary psychology writers discussed possible effects of mate selection from the point of view of heterosexual sexuality but appeared to largely ignore homosexual or bisexual sexuality. Secondly, during my pregnancy I had a conversation with a gay male friend about his desire to parent. This led to my qualitative research report entitled “Gay men’s reflections on experiences of life without children: A grounded analysis”.

As I approached my third year, I felt that I had become slightly more used to being a mother of two and I decided to undertake the third year full time. I felt some trepidation at the thought of working from a cognitive-behavioural perspective and felt eager not to lose my focus on the therapeutic relationship and the use of self as therapeutic tools. I was encouraged in this endeavour by a supervisor who felt comfortable with integrating the mechanistic tools of cognitive-behavioural therapy (CBT) and the use of the therapeutic relationship. I was able, therefore, to continue to investigate process issues in supervision as well as receiving guidance about the use of the tools of CBT. The third essay in the academic dossier ("In cognitive therapy,
how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice) contains some clinical examples of how I integrated the use of the therapeutic relationship with CBT.

During my second year research, I became aware that, for some gay men, the issue of parenting was emotionally complex and painful as well as being steeped in social and political difficulties. For my third year quantitative study, I decided to investigate how therapists might be understanding these issues with a view to looking at whether their professional practice with clients presenting with similar issues might be affected. Throughout the research dossier, reflections on the interaction of self and the research process are presented in italics and parentheses.

While there is some therapeutic work presented in the essays in the academic dossier, a further selection of client work is offered in the appendix to this portfolio. It includes client studies, process reports, log books, placement and training agreements and supervisors reports from all three years of work placements. This is intended to demonstrate the professional skills I have developed over my training, including the use of formulation, interventions, the therapeutic process, ethical issues and the use of research evidence. Through my work placements, I have had experience of working in three therapeutic models (humanistic, psychodynamic and cognitive-behavioural). I have had experience of working in primary care, a psychotherapy department, an occupational health department and a community mental health team. I have also had experience of working short term (six sessions) and long term (fifty sessions) and have worked alongside a diverse set of health professionals. Through these experiences, I have reflected upon and discussed, with colleagues and fellow trainees, the place of counselling psychology within these different contexts. I feel that counselling psychologists are equipped to work in a wide range of settings partly due to the concentration on the phenomenology of the client and the therapeutic relationship. This means that clients are seen as individuals with unique presenting problems rather than groups of people with a particular difficulty for which there should be one set ‘treatment of choice’.

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Throughout this portfolio, the confidentiality of clients and research participants has been protected by the use of pseudonyms and the removal of identifying information.
ACADEMIC DOSSIER
Introduction

This dossier presents three essays written over the duration of my training. The first essay was written as part of a year one module entitled “Theoretical Models of Therapy” and comprises a discussion about the concept of a “therapeutic frame”. Writing this essay early in my training affected my practice so that establishing and maintaining a therapeutic frame has become a core part of my practice. I feel that this reflects my desire to offer my clients a “secure base” from which they can explore.

The second essay was written as part of a year two module entitled “Advanced Theory and Therapy”. I wrote this essay during my pregnancy and enjoyed having an opportunity to reflect on how this personal event could affect therapists’ practice. Due to illness during my pregnancy, I was not able to work with clients and so this essay does not contain any personal clinical material.

The third essay was written as part of a year three module entitled “Theoretical Models of Therapy” and comprises a discussion about the use of the therapeutic relationship within a cognitive therapy framework. I found this essay timely as it enabled me to move away from a mechanistic application of cognitive-behavioural therapy towards a more integrative model of practice.

I hope that this dossier reflects my academic development through the course in terms of gaining an understanding of theory and of personal growth both in my own practice and in essay writing skills.
How do you understand the term “therapeutic frame”? Why is it important to maintain the frame?

The therapeutic frame is a term used as a way of talking about the ground rules of psychotherapy. The metaphor was first employed by Marion Milner (1952) as an attempt to define the analytic space as something that was separate from the outside world of the client in the same way that the frame of a painting defines the picture as something different and distinct from its surrounding space. The concept of the frame can be understood at two levels, although at both levels the aim is the provision of a sense of security to the process of therapy. At one level, there are the practicalities of conducting psychotherapeutic sessions such as time, fee and setting of the sessions. The settling of these formalities provide both client and therapist with a sense of security and containment as well as avoiding embarrassing misunderstanding. At a deeper level, having a secure set of ground rules that may be an analogy, for the client, to early childhood experiences means that any deviance from these can be interpreted and used in the therapy. Originally, the frame was often written about by psychoanalytic writers who were concerned with the setting of private work with clients. The concept of the frame has now been adopted by therapists of many orientations (Molnos, 1995) but in this essay a psychodynamic stance will be taken and the frame will be discussed with reference to early childhood experiences. As mentioned, early writers on the frame assumed therapists had personal control over practicalities such as setting and fees. Therapists are becoming more prevalent in institutions such as primary care practices, where rooms may be limited and there are no fees, and it is important to look at how the notion of a frame fits with this type of setting. This essay will begin by outlining the practicalities of the frame as set out by writers such as Gray (1994) and Langs (1988) and how these are seen to represent a secure base by clients. The importance of maintaining the frame will then be discussed and reference will be made to possible difficulties of maintenance in primary care settings and how these may be overcome by adopting a flexible approach to frame maintenance.
At an initial meeting between a client and therapist, if they have decided to work together, a set of ground rules will need to be made explicit concerning future meetings. This will be the framework (Gray, 1994) upon which the therapy can hang. The therapist should ideally state the location of the meetings and the time and length of each session, which then would remain constant (Langs, 1979) and how many sessions are deemed appropriate. Mann (1973) goes as far as to suggest that the therapist working in brief psychotherapy should show the client a calendar to give the client a picture of the length of the therapy. The charge and how this is to be paid (for example, weekly or monthly and bills or cash) should be made clear and also what may happen in the case of cancelled or missed sessions. Any holidays that may be going to occur during the course of the therapy should be booked at the start. The therapist should also explain the issues surrounding confidentiality including times that call for the necessity of breaking confidentiality. This may vary according to the setting as some GP practices call for therapists to discuss clients at staff meetings. Writers have called for therapists to refuse to take part in such meetings although a lack of integration can cause work place disharmony (Warburton, 1999). Langs (1988) goes even further in his list of ground rules. He includes advising the patient to use the couch in all but the initial hour and the adoption of the fundamental rule of free association by which the patient is advised to say whatever comes to mind. He states that the therapist should sit behind the client with her attention “evenly hovering” while remaining in a state of total anonymity. These rules are only applicable to therapists working in a classical psychoanalytic manner. In general, the constituent parts of the frame are the location, time, fees and confidentiality.

When thinking about why a frame, and its maintenance, offers such a feeling of security to clients, it has been suggested that this way of being with clients will unconsciously remind them of the security of early infancy (Gray, 1994). In this psychodynamic context, emphasis is placed upon the importance of maintaining firm and clear boundaries and therefore providing a safe place from which the client can begin to explore their experience in the same way that a toddler needs safe boundaries in order to explore its environment (Smith, 1999). Drawing from the theoretical framework of attachment theory, Holmes (1994) has identified the role of the therapist as providing a secure base for the client, just as a primary carer provides a
secure base for the toddler, a relationship to which the infant can return when facing the risks of exploration of the external world. The therapist needs to provide a similar relationship for the client to explore their inner world. Gray (1994) takes a more classical psychodynamic approach. She suggests that when a newborn baby enters a confusing world it is aware of only its own body and physical needs. These are met by the primary caregiver who, over time and enough good experiences of responding will give the baby an internal picture of time without fear. The baby learns that the loved one will return even if it is not immediately and from here a sense of individuation and a strong ego is gained. It is this feeling that the secure frame offered by the therapist will build upon hence allowing the client to concentrate on introspection. There are, however, those that experience devastating early experiences and who therefore will not recognise this secure base. In those cases, the therapist can still provide the secure frame but instead of offering a space for introspection, the therapist will be forming a reparative relationship with the aim of providing a setting in which past failures can be re-experienced, perhaps in the transference, and so enabling the client to work these experiences through. At the same time, by internalising the therapist as someone who is able to respond to his or her needs and to contain them, the client will be able to build ego strength.

We can see then that providing a secure frame enables the client to explore life difficulties of different kinds. There are also ways that the therapist can use the frame in her therapeutic work. By remaining constant in as many ways as possible, deviations from the frame can be noted and attempts can be made at interpretations. For example, a client that experienced an overbearing, enmeshing mother may never have been allowed to individuate or separate from mother. In the frame, this may be experienced as the client refusing to leave or becoming upset at the end of the allotted time for the session. In other words, this could be interpreted as a fear of separation. As well as an aid to interpretation, in this case the provision of the secure frame will enable the client to experience containment and hence begin a process of individuation safely. If a therapist were in the habit of letting clients overrun the time at will, this type of behaviour would be impossible to detect and interpret. There are, however, writers who express concern over therapists becoming too rigid in the frame which leaves them acting stiffly towards their clients or becoming more obsessed with
their technique than the client’s issues (Symington, 1986) although it has been suggested that it is useful as a way of minimising the opportunity for self-indulgence (in other words fostering abstinence, anonymity and neutrality) which creates an environment that encourages comprehension in the client (Cherry & Gold, 1989).

For clients who have been either or both physically or mentally abused in the past, maintaining the frame will be especially important and useful. The punctuality and regularity of appointments and the duration of therapy will ensure that the sessions are made safe from the client’s point of view (Jehu, 1994). A client of mine, Ms X suffered bullying at school during which she was told that she smelt of animal urine. She internalised these taunts to the extent that she felt she could no longer “impose” herself on others and could not touch other people. This stopped her from having romantic relationships (she suffered from post-intercourse cystitis) and even from being able to kiss her friends or family. At the beginning of therapy, she sat as far away from me as possible but through constancy in the setting and my behaviour towards her she began to relax enough to begin the therapeutic work.

There is the possibility that the setting of the therapy is such that it is impossible to keep the frame rigid. In many GP practices it is the practice manager who allocates rooms and since many therapists are not full time at one particular surgery, rooms rarely stay the same. It is also unlikely that the room will be soundproofed. If these breaks in the frame are unavoidable it is important for the therapist to address them with the client and understand their meaning to the client. The experience of being moved around week after week can cause the counselling room to be seen as a dumping ground for the unwanted and difficult patients (Noonan, 1988). When considering the boundaries of place in the GP practice, the waiting and reception arrangements need to be thought through. The ideal would be to have clients make arrangements directly with the therapist rather than through the reception as this violates the ground rules of privacy and confidentiality (Langs, 1979). However, in a primary care setting, it is more likely that the client will have to arrive and announce themselves and their appointment with the therapist in public (Chiefetz, 1984). Since the clients in this setting will be referrals from the GPs at the practice it is there will not be the issue of fees. The lack of money transactions in itself is not a problem
although there are times when clients can attribute meaning either to having to pay or not and it is these attributions that are important for the therapist to understand and address.

Warburton (1994) argues that, even in institutions such as primary care settings, that may have an ethos of sharing of information, therapists should strive to maintain a strict frame including total confidentiality. She argues that integration with colleagues from different disciplines is not conducive to therapeutic work and that clients will not benefit from a slackening of their secure base. She agrees with Smith (1991) who understands that in most institutional settings it will be impossible to provide a totally secure frame but that there is always scope for some securing of the frame which he terms “secure frame moments”. Indeed, research suggests that implementing secure frame moments in the setting of general practice surgeries may have a positive effect on patients in therapy shown by an increase in attendance rates and less premature termination (Hoag, 1992). From personal experience of working in primary care, it seems that despite endeavouring to keep the therapeutic frame secure, it is more of a case of keeping it good-enough. Lees (1997) applied the concept of the Extended Clinical Rhombus to the context of the therapist working in primary care setting. It reflects a need for flexibility, a degree of elasticity with regard to the boundaries whilst at the same time having a sound and firm structure that can hold the client and yet move with the setting. Smith (1991) takes this concept further and applies an analogy of a dance to the flexible frame in an attempt to capture the necessary movement that a therapist needs to make in order to provide a framework that articulates the nature of the boundaries in the primary care setting. He suggests that the therapist, rather than rigidly attempting to impose a frame upon the setting, should keep in mind the complex nature of the boundaries in the setting, how the client may experience them and what anxieties or fantasies they may evoke. He stresses that for some clients a firmly secure frame will be of paramount importance if the work is to take place effectively but at the same time the therapist needs to take into account their responsibilities towards the practice and the limits in client autonomy especially when harm to self or others is suspected. It is suggested that this in itself can be experienced as holding by the client.
The analogy of the therapeutic frame is a useful one when discussing the ground rules of therapy that enable the creation of a safe, secure base from which clients can explore their inner lives and also from which therapists can further understand their clients. The most important reason for maintaining the frame is to provide the client with a sense of containment, a supportive ego. The practicality of the frame also enables the therapeutic relationship to be unsullied by misunderstandings. Clear interpersonal boundaries between client and therapist create both appropriate distance and intimacy and thus make the relationship safe and secure. There will also be a feeling of unconscious support for the client’s contact with reality and the client will retain an image of the therapist as sane (Langs, 1979). By understanding that the frame may unconsciously remind clients of their infancy, whether this was a secure time or not, the importance of continuous maintenance can be seen. The classical conception of the frame, as posed by Langs and later by Gray, as rigid and constant is pertinent for therapists who are able to exert control over the constituent parts such as place, time, fees and confidentiality. If, however, through working in institutions such as primary care settings, therapists lose control over certain aspects of the frame such as place or issues of confidentiality, it may be necessary to install a more flexible approach to maintaining the frame. Vitally, the flexibility needs to be transparent to the client so that, for example, the client is fully aware of when it may be necessary to break confidentiality. The therapist also needs to use changes in the frame as a way of understanding the client as she can check out meanings of the changes with the client and perhaps make interpretations. Used in this way, the therapeutic frame will enable the best possible therapeutic space.
References


Discuss an aspect of the therapeutic relationship in relation to psychoanalytic ideas.

The therapeutic relationship is an umbrella term used to describe a complex set of relationships that are vital to the therapeutic work. The set changes according to the model of therapy in question so that, for example, in humanistic work the emphasis may be on warmth and empathy within the relationship. In psychoanalytic terms, there is one aspect of the relationship that is considered to be the mainstay of the therapy. In the immediacy of the therapeutic relationship, how the patient might feel can be taken to indicate how he or she may feel towards others in the outside world either in the past or present. This is called the transference and it is the use of the transference that distinguishes psychoanalytic ideas from all others. This essay will discuss the concept of transference firstly by offering a brief history of the notion beginning with Freud's (1895) and Jung's (1953–1978) ideas on the subject and continuing with a discussion of more modern issues on the clinical use of transferential material. An attempt will then be made to offer illustrations of therapists' use of transference by concentrating on one specific situation that can elicit extremely strong transference reactions in patients. The essay will look at what may happen when a therapist becomes pregnant and continues to see her patients throughout the pregnancy. This is a pertinent topic for two reasons. Firstly, there are many women working as therapists who may at some time find themselves in this situation and may want to think about the possible reactions from their patients. Secondly, for the remit of this essay, the pregnancy of the therapist will indeed affect the therapeutic relationship and should become an integral part of the work, especially with respect to the intense transferential material it will evoke. A brief review of the literature in the area will be given followed by a description of some of the common transference themes that have been noted, especially by Penn (1986).

A history of the concept of transference

Transference is a process that happens within the therapy whereby the client transfers onto the therapist feelings, anticipations and notions that derive from relationships
with important past figures. The therapist seeks to interpret to the client that he or she is behaving as if the therapist were his or her father, mother, grandparent or sibling. The transference relationship is to be distinguished from the therapeutic relationship and the therapeutic alliance. Theoretical differences between the academic schools of analysis change the definition of transference slightly. For instance, Kleininan therapists will see transferential material as representing unconscious fantasy whereas interpersonal approaches will describe transference in terms of an interaction between the therapist and the client. In order to further explicate these theoretical differences, a brief outline of the history of transference from Freud and Jung to the school of object relations will be given.

During his “creative illness”, Freud (1895) developed the concept of transference. He initially saw the transferential material as contaminating to the therapy and as coming about because of aspects of the therapist’s input. However, he soon realised that the transferred material was coming from the client and was reflecting or “re-presenting” pathological aspects of the client’s oedipal past. In order to prevent the transference being seen as a creation of the therapist’s suggestion, Freud maintained that the therapist must present him or herself as an emotional blank slate or mirror in which the client can view their inner conflict as seen through the transference. Freud also distinguished between the mechanism of transference which mirrors the client’s past and the dynamics of the transferential relationship between therapist and client which happens in the here and now. Freud saw the dynamics of the relationship as arising from the mechanism of transference although these two aspects of the transference and their relative importance in clinical work are still being argued today (Bateman & Holmes, 1995). Some modern therapists may use the transference as a main route to the reconstruction of the oedipal situation whereas others see the main work of the therapy as exploration of the dynamics in the here and now transferential relationship. There is also some argument about Freud’s assumption that the therapist needs to present him or herself as an emotionally cold, blank mirror in order to properly elicit pure transferential material (Stephens, 1998). This is a point that will be discussed further in this essay but in short, there are writers (e.g. Ferenzei, 1985) who suggest that the maintenance of such a stance puts clients in a position of extreme emotional vulnerability by offering them no emotional support or reciprocation. Despite some
modern day criticisms of Freud's methodology surrounding the clinical use of transferential material, working with the transference still remains a central theme of modern psychoanalysis.

Jung (1953 – 1978) greatly extended the Freudian view of the transference especially with respect to the emotional stance taken by the therapist. He understood the therapist-client relationship as an archetypal relationship that has been with us since the beginning of time. In the course of analysis, archetypal images are stirred up which, when projected onto the therapist, can confer upon him or her great power. Jung described these archetypal figures as the magician, shaman, witch-doctor, guru, priest and wise old man. Most importantly, the therapist can receive the projection of previously unfulfilled archetypal needs. For example, he may become the powerful father figure that the client lacked in childhood. Finally, unconscious activity in the client causes reciprocal activity in the unconscious of the therapist with the result that the bond between them becomes something more than therapist-client. It now becomes possible for the analyst to recognise what is unconsciously projected from the client and to use this therapeutically.

The development of object relations theory has also had an influence on how transference is conceptualised and used in modern analytic therapy. Klein (1932) saw working with the transference as the wholehearted core of therapeutic work. Her picture of the psyche, in adults as well as children was of an unstable and insecure structure. In her opinion, we are tormented by two basic terrors – the fear of abandonment, which she called "depressive anxiety" and fear of annihilation, which she termed "paranoid anxiety". It is the job of the therapist to detect these unconscious terrors through their manifestations in the transference and interpret them directly back to the client. More recently, the argument has concentrated on whether transference should take up all or part of the analytic process. Slavin and Kreigman (1992) argue that it represents the bringing of learned experiences to a new situation so that the previous experiences may be revised in the light of new experiences. Stolorow et al. (1987) suggest that transference is the way in which an individual uses unconscious organising principles to understand life around him. Schafer (1977) sees
transference as the client experiencing a past experience as he or she remembers it and not as it actually happened.

The common theme running through all the above theoretical explanations of transference is that it is central to the work of psychoanalysis. Henry et al. (1994) attempted to answer the question of whether there is evidence to support the contention that this procedure is crucial for long term success. They undertook a detailed review of empirical studies of transference interpretations and they concluded that far from contributing to positive therapeutic results, several studies linked transference interpretations with poorer outcomes. Furthermore, they suggest that transference interpretations can weaken the therapeutic alliance and are more likely to elicit defensive responding than non-transference interpretations. Since there is universal agreement that a decisive factor for positive outcome in psychotherapy is the establishment of a good working alliance between therapist and client, (Roth & Fonagy, 1996) its would seem that transference analysis may add little to the therapeutic situation. Opinions differ when it comes to the emotional stance of the therapist, in other words whether the therapist is cold and non-directive or shows warmth and understanding in order to elicit the transferential material. There are also differing views of whether the transference makes up the whole work or only part of the work and whether the material transferred actually reflects past experiences or fantasies or emotional memories of past experiences. Finally, the above literature does not take into account the pathology of the client. Robbins (1986) points out that some regressed clients, especially borderline clients or those with very abusive pasts, may not benefit from working in the transference at all and while the therapist might still take note of transferential material, interpretation back to the client may either be impossible or unhelpful from a therapeutic point of view.

Examples of transference material using the therapist's pregnancy as illustration

There have been a few case studies of clients' reactions to their therapist's pregnancy. In 1969, Lax wrote a landmark paper in which she presented an important discussion of the impact of a therapist's pregnancy and offered six extensive case vignettes. She described how each client responded to her pregnancy with a reactivation of those aspects of the oedipal conflict which were most significant for that client's pathology.
Paluszny and Poznanski (1971) presented eight case studies, which they divided in three ways. The first group included those that tended to re-enact a childhood conflict in relation to the pregnant therapist. The second group responded primarily defensively to the pregnancy and the third group integrated in to the therapy the new material and affects stimulated by the pregnancy thus leading to new insights and therapeutic gains. Ulanov (1973) discussed three female clients who had intense transference reactions to her pregnancy and illustrated how her pregnancy was instrumental in helping them to relinquish their daughter-role in the transference and in their broader interpersonal relationships. Cole (1980) offered three cases focussing on the different ways these clients handled their angry feelings towards the therapist during her pregnancy.

There have only been two empirical studies in the area. Berman (1975) collated data on the acting-out behaviour of 129 outpatients of nine female psychiatrists, covering the time of the pregnancy of the therapists and during a six-month control period. She found a higher level of acting-out behaviour during the therapists' pregnancy especially among the group of clients diagnosed as borderline. Naperstak (1976) reported the results of an open-ended questionnaire sent to 32 recently pregnant therapists. The results pointed to the fear of abandonment and loss as the strongest theme across the groups.

As pointed out by Lax (1969), transference reactions will always depend upon the client's own pathology or past trauma. However, Penn (1986) describes a set of five transference reactions, which she has noted as common themes in her clients throughout her two pregnancies. Firstly, there are those clients that come to see the therapist as a maternal object leading to an intensification and highlighting of the maternal transference. Issues of attachment, separation, fears of abandonment or loss and sibling rivalry commonly arise. Common among first children is the re-experiencing of the acute sense of loss that followed the birth of a sibling. There may also be a sense of actual physical loss of mother in childbirth, if for example she had been taken into hospital or had suffered from postpartum depression. The defensive reaction clients use in responding to the therapist's pregnancy are sometimes reflective of the very defences used in response to the birth of their siblings. Penn
(1986) describes a client with four younger siblings who had no memory of any of her mother’s pregnancies or siblings as young babies. In the therapy, she attempted to deny and repress the existence of her therapist’s pregnancy in a similar way. Clients who are prone to separation difficulties because of an overly enmeshed relationship with mother may experience heightened separation anxiety during the therapist’s pregnancy. Lax (1969) describes one client whose inability to separate from mother so powerfully transposed onto her during her pregnancy that the client lost the ability to differentiate between therapist and real mother. Certain of abandonment, this client acted out a primitive identification by marrying and becoming pregnant herself. Finally, another common transference reaction appears to be identification with the baby and this often involves fantasies about the therapist as either a neglectful mother or the good mother.

The second transference reaction that Penn (1986) describes concerns the client seeing the therapist as a separate being. She states that therapists describe the most widespread transferential reaction to their pregnancy as being their clients’ sense of abandonment. This sense is often related to real and fantasised losses of the past. In a slightly different way, there may also be a sense of the loss of the illusion that the therapist exists only in his or her office for the sake of the client. During therapy, clients can come to see themselves as the only child and this may be reminiscent either of the earliest times with mother or of a fantasised time never experienced. For some clients, the pregnancy not only mobilises anxiety related to early mother experiences but also heightens their sense of being existentially alone.

Thirdly, clients may begin to experience the therapist as a sexual being, a state which Penn (1986) describes as “fertile ground for highly charged transferential reactions” (p.296). A common reaction caused by this situation shared by both men and women is a re-experiencing of their oedipal issues. The client is reminded of the presence of a man in the triangle and clients can feel excluded from this oedipal triangle. They are once again on the outside of an intimate relationship with which they are connected but can only view and perhaps feel envy towards. Revulsion at the therapist’s sexuality can lead clients to the realisation of the disgust with which they view their own sexual activities. This can lead to an exploration of the historical roots
of their attitudes towards sex. For lesbian clients in particular the therapist's implicit statement of heterosexuality may be difficult.

Penn's (1986) fourth point is that the therapist may be examined as a parent and this can lead to work in the transference. This may have special resonance for clients who are childless, especially those with fertility problems. Nadelson et al. (1974) describes how for some clients a therapist's pregnancy becomes a time to mourn losses associated with abortion, death, custody or children never conceived. Fantasies about the therapist as a parent may also lead to a re-examination of feelings about the self as a parent and relationships with own children. For clients not yet parents, conflicts about potentially raising a family can arise.

The fifth and final point in Penn's (1986) list of transferential reactions is really a consequence of the above myriad reactions. She suggests that beneath the polite congratulations offered by clients may lie angry feelings. The client may feel anger over feelings of abandonment, anger over perceived rejection, unacceptable sexuality or the greater intimacy with others. Through this transferential reaction, the work can concentrate on how the client expresses (or does not express) their anger. This can be extremely useful work as, in Winnicottian (1954) terms the therapist survives the anger and facilitates an integrated sense of self.

**Conclusion**

It would seem that the concept of transference is a central aspect of the therapeutic relationship with respect to psychoanalytic ideas. There are, however, disagreements in the literature on the way in which the therapist should conduct him or herself in order to best elicit transferential material, on the actual effectiveness on the outcome of therapy of using transference interpretations and also of how much of the therapy the transference should take up. It would seem that the pathology of the client may influence the use, or not, of transference interpretations as those with disturbed pasts may find it untherapeutic. When discussing the effectiveness of using transference interpretations on therapeutic outcome, it becomes clear that like many aspects of psychoanalytic work, more research is needed. Some suggest that the effect may be minimal at best and detrimental at worst and yet the use of transference is still
considered to be clinically useful. Finally, the issue of how the therapist should conduct him or herself in order to elicit transference is in part answered by the illustrations in this essay. The nature of pregnancy is such that it cannot be hidden from the therapeutic relationship and so whether willingly or unwillingly the therapist is disclosing personal details about her life to the client. It seems that such self-disclosure does elicit transferential themes which can, if properly addressed, be used beneficially in the therapy. This suggests that Freud’s original proposition that the therapist should be cold and mirror-like should be revised and a move be made towards a more sharing, warmer style of relationship.
References


In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice.

Until recently, the therapeutic relationship was conceptualised by therapists using cognitive behavioural theory (CBT) as a base from which the tools of cognitive therapy could be used successfully. It was not seen as a vehicle for change in its own right. Beck (1976) described a good working alliance as necessary but not sufficient for successful therapeutic outcome. It was something to be established before therapy began and also that the therapeutic work itself, if done in the spirit of collaboration, would keep the therapeutic relationship positive. Recently, however, there has been increased empirical interest in the non-specific, emotional aspects of the therapeutic relationship as tools to be used for psychological change. Modern cognitive therapists have begun to develop theoretical models through which they can integrate the mechanics of cognitive therapy with the use of the therapeutic relationship. Two examples of such work will be outlined below; the first being the development of the concept of schema (Young, 1990) and the second being the application of interpersonal theory to cognitive behavioural theory (Safran and Segal, 1990). By using clinical examples from my own practice, I will demonstrate how these theoretical models can help cognitive therapists to conceptualise disruptions in the therapeutic relationship as a way of gaining further insight into the phenomenology of their clients and of furthering therapeutic work.

**Evolution of the therapeutic relationship in cognitive therapy**

Traditionally, cognitive behavioural theorists have suggested that successful therapy relies upon a good, collaborative working alliance between the client and therapist. CBT views the client and therapist as a team that are working together towards better understanding of the client's presenting problems and the possible ways in which these difficulties might be addressed. The working alliance is created by the therapist taking the position of interested investigator who asks questions and guides discovery so that the client finds his or her own solutions. The aim is to create psychological
change that makes sense to the client so that the effects are longer lasting and the client may be better equipped for self-help in the future. Beck (1976) outlined certain therapist characteristics which he viewed as necessary, but not sufficient, for good therapeutic outcome. These characteristics included those described by Rogers (1957), namely empathy, understanding, genuineness, congruence and unconditional positive regard. A therapist should be able to read his or her client well enough to ensure that the client is able to trust in the therapist so that he or she can begin to collaborate in the techniques of cognitive therapy. A good working relationship was, therefore, seen as a necessary precursor to useful therapy. The more emotional, non-specific processes of the therapeutic relationship, such as transference, countertransference or emotional connectedness were not seen as being therapeutic tools themselves in the way that they are by other therapeutic models such as psychodynamic or humanistic theories (O’Brien and Houston, 2000; Wachtel, 1982). Indeed, CBT theory suggests that if the therapist-client collaboration is strong enough, and the goals and agendas for therapy are agreed upon by both parties, the therapeutic relationship will be strengthened further leading to less likelihood of negative feelings in either the therapist or client (Beck and Freeman, 1990).

Recently, researchers using meta-analysis research methods have suggested that the non-specific, emotional processes of the therapeutic relationship are consistently found to be an important active ingredient in successful outcome therapy (Orlinsky, Graw and Parks, 1994; Roth and Fonagy, 1996). Lambert and Begin (1992) demonstrated that as much as 57% of the outcome variance could be attributed to the therapeutic relationship and other non-specific relationship factors. This attention to the therapeutic relationship has led modern cognitive therapy authors to begin to speculate about how the tools and techniques of CBT can be linked to the processes of the therapeutic relationship. Sanders and Wills (1999) point out that there is substantial work being done by cognitive therapists such as Beck and Freeman (1990), Layden, Newman, Freeman and Morse (1993), Safran and Segal (1990) and Young (1990) who are developing interpersonal cognitive models of the therapeutic process. The aim appears to be to bring the model closer to the psychodynamic and humanistic theories by using the therapeutic relationship as one active ingredient while maintaining the useful techniques of cognitive therapy of engaging the client in
collaborative and conscious control over the therapeutic work (O'Brien and Houston, 2000).

Safran and colleagues (1993a, 1993b, 1998a, 1998b, 1998c) have attempted to integrate the use of the therapeutic relationship with CBT by embedding cognitive therapy in interpersonal theory. The application of interpersonal theory has allowed the ‘here and now’ experience of the client in relation to the therapist to be a focus of cognitive assessment and formulation. This has been especially beneficial in client groups where the presenting problems lie in relationships with others such as clients presenting with personality disorders (Layden et al., 1993). Taking note of Beck’s (1976) original claim that trust and collaboration are necessary for effective therapeutic work, it can be seen, especially for clients with personality disorders, that difficulty with these relational skills may be part causes of the client’s presenting problems. By applying interpersonal theory, which explores how and why people relate to each other, to a therapeutic model, the suggestion is made that clients may be repeating their interpersonal difficulties in their relationship with their therapist. This has led to the development of theoretical models that can explain the genesis and function of such relationship difficulties (Corrie, 2002). One such theoretical concept is that of schema (Young, 1990). Schema are made up of stable cognitive patterns that have formed when a person attempts to make sense of their experiences of the world. In a psychologically healthy person, schema will enable perception and attention to be focused on personally relevant factors in an idiosyncratic manner depending on past experiences. In people presenting for therapeutic help, they may have maladaptive schema which cause them to think and act in maladaptive ways (Padesky, 1994). Young (1990) suggests that people who suffer childhood trauma might develop early maladaptive schemas as they create negative ways of thinking about themselves, others or the world in order to make sense of the abuse. Safran and Segal (1990) take the notion of schema and apply it to interpersonal theory. They suggest that people will develop interpersonal schema as they make sense of themselves in relation to others. These interpersonal schema are part of cognitive interpersonal cycles in which a person’s core beliefs are activated and reinforced. In other words, a person may behave towards others in a way that causes others to treat them in a manner that confirms the person’s beliefs about himself or herself. A
person who holds a schema that involves a belief that he will be abandoned may behave in a way that will make a significant other leave him thereby creating an interpersonal cycle that has reinforced his maladaptive interpersonal schema.

It seems, therefore, that modern cognitive therapists have access to theoretical models that enable them to begin to understand how to use the therapeutic relationship as an active ingredient while working with the therapeutic tools of cognitive therapy. The notion of interpersonal schema enable a therapist to view the client's feelings, reactions and behaviour towards the therapist as evidence of that client's intrapsychic schema. Since these schema are viewed as interpersonal, it is also necessary for the therapist to have an understanding of his or her feelings towards the client and how these may further elucidate the therapist about the client. In order for a therapist to use this skill, he or she must have a high level of self-awareness so that he or she is able to understand his or her own interpersonal schema and how these are affecting the feelings towards the client. Calls are being made in the cognitive literature for a greater level of self awareness training within the CBT training courses (O'Brien and Houston, 2000; Scaturo, 2002).

Difficulties in the therapeutic relationship

Originally, difficulties in the therapeutic relationship in cognitive therapy may have been seen to be due to a lack of a good working alliance. If a client was resisting an intervention offered by the therapist or appeared to be taking an detrimentally passive role in the therapy, the assumption was that the therapist had not managed to create a trustful, collaborative and strong working alliance before the therapy had begun. The therapist may have taken steps to halt the therapeutic work and concentrate on creating a good working alliance. The disruption would not necessarily have been seen as an opportunity to reformulate about the client or to be of use as a therapeutic tool. With the advent of modern interpersonal, schema related cognitive theories, cognitive therapists can begin to conceptualise disruptions in the therapeutic relationship as "open windows into the patient’s private world" (Beck and Freeman 1990, p. 65). A disruption to the relationship can offer the therapist an opportunity to engage the client in exploration about possible core beliefs and maladaptive schemas that might be at the root of the difficulty. By addressing the disruption in this way, it
is hoped that the clients will be able to understand his or her behaviour better and how this may be affecting relationships with others, both within therapy and outside therapy.

Clinical examples of difficulties in the therapeutic relationship

I will now present two examples from my personal clinical practice to illustrate how difficulties in the therapeutic relationship can be conceptualised and utilised within cognitive therapy. Initials have been used to protect client confidentiality. Both of the following clients were seen within the context of a Community Mental Health Team. They had both been referred for psychological help by their GPs and had been assessed as suitable for CBT.

Mrs H is a forty-two year old married woman. She sought psychotherapeutic help for problems in her relationship with her husband. She stated that she became jealous of her husband when they went out together and that she would scan the environment until she found a pretty girl and then she would experience feelings of anger and sadness. These episodes would usually result in an argument with her husband. When Mrs H was a child, her mother died when she was seven and her father became a distant figure as he went out with girlfriends. Mrs H stated that she had never had many friends and had always felt lonely.

At the start of therapy, Mrs H and I appeared to form a good working alliance. We looked at her negative automatic thoughts when she was in these situations and she stated that she usually thought “He would prefer to be with that girl rather than me.” Through the use of thought records and Socratic questioning, we uncovered assumptions such as “If he sees that girl, he will leave me.” On further investigation, we looked at the possibility that Mrs H held core beliefs surrounding being unlovable and that people she loves always leave her.

After a good start, Mrs H suddenly became passive in the therapeutic relationship. I noticed that she stopped collaborating with me and that she began to lose eye contact. I also noticed that I became more dominant and directive and began to feel exasperated with her and hurt by her withdrawal. Through the use of supervision, I
was able to realise that this was a disruption in our therapeutic relationship that may be useful in my ongoing formulation process. At the start of the next session, I told Mrs H that I felt that she had withdrawn and that I had become dominant in the session. She stated that she had noticed it too but that this was how her relationships usually went. I told Mrs H that I would like to explore this difficulty in our relationship with her if she was happy to do so. Mrs H agreed and over the next few sessions we uncovered that she had begun to feel cared for by me and that this had made her feel uncomfortable and angry as she did not trust that I could mean it. She thought that she had better withdraw from me before I abandoned her as she was sure that I would have a preferred client to see. Together, we looked at how this was a possible example of her abandonment schema affecting her relationship with me and how this may be affecting her relationship with her husband. I went on to explain to her that I had felt hurt by her withdrawal and that my dominant behaviour was my way of compensating for my own feelings of hurt. In this way, she was able to understand that her behaviour might have an effect on others and that perhaps her emotional withdrawal may contribute to the arguments between her and her husband. In following sessions, we were able to return to a collaborative working relationship and we began collecting evidence for and against her old core beliefs and for new, alternative beliefs.

In this example, I felt that I was able to combine the use of cognitive therapy tools such as guided discovery and linking thoughts to feelings with exploration of the processes of the therapeutic relationship. By using Young’s (1994) concept of schema I felt able to understand the difficulties that had arisen in our relationship in terms of how schema from both therapist and client can interact and cause a disruption of the relationship. We were able to further our understanding of Mrs H’s difficulties and strengthen the working alliance so that we could continue our work collaboratively.

The following example can be conceptualised in terms of a dysfunctional cognitive-interpersonal cycle (Safran and Segal, 1990) whereby the client’s way of being in the sessions evoked a reaction in me that reinforced her beliefs about herself and her
world. It seemed that this cycle may have been occurring outside therapy and preventing her experiencing more adaptive interpersonal relationships.

Ms S is a twenty-eight year old doctor, single and living in her parental home. She presented with symptoms of depressions such as insomnia, low mood, feelings of loneliness and tearfulness. In our sessions, I had a strong empathic response to her manifesting as a feeling of sadness and the urge to cry. As she described her life and her negative past experiences of previous therapeutic help, I found myself thinking that she was a gifted, intelligent person whose life was being ruined by her depression and that no one had been able to help her so far. I felt a great responsibility for 'saving' Ms S and therefore reinstating her career and enjoyment of life. I began to doubt my abilities and found myself worrying in between sessions that I was not a good enough therapist for Ms S and that I was going to fail her like all the previous therapists had failed her. During sessions, I began to lose my creativity so that I would not be able to use any therapeutic skills such as guided discovery or use of imagery. I began to accept her view of herself as “too much for anyone to help”.

With the help of supervision, I was able to begin to look at this difficulty in the therapeutic relationship from an interpersonal viewpoint. I clarified that I felt overwhelmed and manipulated by this client and began to think about what the client might be doing to encourage these feelings in me. It seemed that the client activated a defectiveness schema (Young, 2003) in me and by telling me that she was “too bad for anyone to help” she evoked core beliefs in myself of “I’m not good enough” and “I’ll fail”. During supervision, I looked at why Ms S might be maintaining this cognitive interpersonal style and hypothesised that a part of her might not want to be helped despite another part of her presenting for therapy. At the next session, I explained my feelings of inadequacy to the client and enquired how she felt about the thought of recovering from her depression. The client began to uncover that being depressed made her feel special and that she had used illnesses to keep herself close to her parents since she was a child. She stated that she had felt loved by her parents the most when she was sick. This seemed to be linked to the assumption: “If I’m well, my parents won’t look after me anymore and I will have to grow up.” It seemed that Ms S could have been employing an interpersonal cognitive cycle whereby she
evoked thoughts and behaviours in others that influenced their reactions, which in turn maintained her world in a way that seemed safe to her. Her way of being with me encouraged me to care and worry about her but to leave her unchanged.

**Conclusion**

It would seem that the introduction of the concept of schema and the application of interpersonal theory have enabled the therapeutic relationship to evolve within cognitive therapy. Previously, a cognitive therapist might have conceptualised the therapeutic relationship as something that had to be developed in order for useful, collaborative work to take place and that disruptions in the relationship would suggest that the working alliance had not been well formed or that the therapist was not being collaborative enough. A cognitive therapist is now also able to view the therapeutic relationship as a tool that can be used to further conceptualise their client and to engender change in the client. By using interpersonal theory and schema-focused theory, a cognitive therapist can use disruptions or difficulties in the therapeutic relationship to explore a client’s interpersonal cognitive styles, beliefs and assumptions. By assuming that a client will replay outside relationships within the therapy, the cognitive therapist can utilise the here and now experiences of the client to facilitate sel- learning and to examine self-other maladaptive cognitive styles.
References


THERAPEUTIC PRACTICE DOSSIER
Introduction

This dossier provides context for my therapeutic practice throughout the course. It contains brief, anonymous descriptions of my training placements. As mentioned in the Introduction to the portfolio, I did not see clients during my pregnancy (years 2001 – 2002) and hence there is no placement description for this period. In years 2 and 3, I was given the opportunity to undertake split placements. I feel that this enabled me to gain experience of different work settings and has meant that I have had the pleasure of working with four supervisors. Each supervisor offered me new insight into therapeutic work and the supervisory process. I found this stimulating and enlightening and I feel it encouraged me to develop my own style of working with clients and colleagues.

This dossier also contains the “final clinical paper” which was written at the end of training. The final clinical paper offers an account of my personal stance, at the time of writing, to counselling psychology and the factors that I feel have influenced my training. It is hoped that this dossier will offer a view of the practical experiences I have had and a flavour of my understanding of these experiences.

Client confidentiality is maintained by the use of pseudonyms and initials.
My first year placement was provided by a Primary Care Service of a large city-based NHS trust. The primary care service placed psychologists, psychotherapists and counsellors in GP practices that fell within the boundaries of the NHS trust. GPs were given guidelines to aid appropriate referral to the primary care psychotherapy service; the guidelines included examples of mental health problems (anxiety, phobias, mild to moderate depression, relationship difficulties, mild eating disorders), age (over 18 years-old) and an example of some motivation to change (for example, a willingness to work on their problems with a therapist). The GP practice in which I was placed employed six doctors, two practice nurses, various auxiliary health workers and one psychotherapist (my supervisor). The socio-economic status and cultural background of the patients varied but all referrals to the psychotherapy service were registered clients of the GP practice.

The service offered a maximum of twelve sessions plus an assessment session, although I saw one client for twenty sessions. All assessment sessions were conducted by my supervisor, some of which I observed. After assessment, clients that were thought to be suitable for the service were placed on a waiting list and my supervisor passed suitable clients to me. The sessions were held in a designated room at the same time each week and lasted for fifty minutes.

My supervisor held a psychodynamic qualification and supervision was based on psychodynamic theories. This meant that I presented a verbatim transcript from a session and we worked from this on process issues such as the transference, countertransference and on my interventions. We also used audio-tapes of my sessions. Supervision was held weekly and last for an hour and a half.

My own practice was informed by basic counselling skills, such as reflection, summarising and active listening at the beginning of the placement. I then began to incorporate some humanistic core skills, will partly involved offering the client positive regard and adopting a congruent way of working. By the end of the
placement I began to integrate some psychodynamic ideas taken from supervision and from the academic content of the course and I began to offer interventions based on my understanding of the transference or my formulation.
Year 2 Placement: Psychotherapy department
October 2002 – July 2003

One day of my second year placement was spent in a psychotherapy department of a rural NHS mental health trust. The department comprised of a consultant psychotherapist/psychiatrist, two other psychotherapists, senior house officers undertaking psychotherapy training, and myself. Referrals came from GPs, psychiatrists and Community Mental Health Teams. Assessments were conducted by the psychotherapists and some by myself. Suitable clients were then placed on a waiting list until a session time became available. The waiting was about six months at the time of my placement. There was no time limit for therapy or session number limit so that some clients were seen five times a week for many years while others were seen for a few months on a weekly basis. I saw four clients for about fifty sessions each with sessions being held weekly, at the same time and place and lasting for fifty-minutes.

My supervisor held a Kleinian qualification and supervision took the form of me providing verbatim transcripts and sometimes tapes of sessions. Supervision was weekly and lasted for an hour.

Clients referred to the department were over 18 years-old and were predominately of British white ethnic origin and a range of socio-economic backgrounds.

Occupational Health Department
October 2002 – July 2003

The second day of my work placement was spent in an Employee Counselling Service located within the Occupational Health Department of a rural district hospital. The Employee Counselling Service offered psychotherapy to any employee of the hospital. Presenting problems might be work related but did not have to be connected to work for the client to qualify for the service. The service also offered a range of other services such as mediation services for employees, occupational trouble
shooting and smoking cessation sessions all of which I had experience either as a co-therapist or as an observer.

The service comprised of one counselling psychologist (my supervisor) and myself. Assessments were booked in by the occupational health department secretary and were conducted either by my supervisor or myself. Clients deemed suitable for psychotherapy were placed on a waiting list which, at the time of my placement, was about two months.

My supervisor worked from an integrative perspective and supervision was held weekly and lasted one hour.

During this placement, my supervisor and I, as co-therapists, saw two couples.
One day of my third year work placement was spent in a community mental health team (CMHT) situated in a rural town. The team comprised of social workers, community psychiatric nurses, occupational health workers and two psychological therapists (both held cognitive-behavioural qualifications) and myself. As a counselling psychology trainee, my role in the team was to offer cognitive-behavioural therapy (CBT) to clients. Clients were referred for therapy by GPs, their case workers (other members of the team) or psychiatrists within the mental health trust. New referrals to the team were assessed by two team members and the assessments were then discussed at allocation meetings were a care plan for that client was devised. When possible, I took part in the assessment process. This was an interesting experience as these multi-disciplinary assessments were different in structure and tone to psychotherapy assessments.

There were no limits on sessions numbers for each client although long waiting lists added a time pressure. All clients were seen weekly at the same time and place each week and sessions lasted fifty minutes.

Clients were predominantly from a rural, low economic status background and predominantly of white British ethnicity.

My supervisor, for both days of the placement, held a CBT qualification with a nursing background. This meant that supervision took the form of presenting clients in terms of presenting problems, possible diagnoses and CBT formulations, concentrating on negative automatic thoughts, thinking styles and core beliefs that might be contributing to the genesis and maintenance of the presenting problem. This was a new experience for me and it took me a while follow the format. I found it a struggle to incorporate a ‘diagnosis’ but with encouragement from my supervisor, I began to see some use in the term. We also talked about the process of the sessions.
and used the therapeutic relationship as a way of furthering our understanding of my clients’ difficulties.

Primary Care Trust
October 2003 – July 2004

The second day of my third year placement was spent as part of a primary care trust (PCT) in a GP practice. The service offered was short term CBT or solution focused therapy. The PCT offered a maximum of eight sessions with an additional assessment session. The GP practice in which I was placed was part of a busy medical centre in a rural town. The practice was large and comprised of fifteen GPs, practice nurses and other auxiliary health professionals. The client population was diverse in socio-economic status but were predominantly of white British ethnicity. Clients were registered with the practice and referred by the GPs according to guidelines set out by the service. These gave examples of appropriate presenting problems such as low mood, life-event related depression, anxiety and panic disorders and relational difficulties. Referrals were sent to me and those that I saw as appropriate for the service were offered an assessment session with myself. During the assessment, I discussed the client’s options with the client which included being referred on the a specialist service, joining the Stress Control group (see below) or the choice of taking up therapy with myself. During this time, I saw two couples.

The PCT also ran an ongoing Stress Control CBT based group. This is a six week course and is run on a rolling basis with the therapists of the PCT taking it in turns to facilitate. I ran two courses during my placement.
Additional placement activities

During my placements, I have given client presentations at educational staff meetings, presentations of my research at staff meetings, attended ward rounds with consultant psychiatrists and attended different and multi-disciplinary meetings.
Final Clinical Paper: A personal account of integrating theory, research and practice.

The following is an account of how I integrate theory, practice and research and how I believe this integration might be shaping my client work. In order to do this, I would like to talk about influences that I feel have played a part in my training to be a counselling psychologist. Naturally, this written account is in linear form, but my experience of it has been more akin to listening to a musical symphony. The sections presented in this essay are parts of a greater whole and are interwoven and interconnected. Each section could be thought of as a leitmotif\(^1\) that is recognisable at various points throughout the symphony. Each leitmotif both stands alone but also interacts with the larger musical picture. I see the end of my training as the place where I begin to develop the coda\(^2\), where all the leitmotifs can combine to form the symphony.

I would like to begin with some self-reflection in order to give the reader a taste of personal characteristics that I believe are pertinent to my training. This will be a subjective narrative and my aim is to provide some measure of the raw material with which I began my training and the effects of certain aspects of my personal life during my training. I would then like to outline the external factors that I feel have shaped my theoretical and practical development. I will split these into two broad categories. Firstly, I will concentrate on theoretical aspects that I feel arise from my understanding of counselling psychology. The second category will concern my practical experiences including my three work placements within the National Health Service, my experiences of certain clients, supervision and personal therapy. After looking at these influences, I hope to come to a conclusion about my present theoretical orientation and the shape of my continuing professional development.

\(^1\) Leitmotif n. a recurring theme in a musical or literary composition. Origin C19: from German *Leit* ‘leading’ + *motiv* ‘motive’. (Oxford English Dictionary, 2004)

\(^2\) Coda n. the concluding passage of a piece or movement, typically forming an addition to the basic structure. (Oxford English Dictionary, 2004)
Self-reflection motif

Before I began my undergraduate degree, I was a veterinary nurse. During this career, I nursed sick or injured animals in various contexts ranging from small animal practices in England to wilder settings in Southern Africa. The relevant common factor of these experiences is the non-verbal communication that needs to develop between animal and nurse in order for the animal to relax into a state where it can begin to heal. With respect to working with clients, I find a similarity in that clients often arrive anxious, frightened and sometimes aggressive and we need to be able to use some non-verbal communication in order to allow our clients to begin to form a healing relationship. I think that an effect of being a veterinary nurse before training has been my tendency to view human beings as an animal species that has added adaptations of language and higher cognitive skills. This means that I view human beings as social in nature and as having certain cross species desires (e.g. attachment) and that mental distress can be understood as a result of these desires being disrupted. In practice, this will affect my conceptualisations of clients’ difficulties and has oriented my choice of research topic.

During my training, I became a mother to twin girls. This joyous event started a shift in my thinking about my training, my theoretical orientation and myself. I began to better understand the idea of an inner world that develops from birth and I found again that I was communicating at a preverbal level (at home with my babies and at work with clients) and I felt a similarity between this and nursing animals. At this time, I began to read Daniel Stern’s (1977, 1985, 1990) work on the phenomenology of babies and the mental aspects we may maintain as adults.

While working as a veterinary nurse, I decided I wanted further challenges and so embarked on a psychology degree. The ethos of the degree was positivistic and experimental and while I feel this was a good grounding in psychological knowledge, I felt that it was one half of a circle and I was looking for completion. I undertook some voluntary work with MIND and as I was unqualified, my role involved “being with” rather than “doing to”. I was reminded of my nursing days and I began to feel that my relationship with people at MIND gave me pleasure because of a connection
at a person to person level. They seemed to be “real” relationships and left me feeling alive. This is the same feeling I had when nursing animals, in the wild or in hospitals, when parenting my children and when “being with” clients. So, I began the second half of my training with a hope that counselling psychology would provide a theoretical underpinning to my desire to be in relation to others with the aim of relieving mental distress and facilitating personal growth.

**Academic Motifs**

**Counselling Psychology**

Counselling psychology is based in the humanistic tradition, sees the therapeutic relationship as central to the process of therapy, is an integrative discipline in terms of therapeutic model and therapists working as scientist-practitioners and is committed to critiquing the medical model of the client-helper relationship (British Psychological Society, 1998; Woolfe, 1996). Counselling psychologists also work within the framework of the British Psychological Society Code of Conduct (British Psychological Society, 2000) and will probably be affected in some way by the context of their employment. For example, the NHS emphasises offering clients a “treatment” of choice as suggested by the evidence base (Department of Health, 2001). In practice, all of this means attempting to assimilate diverse information and developing a way of working that is flexible and “good enough” (Winnicott, 1965) for our clients while maintaining a professional, critical and educational role.

**The Therapeutic Relationship**

Research consistently suggests that the quality of the therapeutic relationship is an important factor in enabling positive change in clients’ mental well-being (Bergin and Lambert, 1978, Luborsky, Crits-Cristoph, Mintz and Auerbach, 1988, Orlinsky, Graw and Parks, 1994, Roth and Fonagy, 1996, Safran and Segal, 1990). Throughout my training, I have found the therapeutic relationship to be a consistent factor that has underpinned my exploration of three models of therapy (humanistic, psychodynamic and cognitive-behavioural theory). Whilst working from a person-centred approach, I concentrated on gaining the skills outlined as core conditions for therapeutic change by Rogers (1951). These are congruence, unconditional positive regard and empathy.
These skills encourage me to maintain a relationship where the power dynamics between therapist and client remain as even as possible. On starting to use the psychodynamic model, I felt uncomfortable at the thought of adopting the classic psychoanalytic view of therapist as a blank screen. Instead, like some contemporary psychoanalytic writers, I developed a way of being with clients whereby I retained the humanistic core conditions while learning to think about transference and countertransference as ways of understanding the client’s world. At this point, I began to see that there were different levels to the therapeutic relationship. At one level, there is the here and now of the relationship where attention can be given to those factors (internal or external) that may be preventing change from occurring. At another level, there is the client’s past relationships that may be colouring his or her present functioning including the relationship with the therapist. Moving on to a cognitive-behavioural model, I found that when I became used to administering the more mechanistic tools of CBT, I was able to continue to think about, and use, the relationship to encourage therapeutic change.

As mentioned above, I try to take notice of the therapeutic relationship both in terms of the here and now and in transferential terms. My thinking about the relationship has also been informed by evolutionary psychology. Evolutionary psychology suggests that there are certain psychological mentalities that underpin human behaviour (Gilbert, 2000). These mentalities are seen as central to human mental well-being and therefore guide some of our behaviour and are the cause of some psychological distress. These mentalities are social in nature and include attachment behaviours (Bowlby, 1969), alliance formation (Trivers, 1985) and social ranking behaviours (Gilbert, Price and Allan, 1995). The therapist’s role is seen, in part, as providing an experience that can enhance some of these social mentalities. In other words, the therapist can provide a “secure base” from which the client can explore (Holmes, 2001) or can provide a good alliance experience so that the client can continue to make other good alliances. Bailey (2000) talks about the beneficial effects of kin relationships and that a therapeutic relationship can provide a client with an experience of a good kin-type relationship. Taken as a whole, this means that I try to provide clients with a sense of security (Casement, 1985) with unconditional regard that may enable them to explore those aspects of themselves and their environment.
that are causing pain. This is done through the adoption of the core conditions, maintaining the therapeutic frame (Gray, 1994), and thinking about the relationship in the present as well as using transferential and countertransference information.

**Integration**

Research suggests that no single name brand of psychotherapy is superior in terms of efficacy (Roth and Fonagy, 1996, Stiles, Shapiro and Elliott, 1986). In recent years, there has been increased interest in developing the notion of integration of therapeutic models in order to increase efficiency (Clarkson, 1995, 1996; Dryden, 1996; Holmes and Batemen, 2002; Norcross and Goldfried, 1992; O'Brien and Houston, 2000; Palmer and Wolfe, 1999). Norcross and Grencavage (1989) suggest that the integration movement contains three main models: technical eclecticism, common factors, and theoretical integration. Technical eclecticism involves choosing the best techniques from a broad range of models in order to meet the needs of the client (Lazarus, 1995; McLeod, 1993). Common factors approach seeks to determine the core ingredients shared by different therapies (Beitman, 1987; Frank, 1982; Garfield, 1992; Goldfried, 1982). Theoretical integration refers to a process of bringing together elements from different models into a new theory or model (McLeod, 1993) although the purpose is not necessarily to develop another single brand name theory (O'Brien and Houston, 2000). My personal route to integration follows the theoretical integration path. By using the therapeutic relationship and the principles of evolutionary psychology, especially attachment theory, as an underpinning, I use my developing understanding of the three main therapeutic models to guide my practice. By holding in mind these different ways of viewing human functioning, I hope to be flexible so that I can offer each client an individual conceptualisation of their distress and therapeutic needs. I see integration as a changing, developing process as my experience with clients continues, my understanding of human functioning widens and new research emerges.

**Scientist-Practitioner**

Counselling Psychology attempts to use academic and scientific psychology to inform the practice of counselling (Clarkson, 1994). Some writers have stated that this is an irrelevant ambition as scientific pursuits and the search for meaning are incompatible
enterprises (van Duerzen-Smith, 1990). However, others state that without objective criteria of competence, there is no professional basis for counselling psychology (Williams, 1991). It seems that this debate relies upon a definition of "science" that involves positivistic, quantitative research methods that might have little meaning to therapeutic practice. I feel that this type of research can inform about certain aspects of human behaviour and functioning that will be useful when thinking about mental distress. However, I also feel that this is a needlessly narrow definition of science and does not include the importance and relevance of qualitative research methods as ways of measuring process issues that may be of greater relevance to practitioners. I believe that we need an underlying, scientific understanding of human behaviour coupled with continued investigation into the therapeutic process in order to maintain a professional and useful practice that can be evaluated.

Personally, I have enjoyed my experiences of conducting research as part of my training. As mentioned above, my inclination to view human beings as part of the animal world led me to explore the relevance that evolutionary psychology may have for counselling psychology. During my review of relevant literature, I concluded that some ideas from evolutionary psychology could be used as a way of integrating models of psychotherapy. This affects my practice in that I conceptualise clients in terms of their attachment history and other social mentalities (Gilbert, 2000). During my investigations, I became aware that evolutionary psychology authors tend to largely ignore the question of homosexuality (for exceptions see Bagemihl, 2000; Kirkpatrick, 2000) and this informed my research for the next two years. In my second year, I carried out a qualitative research project during which I spoke to gay men about their experiences of living without their own children. I found the research helpful in my own practice in two ways. Firstly, the findings enabled me to have greater empathy for clients who may bring similar issues to therapy and secondly, I found I learnt more about being with a client who is experiencing a different way of life with different pressures to myself. I also feel that my clinical experience was helpful in the research process as I found conducting the interviews to be similar to a therapeutic session so that the resulting transcripts were rich in data. I hope to be able to continue developing my skills as a researcher throughout my working life.
Practical Motifs

In this section, I would like to discuss practical influences on my theoretical development. I will do this by presenting client material that I hope will show how I worked in each of the three models with a discussion about what I feel I found useful or not about each model. I will finish by talking about my personal therapy and supervision.

A humanistic approach

In my first year, my placement was in a Primary Care Trust (PCT) based in a GP practice in South London. At the beginning of the year, I concentrated on consolidating some basic counselling skills such as active listening, summarising and reflection. My way of being with clients was informed by Rogers' (1951) core conditions of empathy, congruence and unconditional positive regard. During this year, Ms C presented for therapy. She was a twenty-eight year old single woman who edited a magazine and she had presented to her GP for help with insomnia and anxiety and feelings of loneliness. Ms C described her childhood as “happy although I was alone for most of it”. She had been brought up on a farm and her parents had been busy with their business. She stated that affection was generally shown to animals rather than people and she had spent most of her time riding horses. At secondary school, she had been bullied and had found making friends difficult. She recalled being told that she smelt of horse urine and that she had believed this and had begun to bath twice a day. When she talked about romantic relationships, it seemed that she found being close to others difficult both mentally and physically and her relationships usually did not last for longer than three months. Ms C stated that she believed that she was feeling stressed because she had just been promoted to editor and she found that “no one else in the office has a clue about their jobs” and they “are all useless”. She said that she could not get anyone to work properly.

When I first met Ms C, I noticed that she was very pretty and well dressed although she seemed very thin. She was abrasive and abrupt and I found our first two assessment sessions difficult as I began to feel inadequate and deskilled. During supervision, I was able to realise that this way of being might be defensive and that this may be how she comes across to others especially at work. During the next
session, I resolved to think about the core conditions and remain empathic and offer unconditional positive regard. Towards the end of the session, I felt that Ms C became less abrasive and she began to cry. At this point, I felt a rush of tenderness for Ms C and, following the principle of congruence, I felt able to comment on this to her. This precipitated a discussion about how I had found her “prickly” to begin with, and how this led me to feel deskillled, but that when she let herself be vulnerable that feeling in me went away. Ms C stated that it felt good to be able to understand, in a safe situation, how she might be coming across to others. This led us to talk about the bullying at school and her family’s tendency to hide affection from each other and how these things may have led her to come over as defensive and brittle to others and how this may be affecting her at work. I feel that this experience showed me the power of offering clients Rogers’ (1951) core conditions of therapy.

A psychodynamic approach

During my second year, I undertook a split placement. One day was spent in the Occupational Health Department of an NHS hospital as part of an Employee Counselling Service. The waiting list was long and hence short-term work was preferred. The other day was spent in the Psychotherapy Department of an NHS trust. I took on four clients and saw them all for about fifty sessions. At the start of this placement, I felt I took a while to understand what it meant to work from this orientation. I found the idea of the therapist taking the role of mute listener (Balint, 1968) uncomfortable and was not sure how this would fit with the ethos of counselling psychology. I decided to continue with the core conditions in mind and try to attain an analytic frame of mind whereby I could attempt to interpret the clients’ stories and actions. To my surprise, I found this way of working to elicit powerful affect in the clients and during supervision, I understood this as the effect of being heard and understood (Winnicott, 1965). I now see this as similar to the effect on animals and babies when a carer understands their needs (the good breast, Klein (1975)) at a preverbal level.

As an underlying theory, I found object relations theory (Balint, 1952; Fairbairn, 1952; Guntrip, 1961; Winnicott, 1958) most useful. To illustrate this point, I will describe my work with Mrs M. She was a thirty-five year old single mother with
three children. She had presented to her GP asking for antidepressants as she was suffering from low mood with angry outbursts. At the beginning of therapy, Mrs M said that her childhood had been “fine”. On further exploration, it seemed that she and her sister had looked after themselves as their father was a long distance lorry driver and their mother suffered from alcoholism. Mrs M had married young and had two sons. When the boys were young, her husband was arrested and charged for raping Mrs M’s nieces. A few years later, Mrs M remarried and had her daughter. When the child was three weeks old, her husband was arrested and charged with child abuse including the repeated rape of her two sons. At the start of therapy, Mrs M sat and looked at the floor. She said very little and shrugged her shoulders. The only time she spoke was when she complained that no one in authority (GPs, benefits office, sons’ school) listened to her or to state, without affect, that the only way out of her misery was to murder her ex husband when he came out of prison.

Using the object relations idea that the maternal environment provides the conditions for psychological growth and integration (Bateman and Holmes, 1995), I hypothesised that Mrs M’s early maternal experiences had left her yearning for a loving relationship where she felt looked after. This may have left her vulnerable to the manipulations of the men she married. I felt that her frustrated attempts to be part of a loving relationship combined with her guilt she said she felt for letting these men near her sons and nieces could have led to her depression (Gilbert, 1998). My aim in the therapy was to encourage change by offering Mrs M a new experience of empathy and attention, from which she could build a secure sense of herself in relation to another person. This decision was partly informed by the idea, from evolutionary psychopathology (Troisi and McGuire, 2000), that depression is an adaptive response to overwhelming feelings of guilt. The function of depression can be understood as an individual adopting a submissive role with the social group at a time when her feelings of guilt tell her that others are thinking badly of her. My job as therapist is to give her an experience of positive regard so that her depression is no longer necessary.

At the start of therapy, I felt overwhelmed by Mrs M’s story. I had recently had my twins and I found myself more affected than usual to the point of being unable to stop
myself from crying in one session. At first, I tried to hide this from Mrs M but when she saw my affect she began to show her own pain for the first time. My supervisor suggested that the treatment might have begun as she had possibly had her first experience of someone being moved by her pain. At the next session, Mrs M returned and was very different in the session. She began to show her affect easily and appeared to take part in the therapy willingly. I wondered, however, if this was evidence of her tendency to idealise close relationships and, using the idea of “the triangle of person” (Malan, 1979; Menninger, 1958) as a guide, I made an interpretation suggesting that this was how she might have behaved with her mother and later with her husbands. The rest of the session was spent in silence and Mrs M did not arrive for her next two sessions. I felt anxious and hurt by her and hypothesised that she was showing her aggression to the “bad breast” (Klein, 1975). I sent Mrs M a letter asking her to return and when she did, we worked through her reactions to my interpretation. This was a breakthrough in the therapy and enabled us to move onto other areas such as her relationship with her own children.

A cognitive-behavioural approach

During my third year, I again undertook a split placement. One day was spent in a PCT based in a GP practice and the other day was spent in a Community Mental Health Team (CMHT). The PCT work had the restriction of eight sessions and so the work needed to be symptom and goal focused. At first, I found this change in model difficult and again I felt deskill. However, I came to value a more directive approach when I worked with Mr B in the PCT.

Mr B was a fifty year old married man who had been diagnosed with cerebella ataxia\textsuperscript{3} ten years ago. Besides his physical symptoms (slurred speech, impaired mobility), Mr B said that he was feeling low in mood and found himself snapping at his family. He was suffering from feelings of anxiety, especially at night, because of his weakening physical condition and his worry about what would happen to his family financially as he stopped being able to work. Mr B described his family background as happy. He said that his father worked hard and expected his three sons to do the same. Mr B

\textsuperscript{3} Mr B is gradually losing control of bodily movements although his cognitive and emotional faculties are not affected.
has a twin brother who was diagnosed with the same condition before Mr B. At assessment, I found Mr B to be pleasant but lacking in affect. He appeared to be able to talk about his future and his brother with no visible emotion. When I asked him whether he found his brother to be a source of comfort or support, he seemed surprised and stated that they never spoke about their condition. My hypothesis was that Mr B came from a family where talking about feelings was not encouraged and that work was seen as a necessary part of being a useful person. This appeared to have left Mr B with beliefs that he was useless or worthless and that he had to work to prove that he was worthwhile to his family.

During the first session after assessment, Mr B remained in control of his affect while I socialised him to the cognitive model (Beck, 1976) and we outlined our goals for therapy. During supervision, we decided that I should begin to investigate Mr B’s beliefs about himself concerning his medical condition. In the following session, Mr B again seemed to be cut off from his affect until I asked him how he thought about himself post diagnosis. At first, Mr B struggled with this question but with some space he began to tell me. It seemed that this was the first time that Mr B had allowed himself to uncover these cognitions and as he talked he became emotional. It seemed that by investigating cognitions, the affect that was attached was revealed (Beck, 1995). We were then able to make a better understanding about Mr B’s current functioning and look at ways of reframing his self and other cognitions in order to lift his mood (Greenberger and Padesky, 1995).

In the context of the CMHT, I was able to offer clients longer-term work. During this time, I have found that, for some clients, CBT is appropriate although I feel that my brand of CBT is coloured by my previous two years experiences of working within the relationship. For other clients, I have found schema-focused theory (Young, 1990) to be useful. A Community Psychiatric Nurse with the CMHT referred Mrs W to me. On reading Mrs W’s file, I experienced some nervousness as it seemed that she had had many multi-disciplinary interventions ranging from psychiatrists to anxiety management courses. Mrs W had a troubled past which included being raped by her father at gunpoint for many years as a child. She had also lost an eighteen-month-old son in an accident. She had suffered from severe bouts of...
depression since his death fifteen years ago and had been medicated and had undergone electro-convulsive therapy. At assessment, I was struck by a pattern of stories that involved people that she had counted on as friends becoming abusive and violent. She felt that this had caused her to become reclusive and depressed. I hypothesised with Mrs W about some beliefs that she had formed while she was being abused by her father (e.g. “If I show someone my vulnerability, they will attack me”, “I need to hit out first so that I don’t get hurt”). I felt that Mrs W would benefit from an emphasis on the therapeutic relationship, on affect regulation and on coping styles (Young, 1990). Using role play and imagery, we were able to look at how her schemas may have developed in her childhood and how they were affecting her now. During supervision, I became aware that Mrs W might start by making a good relationship with me but that this may change during therapy. By bringing her each week to supervision, I was able to continually examine the process of the relationship and hence I was able to include some interventions about our relationship. I feel that Mrs W felt this to be a stable relationship that was able to withstand some strong affect including anger and aggression and that this was a useful experience for her.

Personal therapy and supervision
I see the use of the self as an integral tool of therapy. My aim is twofold; firstly, I use myself as a tool to gain a better understanding of my clients’ world. This means listening to my own feelings within and after sessions and having an understanding of how I may come across to clients and how this might be affecting them. Secondly, I try to use myself as a way of creating a good relationship experience for clients. I have found the use of personal therapy and supervision to be essential to these endeavours. I have also found the experience of being a client useful, as I was surprised at my own anxieties and occasional unwillingness to explore hidden parts of myself.

Evaluation
I have had experience of using various measurement tools (e.g. Beck Depression/Anxiety Inventory, General Health Questionnaire, CORE). These have either been administered as part of an auditing scheme for the service or as a method of showing clients that they are progressing (used in CBT). While these tools can be
useful for individual therapists' evaluation, I prefer to use a tool that concentrates on
the process of therapy. This can either be constructed using a list of statements ("I
found the therapist easy to talk to") followed by a Likert scale or through a series of
open ended questions to which the client has to write answers. I prefer a mixture of
these as I feel that clients who do not want to take time can fill in the form quickly,
but that those who want to express something can also have space. These would be
administered in a way that they can be returned anonymously.

Coda

At this stage in my training, my aim is to learn to listen to the leitmotifs as a
symphony rather than as individual parts. Each client I meet guides my use of
research and my continuing profession development. I see my theoretical orientation
as an idea in flux. My present approach to synthesis is to use ideas from object
relations theory, attachment theory and evolutionary psychology as my guide to
human nature. My practice is driven by maintenance of the core conditions with an
emphasis on the therapeutic relationship. I aim to maintain an analytic mindframe so
that the transference and countertransference is examined and interpretations used as
necessary. I have also found the use of goal setting (taken from CBT) useful as a way
of focusing on therapeutic change.
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RESEARCH DOSSIER
Introduction

This dossier presents a literature review written during the first year of the course, a qualitative research report written during the second year and a quantitative research report from the third year. The literature review explores the field of evolutionary psychology (including evolutionary psychopathology and evolutionary psychotherapy) and examines what relevance it might hold for counselling psychology. Whilst reading the literature on evolutionary psychology, I became aware that, while much is made of mate selection theories, from the point of view of heterosexual sexuality, and their psychological consequences, little is written about homosexual and bi-sexual sexuality. This led to my second year research, which centred on gay men’s’ experiences of living without children of their own. I enjoyed conducting this research as I felt that it reflected my interest in individual’s phenomenology and I also found that my experience as a therapist enabled me to elicit rich data from the interviews. One conclusion that I reached was that this issue was potentially emotionally painful for some men and I felt that it could arise in the therapeutic situation. This led to my third year research, which investigated therapists’ social representations of gay male parenting using quantitative research methods. I began this investigation with enthusiasm and developed a questionnaire. Unfortunately, for possible reasons discussed in the report, the results were mostly not significant. Due to the time pressures of the course, I was unable to re-design any part of the research or to send out more questionnaires. The report as it stands should be taken as evidence of my education in the field of quantitative research in particular and I hope that the dossier as a whole demonstrates my experiences as a researcher including the difficulties that can arise as well as the enjoyment.

In the future, I would like to be able to have the chance to further research the constructs of sexuality and gender and how these are portrayed by the literature in the field of evolutionary psychology.

Throughout the three research reports, reflections of the use of self in the research process are presented in italics and parentheses.
“Putting people in their place”. How an evolutionary context can help the modern therapist.

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“Putting people in their place”. How an evolutionary context can help the modern therapist.

Abstract

Recently, authors have been positing models for psychotherapy based on a framework of evolutionary theory (e.g. Gilbert, 2000). This literature is reviewed here with an investigation into possible relevance for counselling psychology. A brief description of those modern evolutionary concepts that are relevant to the reviewed literature, such as kin and non-kin altruism (Hamilton, 1964), parent-offspring conflict (Trivers, 1974) and life history theory (e.g. Clutton-Brock, 1991) is offered followed by a discussion of some evolutionary views of psychopathology. Whilst reviewing the “evolutionary psychotherapy” literature special attention is paid to the therapeutic relationship and cognitive restructuring as these are recurrent themes. It is concluded that, provided an evolutionary view takes into account that human behaviour is the sum of culture, intelligence and the effects of having an evolved mind, it could offer counselling psychology a basis for theoretical integration. Finally, it is suggested that our adaptive wish to share altruistically with others could be related to the numerical phenomenon of people in therapy today.
“Putting people in their place”. How an evolutionary context can help the modern therapist.

Introduction

In the previous few decades, there has been an explosion of literature concerning the application of evolutionary theory to human psychology and psychopathology. Recently, literature has begun to appear offering ideas for new models and interventions in psychotherapy based upon evolutionary ideas and findings. The aim of this review is to investigate this literature in order to explore the directions that a new evolutionary psychotherapy may take and to ask whether there is any relevance for the field of counselling psychology.

Since the beginning of the development of his ‘talking cure’ in psychoanalysis, Freud (1913) advocated an evolutionary approach and was an admirer of Darwin’s work. Freud’s theory of human distress was based on the power of instinctual drives that are innate and present in all of us. Darwin himself, in *The Descent of Man* (1871), described how in the future, the study of the human mind would be informed by evolutionary theory. However, Freud mistakenly believed in the Lamarckian contention that those behaviours or ideas that an individual learns in her lifetime are inherited by her children (Plotkin, 1994). Darwin himself was still concentrating on finding the unit of inheritance and never proceeded with his ideas on the evolution of the human mind. It was not until the 1960’s that modern evolutionary theories began to appear and it is upon these theories that the literature reviewed here is based. Throughout this review, only one gender will be used at a time. The intention is not
to be sexist but rather to save repetition. When one gender appears, the hope is that both should be included in the mind of the reader.

At the present time, counselling psychologists are trained in a series of theoretical approaches and are then encouraged to find their own way to integrate or to use discrete approaches eclectically according to their personal views and the needs of the client they are seeing. While this is useful in many ways, it can cause confusion, as different approaches often do not sit comfortably with each other. For example, the application of cognitive-behavioural theory requires a strict adherence to a set of guidelines and does not allow for much exploration of the client’s past or present social environment. A psychodynamic approach on the other hand requires investigation of early object relations but leaves little time for examination of current cognitive functioning other than possible employment of defences. As will become clear during this review the application of an evolutionary framework to the study of human nature results in a broad encompassing view of the person, which includes their social environment, their current cognitive functioning, their developmental trajectory and the effects of having an evolved ancient mind. Critics of such an approach have suggested that this is a reductionist, determinist view that sees behaviour as being dictated by genes (Rose, 2000). However, the aim is not to create a map of links between genes and human behaviour. The aim of these writers appears to be the creation of a theory of human nature that allows equal importance to be given to the examination of possible evolved traits and the influence of human intelligence and culture. If this is possible, this will have relevance for counselling psychology, as it will be a framework upon which unification of different therapeutic approaches can hang.
In the past, some writers have proposed the morally offensive (and scientifically nonsensical) argument that evolutionary theory suggests that there are “fitter” and therefore “better” individuals than others. Such a notion was part of the eugenics movement in the 1930’s and was taken to horrific extremes in Nazi Germany with extermination of Jews, gay men, and Gypsies and people with psychiatric disabilities. The eugenics movement in the USA also led to compulsory sterilisation of tens of thousands of people who were deemed “mentally retarded”. These dark policies actually had nothing to do with the way evolutionary theory was set out but this history is partly responsible for the fact that evolutionary theory has largely been avoided in the field of mental health research.

This review begins with a brief presentation of modern evolutionary theories that are relevant to human psychology. These mostly came about in answer to Darwin’s question about the appearance of seemingly altruistic behaviour in animals sometimes leading to their own death. Bowlby (1969) published his theory of attachment at the same time as these answers to the problem of altruism were posited and has come to be seen as one of the first evolutionary psychologists (Bacciagaluppi, 1998). Attachment theory is mentioned here but is too large a topic for analysis under remit of this review. Taking these theories into account, a brief presentation of some evolutionary approaches to psychopathology is offered followed by a discussion about their relevance to the field of psychotherapy. Finally, taking account of the views discussed in the sections covering psychopathology and psychotherapy, the literature concerning the possible development of an evolutionary psychotherapy is reviewed and then discussed in relation to possible applications to counselling psychology. The
Modern evolutionary concepts

After Darwin’s second landmark book, The Descent of Man, was published in 1871, there were surprisingly few theoretical advances in the evolutionary field. Darwin himself had been sure that evolutionary theory would eventually inform psychology and furthermore he suggested that the evolution of social behaviours would be selected for in humans (Darwin, 1871). It was not until Hamilton (1964) made his theoretical breakthrough with the theory of inclusive fitness that the rush of modern evolutionary theories began. By concentrating on the gene rather than the group of individuals as the primary unit upon which selective pressures operate, Hamilton (1964) was able to explain factors of human nature that had been baffling previous evolutionary theorists. Before offering an explanation of inclusive fitness a few technical points need to be outlined.

Darwinian evolutionary theory suggests that there are at least three forms of selective pressure that influence which traits are passed from generation to generation. First, there is natural selection of attributes that give an advantage in survival such as predator avoidance or means of locomotion. This means that the environment acts as the pressure upon the traits shown by the animal. Bowlby (1969,1973) introduced the idea of the environment of evolutionary adaptedness (EEA) with which he attempted to explain the environmental conditions that prevailed when attachment behaviours would have been selected. Since the concept was first offered there has been much
speculation about the condition of the physical EEA and anthropologists have offered evidence from hunter-gatherer societies that still exist. However, evolutionary psychology needs instead to concentrate on the social EEA. The literature suggests that humans appear to have evolved in small groups (up to fifty group members) that contained members that were mostly related (Gilbert, 2000). Secondly, there is intersexual selection in which one sex chooses and attracts the other for mating and thirdly there is intrasexual selection in which one sex competes with and prevents other members of the same sex from having access to breeding resources. The use of the terms “natural” and “sexual” is slightly unfortunate as these can appear heterosexist. This is not the intention here at all and as will be seen by the explanation of Hamilton’s law of inclusive fitness and by further discussions in this review, there is no place in modern evolutionary thinking for such prejudice.

As mentioned above, before 1964, many theorists believed that selection acted at the level of the individual’s survival and therefore acts of apparent altruism or cooperation that often involved self-sacrifice were inexplicable. By concentrating on the gene as the vehicle for selection, Hamilton pointed out the primary importance of the replication of the gene. Therefore, if a gene (or of course a combination of genes) code for an adaptation that helps a person to reproduce, it is successful. This “selfish gene theory” was later written about in a brilliant but controversial book by Richard Dawkins (1976). Hamilton then posited his theory of inclusive fitness that has remained of central importance in modern evolutionary theory. The suggestion is that, since our relatives contain some of the same genes as us, if they survive to reproduce, our genes are being numerically even more successful. Therefore, at times, it may be better from the point of view of the gene for you to sacrifice your
own reproductive success (even if this means death) if this sacrifice means that enough of your siblings survive (i.e. altruistic behaviour should be seen when \( C < B \cdot r \), where \( C = \) costs, \( B = \) benefits, and \( r = \) relatedness).

In the decade that followed the publication of inclusive fitness theory, several highly influential theories appeared. Bowlby (1969) developed his theory of attachment in which he was trying to understand and explain how our ancestors successfully solved the first barrier to inclusive fitness. In other words, how to survive the perils of infancy (Simpson, 1999). Guided by Darwin, Bowlby believed that the attachment system was genetically “wired” into our species through intense directional selection during our evolutionary history.

In 1971, Robert Trivers introduced the theory of reciprocal altruism, which is an attempt to account for the way in which people at times behave in a cooperative manner with non-kin. Trivers outlined certain conditions under which reciprocal altruism should enhance inclusive fitness. Although kinship is a major predictor of food sharing in vampire bats, for example, they also share food with certain nonrelatives as well (Wilkinson, 1988). Williams (1966), Trivers (1971), Axelrod and Hamilton (1981) and Axelrod (1984) all provided approaches to reciprocal altruism using game theory. Social exchanges that appear to be altruistic are understood as advantageous whenever there exists what economists call “gains in trade”. For example, if a vampire bat fails to find food for two nights in a row it will die, and there is high variance in food-gathering success. Sharing food allows the bats to cope with this variance and the major predictor of whether a bat will share food with a nonrelative is whether the nonrelative has shared with that individual in the
past (Wilkinson, 1988). The suggestion here is that organisms possess a design feature that enables them to assess the benefits and costs of altruistic acts.

In 1974, Trivers introduced the theory of parent-offspring conflict, which has many important implications for evolutionary psychology. The theory attempts to explain why the relationship between a parent and child can be so tempestuous. The theory again relies upon inclusive fitness and suggests that there will be a stage in a child’s development when the parent may begin to concentrate on a new child and hence it is in the parent’s genetic interest to realise that the first child needs to become independent so that the new child may be nurtured. The first child needs to struggle between the wish to stay protected or to begin her adult life. Her inclusive fitness may also be increased if the parents have more children as her siblings will each contain fifty per cent of her genes.

More recently, life history theory has emerged as a major perspective in evolutionary thinking (e.g. Clutton-Brock, 1991; Lessells, 1991; Stearns, 1976, 1992; Williams, 1966). The suggestion here is that in order to leave descendants, individuals need to concentrate on the everyday problems of social life, growth, development and reproduction across their lifespan. This gives rise to an important theoretical highlight in modern evolutionary thinking. Evolutionary psychology makes an important distinction between ultimate and proximate causes of behaviour. Ultimate causes (e.g. the reproductive success of yourself and all your kin relations) have been shaped over millions of years by natural selection and lead to the reproductive success of the genome (genetic map) of the individual. Proximate causes operate on the individual over her life span and it is these that are deemed to be the focus of
evolutionary psychotherapy (Gilbert, Bailey & McGuire, 2000). The ultimate predispositions encoded in the brain of the infant provide the basic plans on which proximate development proceeds. Ultimate predispositions also act as constraints that limit the scope of proximate functions and their development. The major concern of writers attempting to develop an evolutionary psychotherapy is the nature and function of proximate mechanisms rather than the fulfilment of ultimate causes. In other words, the focus is on the choices we have, within the givens of our existence.

Most recently, writers are beginning to use ethological (the study of animal behaviour) literature and apply this to explanations of human behaviour that underpin much of the evolutionary explanations of psychopathology and the nature of therapy. While there are limitations to this approach, it is useful in that cross species comparisons of behaviour can offer suggestions about fundamental underlying psychological mechanisms. Social ranking behaviour involves direct competition for resources, gaining and maintaining rank or status, making social comparisons and accommodating to those of higher rank and making cost/benefit decisions about aggressive behaviours (Gilbert, 1992; Price et al., 1994; Sloman, 2000). In nearly all mammalian and primate groups, social structures are hierarchically organised with leaders seeming to behave confidently and subordinates appearing wary of down-rank attacks. When subordinates do not obey the social rules and strategies, they elicit attacks that are likely to cause physical, social or cultural injury (Higely et al., 1996). Gilbert (1992) suggests that in evolutionary terms shame, social anxiety and depression can be seen as reflections of defensive social strategies in individuals who see themselves as subordinate and powerless. The argument is that there are not only a variety of different submissive strategies but also many of these strategies underpin
various forms of psychopathology (Gilbert, 1989, 1992, 2000a). If this is the case and we have evolved psychological mechanisms for detecting the power differentials between others and us this will have implications for the nature of the therapeutic relationship. This may be why the ethos behind "therapeutic communities" has been said to be successful in the treatment of certain mental illnesses, as the aim was to empower the inpatients through egalitarian relationships (Winship, 1996).

**Evolutionary Theory and Psychopathology**

By investigating psychopathology using an evolutionary perspective, some writers suggest that what other approaches call mental illness is, in fact, the activation of adaptive, evolved mental strategies (Stevens, 2000). To reiterate, the distal (ultimate) evolutionary assumption, traits or strategies will have been selected because they enhance inclusive fitness. The proximal goals of an individual will include social strategies that will lead (if unconsciously) to distal success. This theory suggests, then, that conditions such as depression, anxiety, schizophrenia or borderline personality disorder may have been positively selected. This apparent anomaly is explained in various ways by different writers. There are those that see mental distress as a result of conflict between biological evolution and cultural evolution (e.g. Abed, 1998; Stevens and Price, 2000). For example, Abed (1998) suggests that women have an innate predisposition to be attentive to their physical appearance in order to attract and then keep hold of a sexual partner. In modern (mostly Western) environments where there is a current preoccupation with thinness as being the idealised female image, this previously adaptive strategy becomes maladaptive if it leads to the onset of anorexia. In their book, *Evolutionary Psychiatry*, Stevens and Price (2000) offer a list of mental illnesses with explanations of their previously
adaptive functions and mismatches with modern culture. However, the mismatch problem offered here is not concerned with distress occurring as a result of the environment being other than the EEA. Rather it is because the individual finds herself in an environment to which she is constitutionally unsuited. For example, a person who has the genetic makeup predisposing them to extraversion might, in a fertile and crowded habitat, adjust well and be happy. However, if she was to find herself in an arid and underpopulated environment, she may develop neuroses.

Gilbert (1998) offers a view of cognitive distortions, found in people suffering mental illness, as adaptive strategies. The social environment is seen as the trigger for these strategies although rather than seeing the distress as a result of mismatch between genotype and environment, the suggestion is that the cognitive distortions are innate in all of us and would be recruited in situations relevant to the individual. In other words, we all have the potential to restrict our eating, withdraw socially as well as have negative self concepts or automatic thoughts. Gilbert (1998) suggests that cognitive distortions are the consequences of the employment of psychological mechanisms that forego logical thinking (in other words biases and heuristics) in order to react quickly to perceived threat. The assumption is that the person who has the ability to react quickly to any perceived threat, even if in fact there is no actual threat, will be better off in the survival stakes than the person who thinks before she acts. However, at times this will lead the person to adopt defensive cognitions at inappropriate times. Therefore, cognitive vulnerabilities to psychopathology can be attributed to changes in the styles of cognition that arise as people shift into defensive styles of processing. Gilbert (1998) then explains that since cognitive distortions can be seen as adaptations, the assumption can be made that they are biologically based.
He offers examples of drug induced depressions and panic and brain-trauma related depression as examples of the connection between biology and cognition. The suggestion is that a person who finds herself in a social environment that she perceives as threatening will employ cognitive distortions hence the social environment exerts powerful influences, via cognition, on biological states.

Slavin and Kriegman (1992) take the view that human conflict is natural and happens within the person rather than as a result of a mismatch between mind/brain and environment. Whereas the writers described above have all attempted to root their explanations of psychopathology in biology, Slavin and Kriegman (1992) concern themselves with defining the evolutionary origin of structures such as the self, defences and repression. In other words, they attempt to create an evolutionary psychoanalysis. For example, Slavin (1990) points out that, according to the psychoanalytic relational position, repression is used to protect vulnerable parts of the self. Using Triver's theory of parent-child conflict at the point when the parent's inclusive fitness and the child's self interest clashes, typically when another child is born, Slavin (1990) suggests that at this point the child may use defences to build up a child identity. At adolescence, repressed elements are retrieved to build up an adult identity.

Dixon (1998) uses ethological studies to propose an evolutionary explanation for the onset of depression and the development of ego defences in the evolved mind. The suggestion is that animals and humans have two strategies for defensive behaviour: flight or fight. Flight behaviour itself has a dynamic form and a static form called arrested flight. When an animal is exposed to inescapable threat, they employ
postures such as gaze avoidance, and covert surveillance of their surroundings. Dixon (1998) suggests that in interviews, people suffering with depression and/or paranoia show the same behaviours suggesting that they are employing an arrested flight defensive strategy. The article then states that the behavioural cut-offs shown in animals displaying arrested flight can be seen as an analogy for the mental cut-offs that depressed patients are using. So, a human might use an ego defence to preserve self-esteem by hindering the access of disturbing emotional material into awareness, hence the patient is employing mental cut-offs in the same way that an animal employs behavioural cut-offs. Since, as animals, we share an evolutionary past (Stevens & Price, 1996) it is not surprising that there are certain similarities in observable behaviours between species and indeed some important psychological theories have been proposed using an ethological observation as the starting point (e.g. Bowlby's (1969) attachment theory; Blair's (1995) violence inhibition mechanism). However, whereas these theorists noticed a similarity in behaviour and then went on to investigate underlying human psychological mechanisms, Dixon (1998) appears to be relying on the use of an analogy between observable behaviour and human mental life.

**Evolutionary Theory and Psychotherapy**

Writers who are investigating psychopathology and psychotherapy using a framework of evolutionary theory have one explicit intention in common. The suggestion is that, broadly speaking, there are species norms and deviations from these (Wright, 1994). Those investigating psychopathology attend to unhealthy deviations by assessment and diagnoses whereas psychotherapy researchers are looking at ways to reduce the deviations. It is suggested that evolutionary theory can offer psychology and
therapeutic theories a baseline of human nature and that this will enable a unification or integration of the currently opposing or differing theoretical therapies (Glantz & Pearce, 1989). It is not clear yet whether this is possible and presumably some epistemological stances will view this as undesirable. At this point in the development of what may come to be termed evolutionary psychotherapy, authors have yet to agree on much of the framework of human nature. Despite this, however, trends in the literature are beginning to be observable and the differences and similarities will be outlined here followed by a discussion on the ways in which these affect our view of therapy. Before that, it is necessary to explain what might be meant by the term 'species norm' as anyone who has any knowledge of psychological theories may point towards individual differences at this moment. When talking about species norms, it must be made clear that this is a very high level view of human nature. Also, the word 'norm' includes behaviours that appear maladaptive in certain environments and also should not be taken to mean that there is no room for the 'other'. A relevant analogy would be to speak about the human gene pool, which can be conceptualised as an entity on its own containing all the human genes in the population. Individuals dip into the pool and take out their own personal handful and hence are not like anyone else. When they procreate they are in essence delivering their 'chosen' genes back to the pool and their offspring take a new(ish) set. In the same way, there can be visualised a set of biosocial goals and a human brain that is made up of psychological mechanisms. Which goals become important to us personally and what mechanisms we each posses will differ and their development will depend upon our environment (Tooby & Cosmides, 1992). The next section will begin by discussing the diverse literature concerning descriptions of human species norms and whether these are useful to psychotherapeutic and psychological theories.
The Social Brain and Biosocial Goals

In the same way that the physiology of the wing of a bird can tell us something about that bird’s habitat, so the mind can tell us about our past. Some authors speculate more than others about the condition of the environment of the EEA. What does seem to be agreed upon by the authors is that the social environment is constant in some respects and that people who got on with their neighbours were more likely to survive and, even more importantly, to reproduce. A loner or someone who was cast out of society would have been easy picking for predators, the elements or any other relevant dangers and unlikely to find a mate or be able to help kin. It seems then, that our social environment has led to the evolution of a human mind that has adaptations specific to “doing well” in society.

As mentioned earlier, the major concern of evolutionary psychotherapy is the nature and function of proximate mechanisms rather than the fulfilment of ultimate causes. These proximate mechanisms have been called biosocial goals (Stevens & Price, 2000) or social mentalities (Gilbert, 2000) and while the pursuit of biosocial goals may have the unconscious consequence of facilitating inclusive fitness it is the failure of attaining these goals that may result in mental distress. The nature and number of the primary biosocial goals responsible for initiating human behaviour are at the core of the debate in evolutionary psychotherapy. Most writers agree on the following: care eliciting or seeking behaviours which form the basis of attachment relationships; care giving or providing behaviours which take into account the cost of providing care (Trivers, 1985) and will mostly be directed at kin (Bailey, 2000) and those most likely to reciprocate (Glantz and Pearce, 1989); mate selection which may involve
attraction, being attracted to (Buss, 1995) and mate retention (Wilson and Daly, 1992); cooperation and the formation of alliances which will involve aggression inhibition and sharing, group living and reciprocal altruistic behaviour (Trivers, 1985); and finally social ranking behaviour which involves competition for resources, gaining and maintaining rank and accommodating to those of higher rank (Gilbert, 1992).

While the above views of the evolved mind/brain suggest a series of modular-like mechanisms, Paul MacLean (1985; 1990) has offered a structural theory of the evolution of the brain. The theory suggests that, while the human forebrain has expanded greatly, it has retained commonalities of three neural assemblies that reflect an ancestral relationship to reptiles (brain stem), early mammals (the limbic system) and late mammals (neocortex). They are radically different in their chemistry and structure and in evolutionary terms aeons apart and it is mismatches between the layers that cause human distress. The suggestion is that the three levels are analogous to reason, emotion and involuntary actions. This concept will be discussed in the following section in relation to therapeutic theories.

**Building an Evolutionary Psychotherapy**

As mentioned above, there is agreement that we have evolved mechanisms for eliciting and providing care for others and this will be briefly discussed with reference to attachment theory (Bowlby, 1969). A theme that runs through much of the evolutionary psychotherapy literature is the importance of the therapeutic relationship (e.g. Troisi & McGuire, 2000; Lioti, 2000; O'Connor 2000) and also the use of cognitive restructuring (e.g. Gilbert, 2000). Finally, some writers have offered
evolutionary explanations of existing theories (e.g. Stephens, 2000) and the utility of this will be discussed.

**Attachment Theory**

Bowlby’s attachment theory (1969, 1973, 1980) was developed using an amalgamation of Darwin’s theory of natural selection, object relations theory and ethology (Simpson, 1999). As mentioned above, evolutionary theorists focus on the importance of attempting to account for both normative behaviours and individual differences. Attachment theory offers explanations for both these issues including deviations from the normative, secure attachment. Whereas Bowlby concentrated on offering attachment theory as an explanation of how infants survive their vulnerability, modern attachment theorists are beginning to expand on Bowlby’s evolutionary leanings by using modern evolutionary theories such as Hamilton’s inclusive fitness theory. Theorists now suggest that it is not just the infant’s survival that is the engine for selection, but rather the reproductive success of the individual and the following success of future generations. Using modern evolutionary theories such as Stearns’ (1992) life history theory recent work is investigating how the attachment system in adulthood serves the evolutionary function of increasing inclusive fitness through the adoption of environmentally contingent reproductive strategies (Simpson, 1999).

Bowlby (1979) suggested that, in therapy, clients might come to view the therapist as “stronger and/or wiser” than themselves. Liotti (2000) suggests that this will activate the inborn attachment system at some point in the therapy and that the therapeutic transference relationship at this time should be examined closely. The suggestion is
that previous attachment history as well as current attachment behaviours may be
gleaned from the therapeutic relationship. As an example, Liotti (2000) suggests that
borderline patients may have experienced negative affect when their attachment
systems have been activated in the past. It is possible that their anger may be the
anger shown by children who would be classified as having disorganised attachment
in the Strange Situation (Ainsworth, 1978). In this way in can be seen that the patient
is not angry with the therapist but angry at her inner feelings that have been activated
by the attachment system.

The Therapeutic Relationship

The nature of the therapeutic relationship is written about by many of the authors who
are advocating the development of an evolutionary psychotherapy. There appear to
be three aspects to the discussion although all agree that the relationship is the major
mechanism of change in the therapy. The first theory to be discussed here is kinship-
based therapy (e.g. Bailey, 1997b) which makes the suggestion that the relationship
should activate the kin recognition system in the client. The second argument is a
more biologically based theory of change, which suggests that the relationship acts as
a central nervous system regulator (McGuire & Triosi, 1998). Finally, the potential
relevance of gender with respect to the relationship will be discussed.

Bailey (1997b, 2000) uses Hamilton's theory of inclusive fitness and literature from
social psychology research into in/out groups (Kerbs and Denton, 1997) to develop a
kinship theory of human nature. The suggestion is that humans evolved in small (fifty
or so members) groups that were mostly genetically related and that social
togetherness is central to our physical and mental well being. The person who
possessed the abilities to get on well with the group would be most likely to survive and, more importantly, reproduce. Bailey suggests that our psychological makeup includes mechanisms designed to promote social living (attachment behaviours, care of your neighbours) and to recognise the difference between those from your group (in groupers) and outsiders (out groupers). Any disruptions or threats to this natural sociality are aversive because it is likely to carry costs to personal and inclusive fitness. Two mechanisms for successful group living are offered by the theory. The first is a mechanism for kin recognition. If a person is assessed as non-kin, this mechanism is deactivated and a cost-benefit assessment mechanism takes over. Bailey then makes a distinction between psychological and biological kinship so that if a person is not kin, they can be recognised as a strong ally who is classed as psychological kin.

Kinship theory sees human distress as being caused by a mismatch between our modern way of living and the social groups of the EEA (Bailey, 1995). It would have been adaptive to have a strong response to strangers. In our modern world, we no longer live amongst kin or even that many psychological kin but we are rather surrounded by strangers and a suggestion is that reducing the anxiety and conflicts surrounding the mismatch stress of the stranger is a major goal of evolutionary kinship therapy. Another suggestion for therapeutic interaction concentrates on the nature of the therapeutic relationship. Since the therapist and client will initially be strangers, the therapist needs to create the warmth and satisfaction of a kin-like relationship so that the client will assess the therapist as psychological kin. Bailey cites literature from studies suggesting that the effects of social support are conducive to feelings of wellbeing, happiness and enhanced immune functioning and other
health benefits. Although there is little doubt that most kin-like relationships lead to wellbeing, kinship theory does not take into account the competitive stresses that come with some kin relationships (Trivers, 1974). It may be that a client has suffered a painful experience of being abandoned by parents who concentrated on a sibling who appeared to them to be more reproductively viable. In this case, affecting a kin-like relationship may not be suitable. However, this discussion is important for existing therapeutic theories as it suggests an alternative way of being than the detached professionalism of more analytic styles.

McGuire and Troisi (1987) attempted to build a biological theory of therapeutic change. The notion is that the quality of the client-therapist relationship exerts a physiological and psychological regulating effect on the client’s internal emotional, behavioural and cognitive systems. It is suggested that social signals are essential for the maintenance of central nervous system homeostasis and the therapeutic relationship works because the interactions between the therapist and client effect beneficial neurobiological changes. If this theory is correct, it poses interesting questions for therapists using current psychotherapeutic techniques. Firstly, it suggests that there should not be a need for psychopharmaceutical therapy, which at the present does not seem to be the case. Many counselling psychologists see clients that have been treated with some sort of drug therapy. It also suggests, however, that drug therapy may be detrimental to the efficacy of the talking therapies. Finally, if a therapist is able to offer the client the social signals that she needs for homeostasis, should this not suggest that the change should be more permanent than appears possible in therapy in it’s present state (Roth & Fonagy, 1996).
Ragson, McGuire & Troisi (2000) argue that an evolutionary perspective suggests that there will be gender differences in psychotherapy response and that research should be conducted into gender-related psychotherapy questions and also the possibility of gender matching. However, the arguments they use are not supported by relevant data and they merely offer what they call “clinical intuition”. Much of their argument is based upon so-called sex differences in the energy and time invested in offspring and the differences in types of preferred social interaction between the genders. An example is that they suggest that males bond less intensely with peers than females and prefer to be in hierarchical groups and this will have an effect on psychotherapeutic outcome. This, however, is not the view offered by Kirkpatrick (2000) who outlines an evolutionary explanation of human homosexual behaviour which suggests that same-sex alliances are reproductively advantageous as they reinforce reciprocal altruism. It appears that the evolutionary literature on gender roles is still very divided. This may suggest that these explanations do not take into account the social construction of gender. It may also be that, by offering gender role explanations, evolutionary psychologists are becoming too involved in providing stories for all behaviours. By taking a step back, for example by suggesting that all humans have attachment mechanisms of some sort which will then be activated according to their environment, it may be easier to create an evolutionary psychotherapy that maintains a phenomenological style.

**Cognitive Restructuring**

Intelligence, and the capacity for self-reflection, is our most distinctive human adaptation. Whereas many cognitive theorists argue that distorted cognitions lie at the root of most human distress and mental pathology (Beck, 1987), evolutionary
cognitive theorists add a major element to this traditional approach (Gilbert, 2000). The suggestion is that the inner world of a person is not only made up of the self and all the sub-selves (Gilbert, 2000) but this world also contains the ancestral mind of our evolutionary past. This does not mean that there are such things as innate thoughts but rather that the design of the brain is such that motivations, emotions and thinking is biased in directions that favour survival proximally and inclusive fitness distally. This leads to the fact that writers about evolutionary cognitive therapy investigate “distorted cognitions” (such as anxiety or depressive thoughts) from the point of view that they were adaptive biases once and it is through this understanding that they can be restructured if they have become maladaptive in the present time.

Gilbert (2000) offers a new approach to cognitive therapy, which uses much of the original techniques such as education of the client but includes an evolutionary explanation of how their symptoms may have been previously adaptive in the form of a shared formulation. A major addition to the theory comes from the use of ranking theory and submission in the face of behaviours that are seen as aggressive or attacking. Gilbert (2000) suggests that the human mind has evolved to be sensitive to attacks from conspecifics and that a useful way of avoiding aggression is to submit or show symptoms of depression until you are forgiven and brought back into the social group. He notes that the psyche is rarely seen as one integrated system but rather as various, often competing, motives, desires and ambivalent cognitive processes. He names these our sub-selves (Gilbert, 2000) and suggests that if one of these selves starts to attack another (for example, we call ourselves “stupid”) it may be that the mind’s reaction is to take a defensive, depressive position to protect itself from this attack. The therapist’s job in this situation is to attempt to teach the client about the “internal social conflict” and to engender more warm and compassionate cognitions in
order to allow the defensive behaviour to cease. In other words, the therapist needs to activate a care-giving mentality in the client towards herself.

This is an interesting view of cognitive therapy for the counselling psychologist as it appears to be integrating the traditional skills with a more humanistic and phenomenological stance while also taking into account a psychodynamic view of human distress in the form of competing inner worlds. It allows the client to be viewed from a non-pathological point of view while at the same time giving importance to the personal cognitive meaning of her situation.

**Evolutionary explanations of existing theories**

There have been other efforts to integrate an evolutionary explanation with existing theories. Stevens (2000) suggests that Jungian archetypes are similar to the innate strategies or algorithms suggested by evolutionary theory. Unfortunately, Jung followed Lamarcke’s now discredited ideas of inheriting behaviours that previous generations had learnt. However, it is possible to conceive of archetypes as innate neuropsychic structures that evolved by natural selection to accomplish certain goals. In this view, psychopathology can be understood to be a result of archetypal strategies malfunctioning due to environmental insults at critical stages of development. MacLean’s (1985) triune brain can be related to the psychoanalytic model of the mind whereby the neocortex might by the ego, the limbic system the superego and the brain stem the id. It is interesting that psychoanalytic theory suggests that human distress is caused by the constant struggle between these three parts and in a similar way MacLean (1985) suggests that people become distressed when the three systems are out of sync. While these theories are interesting academic arguments, it is difficult to
see how they may influence or add anything new to the therapeutic literature other than providing a framework for a possible unification of diverse theories.

Shapiro and Gabbard (1994) attempt to show how the evolution of the mind and cultural evolution are inexorably linked. They suggest that the development of civilised society and promotion of individual genetic survival in communal groups depend upon both altruistic and cooperative strategies. Language is seen to have developed as a way of enhancing cooperative efforts which in turn forms the foundation for self-awareness and the higher motivational systems of attachment, mastery and meaning (Lechtenberg, 1989) that come to full play in modern human society. The need for attachment has influenced psychodynamic literature towards an emphasis on object relations and developmental psychology has been influenced by the human need for instrumental mastery (Piaget, 1954). Finally, the search for meaning is uniquely human and satisfies the fundamental existential need to understand one's place in relation to the phenomenal world (Frankl, 1963). Shapiro and Gabbard (1994) suggest that the intrapsychic processes central to psychodynamic theory – affects, motivation, mechanisms of defence and patterns of interpersonal communication – have evolved in the course of natural selection. Through the application of an evolutionary framework these phenomena can be better understood as leading to the creation of a more coherent picture of human behaviour and psychopathology.

Discussion

The theme that runs most strongly through the literature reviewed here is that by using evolutionary theory as a framework for the study of human behaviour, it becomes
possible to include multiple variables in the causal analysis. An evolutionary explanation can encompass variables such as ultimate causation (i.e. kin investment), social mentalities, the effects of attaining or failing to attain biosocial goals, possible direct genetic links, ancient design effects on the mind, past and current environment and the interactions between these factors. The idea is that we take both a long, historical view of human nature and at the same time look at individual variation. The theory may appear reductionist in that there is the assumption that when we talk about an evolved mind, there must be a direct link between genes and behaviour and at some level this may be true. For example, we may have hardwired social mentalities (Gilbert, 1989) that predispose the infant towards care eliciting attachment behaviours (Bowlby, 1969). In the same way, we may also have kin-recognition systems (Bailey, 1997b). However, that does not mean that this is a reductionist view. Environmental effects are considered paramount to an explanation for an individual’s state of mind. Humans are seen as a highly social species that is significantly influenced by the social environment and significantly influences the environment. The child who is thwarted in its attempts to elicit care may learn disorganised attachment behaviours. A human evolutionary view should take into account that human behaviour is the sum of culture, intelligence and evolutionary causal forces (Plotkin, 1997). Indeed there is an important relevance of culture to the study of the mind. Culture is seen as more than the sum of its parts in that it is more than a collection of individual minds. There needs to be a mass agreement among the participants for culture to develop and when this occurs culture can begin to have an effect upon the minds of participants. It is a question of whether modern culture can effect selection although it is probable that modern cultures change too quickly for any trait variations to enter the population.
The evolutionary views of psychopathology examined earlier have commonalities that may have relevance for counselling psychology. The general theme involves a step away from the biomedical model and offers an explanation that suggests that many conditions are traits that have been previously adaptive. The suggestion is that in order to understand why a person may be employing the behaviours, cognitions, feelings that she is, a therapist must investigate aspects of her social and physical environment as well as her inner world. In this way, aspects of psychodynamic, cognitive, humanistic and existential theories are unified in the assessment process. At present, counselling psychologists are trained in a series of almost discrete therapeutic theories and are invited to find their own way to integration. By adopting an evolutionary approach to psychopathology, a therapist is attempting to view the client holistically.

In the past two decades there have been more than one hundred research reports published concerning the therapeutic relationship and many of these writers have suggested that the therapeutic relationship is more important for psychological change than the technique employed by the therapist (Roth and Fonagy, 1996). By emphasising the social nature of people and by offering suggestions that the human mind contains mostly unconscious, possibly modular-like social mentalities that will respond to a relationship with another, evolutionary theory suggests reasons for the importance of the therapeutic alliance. Kinship based therapy (Bailey, 1997b) suggests that the therapist needs to activate the kin recognition system in the client and hence advocates a warm, unconditional attitude from the therapist which is similar to that described in humanistic theories (Rogers, 1957). Gilbert’s (2000) call
for a teaching of inner warmth and compassion in cognitive therapy suggests a similar way of being for the therapist. This is relevant for the counselling psychologists who may have been trained in both classical cognitive and psychodynamic approaches and may feel that they have to change the emotional level of the relationship accordingly. Gilbert (2000) suggests that emotional warmth is essential to cognitive therapy and Bailey’s kinship theory would suggest a move away from the colder technical styles of traditional cognitive therapists and the depersonalising attitude of some psychoanalytic approaches.

Ragson, Mcguire & Troisi (2000) argue for further research to be conducted into gender differences in therapy. They suggest that evolutionary theory points towards specialised gender roles, which will lead to behavioural and emotional differences in the therapeutic setting. Their argument here is weak as they admit that previous gender matching research has not offered any evidence for this necessity and that their ideas are a result of their own intuition. It is possible that they take evolutionary psychology too far in its predictive powers. Their predictions rely on the assumption that females invest more than males in their offspring and that this leads to role related behaviours and emotions. This assumption has been questioned by evolutionary researchers (Einon, 1997) and is shaky ground upon which to make such grand scale sweeping statements that seem deterministic in nature. They do not take into account the social construction of gender nor do they take into account homosexuality. These kinds of deterministic accounts of behaviour also do not take into account human intelligence and the power of culture (Gould, 2000) and authors should be wary of making claims about the EEA that can never be answered. By concentrating on the importance of the proximate causes such as the biosocial goals of
status or friendship, behaviours that apparently undermine reproductive success are understandable. For example, a celibate priest may find more pleasure in his high status role than in the thought of his 'male gender role'.

Modern evolutionary theories have suggested that altruism (both kin directed and non-kin reciprocal cooperation) is an ancient evolved strategy that is vital to personal survival and inclusive fitness. Shapiro and Gabbard (1994) take the notion of altruism as an evolved adaptation a step further and consider altruism from a therapeutic and evolutionary perspective. They state that altruistic behaviour in the past has been regarded as a defence mechanism designed to deal with selfish motives. They offer an alternative view that self-interest and altruism are in fact fundamental, balanced motivational systems. These give rise to higher motivational systems such as object relatedness (attachment). Shapiro and Gabbard (1994) state that to view altruism as purely defensive does not take into account the fact that altruistic behaviour derives, in part, from complex internal object relations. This may be an interesting notion for investigating the therapeutic relationship from both the point of view of the client and the therapist. There is a possibility that people who become therapists may find the cooperative, perhaps altruistic, nature of the therapist role fulfilling and this may be because, perhaps due to environmental pressures, they are adopting an altruistic adaptive strategy, which in the past they have found useful. Taking a species wide view, altruistic and cooperative (possibly kin-like) relationships are said to make us feel warm and safe. In our present environment where people we know and love no longer surround us we do not have the same opportunities to display such behaviour. The therapeutic relationship, with its kin-like, altruistic nature, offers people such an encounter and the satisfaction this may give people could go towards explaining the
current phenomena of the explosion of people entering into therapy. At the same
time, it could offer explanations for the limitations of short-term therapy and the over-
dependence of some on long-term therapy.

**Conclusion**

In the last few decades, writers have been using an evolutionary framework to
develop a psychotherapy that encompasses more aspects of human life than existing
individual theories. This has relevance to counselling psychologists who at present
are left to pick and choose theoretical approaches as they see fit according to their
client. Evolutionary theory suggests that humans are social creatures that have
evolved mentalities that guide us through our social environment. By taking such a
wide view of human nature, it is possible to add to the existing theories of human
nature and find a way toward unification.

Some writers rely on explanations of human behaviour that they have developed after
assuming knowledge of the physical state of the environment in which humans
evolved. This may be a mistake as the only part of the EEA that writers can agree
upon is the social environment. It is also a mistake to fall into the trap of determinism
and forgetting the importance of culture and intelligence to human behaviour. The
evolutionary psychotherapy model reviewed here suggests that the existing theories
such as psychodynamic, cognitive, humanistic and existential theory should be
considered with the added thought of the ancient evolved mind that we carry as well.
Human distress should be assessed in relation to the person’s environment both social
and physical, which biosocial goals are important to that individual and whether they
are functioning in a way in order to attain them, and the ancient design effects on the mind.

Evolutionary psychotherapy also suggests that the therapeutic relationship is a powerful mediator of change in therapy. Psychopathology is seen by some to be the result of previously adaptive behaviours becoming problematic to the person in their current environment. Through offering the client an experience of a warm, kin-like and/or an altruistic, cooperative relationship, the therapist may be able to activate mentalities that will reduce the level of distress felt by the client. In our modern social environment we often do not get the chance to behave altruistically either to kin or non-kin. This could be a reason why people (both the client and the therapist) are looking for such a relationship in the safety of the therapeutic setting and this is an area of interest for future research.
References


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Gay men's reflections on experiences of life without children: A grounded analysis

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While lesbian and gay parenting is receiving considerable research attention, the majority of gay men in Britain live without children of their own. This study explored the reflections of 18 gay men, who have never fathered a child, on their life without children. The data were analysed using grounded theory. The analysis resulted in the construction of a theoretical model incorporating the impact of societal attitudes, the gains, losses and ambivalent feelings towards a life without offspring, the effects of culture and the distinction between a desire to nurture and a desire to father a biological child. This study was seen as contributing to an expanding knowledge base from which therapeutic practitioners can inform their practice with gay men who raise these issues in therapy.
Gay men’s reflections on experiences of life without children: A grounded analysis

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Abstract

While lesbian and gay parenting is receiving considerable research attention, the majority of gay men in Britain live without children of their own. This study explored the reflections of 18 gay men, who have never fathered a child, on their life without children. The data were analysed using grounded theory. The analysis resulted in the construction of a theoretical model incorporating the impact of societal attitudes, the gains, losses and ambivalent feelings towards a life without offspring, the effects of culture and the distinction between a desire to nurture and a desire to father a biological child. This study was seen as contributing to an expanding knowledge base from which therapeutic practitioners can inform their practice with gay men who raise these issues in therapy.

KEYWORDS: Children, gay, generativity, nurturing, qualitative.

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Introduction

Throughout history, homosexual/gay men have fathered children and fulfilled parental roles. Parenting for a homosexual/gay man, however, often meant living in a heterosexual relationship or at least not having an open homosexual/gay identity. Indeed, today many gay male parents have had children within the context of heterosexual relationships/ marriages prior to 'coming out'. Recent developments in societal thinking (Weeks, Heaphy & Donovan, 2001) and research on gay and lesbian parenting issues from America (Armesto, 2002; Baum, 1996; Beers, 1996; Bigner, 1999; Crawford & Solliday, 1996; Laird, 1993; McIntyre, 1994; McLeod & Crawford, 1998; Patterson, 1992, 1994, 1995, 1997, 2000; Rooney, 2002; Sbordone, 1993) and from Britain (Barrett & Tasker, 2002; Clarke, 1999, 2000, 2001, 2002a, 2002b; Golombok & Tasker, 1994; Hargaden & Llewellin, 1996; Harris & Turner, 1986; James, 2000; Saffron, 1996; Tasker, 2002; Weeks, Heaphy & Donovan, 2001) has meant that issues concerning gay men choosing to become parents have received raised prominence in both academic and social arenas. While this research is important, it tends to obliterate the fact that the majority of gay men, especially in Britain, are remaining childfree (Hargaden & Llewellin, 1996).

There are many reasons why a gay man might be living without children of his own. The most obvious reason would be that the man has made a considered decision in favour of a life without children of his own and feels that he benefits from this decision (for example, in terms of having more disposable income and greater freedom). Another reason could be that the logistics of setting up a surrogacy arrangement or finding a suitable (often lesbian) co-parent may seem too difficult or daunting (see Touroni & Coyle, 2002, on the potential difficulties of this from a lesbian perspective). A man may feel that his social context is too prejudiced against gay parenting for him to feel comfortable with the idea of himself parenting and he may worry about the effects of social attitudes on a child. It may be that he is from a generation for whom having children was not an option for gay men or he may be someone with HIV or AIDS which could affect his decisions concerning his future. Homophobic articles in the media have portrayed gay men who show an interest in children as bad role models in terms of orienting the child’s sexuality towards
homosexuality, which is seen as harmful for the child (Clark, 1999). At other times, the media have suggested that gay men who have contact with children only do so for their own paedophiliac motives (Gamson, 1998). These factors may contribute towards encouraging a gay man not to give serious consideration to the possibility of having a child, even if he experiences strong parenting urges. Despite this, research has suggested that the desire to parent may be relatively common among gay men. Beers (1996) and Sbordone (1993) have both measured the desire to parent in gay male samples and both found that about 50 per cent of their sample of gay men without offspring expressed this desire.

Since it seems that there is a substantial population of gay men living without offspring, it seems strange that their voices (as gay men without children) are missing from the psychological and sociological research literature on gay men. There is some research looking at the experiences of heterosexual men who do not have children of their own (Bram, 1985; Gerson, Berman & Morris, 1991; Krick, 1988; Lunneburg, 1999; MacNab, 1986; Somers, 1993) although they are a minority voice compared to heterosexual women without children (Ainsworth, 1996; Gillespie, 2003; Jeffries & Konnert, 2002; Letherby, 2002). This literature suggests that, if the childlessness was voluntary, the men described themselves as satisfied with this aspect of their lives (Somers, 1993) although they perceived themselves (and others perceive them) as selfish, irresponsible and uncaring compared to childless heterosexual women. The childless women were in turn perceived more negatively than married women with children (Jamison, Franzini & Kaplan, 1979) which exemplifies the pro-natal bias of modern society (Gold & Wilson, 2002). Of course, what little literature that exists on heterosexual men without children may not be wholly relevant to the specific life experiences and views of gay men without children.

One possible reason for the lack of research into the experiences of gay men without children could be the assumption that gay men are not interested in parenting (Barrett & Tasker, 2002) and so, when framing research questions on gay lives, the possibility that it might be worth exploring this issue does not arise. Gay men may also find themselves living in a (sub)culture that can be singles-oriented and unsupportive of
parenting and so they find themselves unable or unwilling to voice their desire to parent or their feelings about not having children (Bigner, 1999).

As suggested in the research conducted into the experiences of heterosexual men without children, it would be expected that if a gay man had chosen - without any influence from societal prejudices or conditioning - to remain childfree, he would probably experience satisfaction with this situation, even if, at times, he had periods of regret about or merely reflection on his decision. If, however, he felt that a childless life had been imposed upon him in some way, he might experience periods of grief at the loss associated with giving up the idea of parenting or even periods of confusion or identity ambivalence as he may feel that he has to give up fatherhood in order to self-identify as gay. As well as the internal struggle, he will be living in the broader context of a world that values parents while viewing childlessness in terms of wasted potential and lack of “natural fulfilment” (Hargaden & Llewellin, 1996).

Deciding whether or not to have children or coming to terms with living a life without children could be, for some, a difficult issue that may arise in a therapeutic context. Whether or not it causes distress, gay men’s experiences of living without offspring may not be something about which many (especially heterosexual or even lesbian or bisexual) therapists have an understanding. While it is important that therapists view each client’s experiences as individual and special to that client, it could be uncomfortable for a client to be in the position of educator with respect to the therapist. In a qualitative study looking at the views and practices of clinical and counselling psychologists working with gay and lesbian clients, Milton & Coyle (1998) reported that client participants reflected on the importance of therapists having some knowledge of the client’s world in order that the client did not feel like she or he was instructing the therapist. Counselling psychology is committed to anti-discriminatory practice (British Psychological Society Division of Counselling Psychology, 2001) and it is up to all counselling psychologists particularly to take the lead in developing an affirmative psychology that aims to understand and empower the experiences of groups such as gay and lesbian clients who have previously often been discriminated against (Kitzinger & Coyle, 2002).
The experiences of gay men living without offspring have not been explored in psychological literature and yet these issues could arise in a therapeutic context. There is, therefore, no psychological or sociological theorising that is suitable for helping therapeutic practitioners to understand these men's experiences. This research investigates the experiences of a sample of gay men who are living without offspring. The aim is to analyse the data, using grounded theory, and elucidate a localised theory from the data that will account for these men's experiences and reflections. The development of localised theory is felt to be important in this case as a more macro-theorising approach may miss the personal nuances that might explicate the experiences of this sample. While it is recognised that a female heterosexual mother (the author of this research) may not easily be able to represent the experiences of gay men without children with complete confidence (Wilkinson & Kitzinger, 1996), this research could be seen as an attempt to present a conversation between gay men without children and a female heterosexual researcher who is a parent. It is hoped that this conversation will offer a view of these men's experiences that can help therapists to better understand their clients who may present with issues relevant to those that are explored in this study. Throughout the article, text that appears in italics and between square brackets concerns personal reflections by the author on aspects of the research process.

*Do gay men want children...?*

[The idea for this research began to formulate during a literature review in the field of evolutionary psychology. I was struck by the almost complete absence of discussion concerning gay, lesbian and bisexual sexual identities (for exceptions see Bagemihl, 2000; Kirkpatrick, 2000) and how these may fit with evolutionary psychology theories. There are many discourses about differences or similarities between male and female heterosexual reproductive strategies and I wondered how gay and lesbian sexuality fitted into this way of looking at human behaviour. I found myself thinking "Do gay men want children?". From my personal context, I did not know any gay men who were parenting although I did have friends who had had a baby while in a lesbian relationship. I soon received an answer to my question from a gay friend. I found out that I was pregnant and on telling my friend the news he]
replied that he would love to have a baby. Excellent! A perfect excuse for starting a conversation! “Do gay men want children?” I asked...

Method

Participants

Participants were recruited who self-identified as gay men and who had never fathered a child. Three participants were recruited through a gay and lesbian social club in a small rural town in the south west of England. The researcher handed out information sheets about the research (see Appendix A) and men who were interested contacted her by email. Four participants were recruited through social contacts and were based in London. These people had heard about the research and expressed an interest in taking part. The first four participants to be interviewed described themselves as White British. In order to avoid the sample becoming too homogenous with respect to ethnicity, the remaining participants were chosen because they described their ethnicity as other than White British. This technique of recruiting participants as the analysis progresses in order to add new and different voices to the data set is known as theoretical sampling and is an analytic tool of grounded theory (Glaser, 1978). Information about the research was also posted on a message board at a British gay internet chat site and three participants were recruited this way. Members of the internet site were also invited to post their views on the research topic: comments were received from eight men and were included in the data set.

Interview Schedule

Before the interviews began, ethical approval was obtained from the University of Surrey Advisory Committee on Ethics (see Appendix B for a copy of the letter of ethic approval confirmation). Ten men were interviewed face to face at locations convenient to both the participant and the researcher. The interviews lasted about an hour and were audio-taped and later transcribed verbatim. The interviews began with a brief explanation of the research aims. An explanation of the unstructured interview schedule (see Appendix C) and consent form (see Appendix D) was then offered. It was explained that the interview would take the form of a “directed conversation” (Mischler, 1986) so that the participants should feel free to tell their own stories and that the role of the researcher would be to help the participant to explore and expand
on his experiences. The participant was then given a demographic questionnaire to fill out after which the interview began. The interview schedule was created through discussions with key informants (Gilchrist, 1992) (gay men who were living without offspring but who were not participants in the research) and through brainstorming sessions with the researcher and her chief research supervisor (a gay male psychologist who has research interests in gay and lesbian psychology). The interview schedule started with questions concerning the participant’s family, ‘family of choice’ and any children with whom he felt he had significant relationships. The participant was then handed a ‘time-line’ and asked if and when he had ever thought of fatherhood and what he felt might have been going on in his life at that time. The final section concentrated on more general questions concerning societal attitudes and the attitudes of his social circle. At the end of the interview, the participant was asked if there was anything he would like to add and then was thanked for taking part. Throughout the interview, the researcher’s style of interaction was based on methods used in counselling sessions (Coyle, 1998) with the aim of enabling the participant to feel understood and listened to in an empathic manner (see Appendix E for copy of a transcript of an interview). The interview schedule was piloted on two participants in order to check for relevance of questions to the participants and to check how long the interview took.

Analytic Strategy

The data collected from the interviews and the web-site were analysed using grounded theory (Glaser & Strauss, 1967; Pidgeon, 1996; Pidgeon & Henwood, 1996; Charmaz, 1995, 2003). Grounded theory was developed as a reaction against the macro-theorising that dominated sociology in the 1960s. The aim of grounded theory was to produce localised theorising which was grounded in people’s accounts of their lived experience. The roots of grounded theory are in the symbolic interactionist perspective that sees an individual’s world as involving the interplay of systems of meaning embedded within a social context. This research was concerned with investigating gay men’s accounts and reflections on lives without offspring and elucidating an emerging localised theory which could be used by therapeutic practitioners to further understand the experiences of such a client group. It seemed appropriate therefore to employ an analytic strategy such as grounded theory that
would allow close inspection of qualitative data resulting in localised and contextual theory that would be relevant to the participants. Since the researcher was unable to find any literature concerning gay men’s experiences of living childfree lives, it was important to employ a methodology that is not driven by testing hypotheses that have been built from previous theoretical knowledge. Grounded theory is suitable for the development of localised theorising on topics on which existing theorising is incomplete, inappropriate or absent (Henwood & Pidgeon, 1994).

To break open the data (Chamberlain, 1999) each transcript was given a code initial and each line within the transcripts was numbered. Starting with one transcript, an indexing system was initiated by taking units of meaning in turn (that is, a phrase, sentence or longer extract that was seen as constituting a discrete point) and giving this a category name which captured its essence; this name was recorded on a category card along with the datum that gave rise to it (and an identifier of its location in the data set). As this analytic process unfolded, the number of category cards grew, although when data were considered examples of existing cards, they were simply added to those cards (with the category name being altered if necessary to accommodate the new data). As the categories developed they were constantly compared (Glaser & Strauss, 1967) so that links could be made and recorded which would be vital at a later stage of analysis. Links between categories were made when an extract of data used as an example of a category was seen to have relevance to other categories. At the same time, the researcher created ‘theoretical memos’ to record any changes in card names, any splitting or amalgamations of cards, any thoughts that the researcher had about possible connections to existing theoretical literature or any hunches or reflections concerning the emerging theory. The analytic process is thus a creative one that both uses the interpretative powers of the researcher but also stays closely grounded in the data.

As the categories developed, the researcher found that no new examples were being produced that added new richness or diversity to the category. At this point, the category was said to be saturated. When a final set of saturated categories was produced, a detailed definition of each category was written, which summarises the commonalities between the data extracts that constitute the category. At this point, a
diagrammatic representation of the categories was created which included the links between the categories (see Appendix F). The categories were then scrutinised again and those that were seen to have become irrelevant to the research aim or to have no more than one example from the data set were abandoned (See Appendix G for a history of the category cards). The remaining categories and their links are represented in Figure 1. At this stage, a theoretical model began to emerge as certain categories, and the links between these categories, appeared to resonate most with the research aim.

Such a method relies upon the subjective interpretations of the researcher. The researcher in this case is working from a position of “other” compared to the participants as she identifies as a white, heterosexual, married mother who is knowledgeable about gay male parenting issues through academic research and through social contacts. In order to identify areas of “blind spots” (Coyle & Rafalin, 2000) the researcher underwent regular supervision sessions with a gay, male psychologist and also consulted another gay, male psychologist. The sessions took the form of the researcher explaining her understanding of the data and the subsequent analysis to the supervisors who then offered different or new perspectives. Since the methodology relies upon subjectivity, the traditional methods of evaluating research which concentrate on checking for researcher objectivity and disengagement are inappropriate for assessing this study (Henwood & Pidgeon, 1994). Instead, alternative evaluative criteria have been suggested by qualitative researchers and these include the criterion of persuasiveness by grounding in examples (Elliott, Fischer & Rennie, 1999). Meeting this criterion involves illustrating the analysis with extracts from the data so that the reader can evaluate the interpretations in light of the data. Finally, the work as a whole should be transparent so that readers may understand the motives and interpretations of the researcher as well as be able to follow arguments clearly (Yardley, 2000). This criterion is met by offering a clear account of the process and analysis of the research and by including sections (presented in the text in boxes) on the use and the effect of the self on the research process and the effect of the research on the researcher.
You're not a gay man...

["Thank you Bob, I think that that's all the questions I have. Is there anything you would like to add or to ask me?"

"Yes, why are you doing this research? I mean, you're not a gay man."

The majority of the participants asked me this question in various ways and it raised two issues for me. Firstly, I wondered why is seemed so odd to the participants that someone who is not a gay man would want to investigate this area. Are all the investigations into minority groups conducted by researchers who identify as members of that group? Am I supposed to be interested only in issues that directly affect my life? This led me to think about the second issue. How am I coming across to my participants and how has this affected the data? I suppose that my positioning in the world could be described as coming from a traditional, heterosexist background (while, middle class, married, mother of two children). I was hoping that by using some core counselling skills in the interviews that I would encourage the participants to tell their stories in their own words. However, at times I had the impression that some of the participants were “on their soapbox” (a couple of participants actually used this expression) and that I was being told about their feelings towards the traditionalists view of family life.

I also wondered whether having a conversation with a heterosexual, married woman may have led to the (perhaps unconscious) recall of heterosexist prejudices and assumptions and it could be that this came through in the data when the participants were talking about their fears for a child living in a gay parented family.]
Figure 1. Shows the revised categories in the boxes. The lines between the boxes represent the links between the categories.
Analysis

Background Information on Participants

The mean age of the interview participants was 38.4 years (range 28 – 56; SD 9.0). In terms of ethnicity, four men described themselves as White British, one as White European, one as Black African, one as African American, one as Turkish, one as South American and one as British Asian. Five men (50%) were educated to postgraduate level, four men were educated to degree level and one to diploma level. Using the International Standard Classification of Occupations (International Labour Office, 1990), eight (80%) were classified as holding professional jobs, one was an associate professional and one was classified as a clerk. Eight men described their current sexual feelings as exclusively homosexual and two men described them as mainly homosexual but with a small degree of heterosexuality; all ten men described their current sexual activity as exclusively homosexual. In terms of their current relationship status, eight men had no regular partner and two had one regular partner. None of the participants had experience as adoptive or foster parents.

The mean age of the additional eight men that responded via the web-site was 28.2 years (range 21 – 38; SD 6.1). All eight men described themselves as White and all identified as gay on their website profiles. Seven men described themselves as single and one man reported being in an open relationship. Two men did not specify their job status and (using the International Standard Classification of Occupations) four men were classified as professionals and two were students.

Analysis of the data

Analysis of the data led to a construction of a theoretical model of the participants’ experiences of living without their own offspring. Using the diagrammatic representation of the model in Figure 2, the categories and their associated links that make up the model will be presented and discussed.
Further discussions concerning links to existing literature, relevance to clinical practice and implications for future research will be presented in the overview. In the quotations that follow, three dots indicate a short pause, empty square brackets indicate that material has been left out and material that has been added for clarification appears in square brackets. Pseudonyms are used to indicate the sources of the quotations.

**Impact of societal attitudes and the media.**
Taking the box at the top left of the model, the impact of societal attitudes and the effects of the media on the participants' lives were explored. All ten participants reflected on how they felt societal prejudices had affected their decision not to have children. In some cases, remaining childfree was seen as a way of life imposed upon the men because of their concerns about how prejudice and discrimination would affect them and a child. Bob talked about a case that had attracted much attention in
the British media, concerning two gay men who brought their children back to
England from the USA:

What stops me from being able to do it is the case of the two guys who
had the twins by a surrogate mother in the States and it was the publicity
that surrounded it. It was the strength of feeling and hate that it still
generates in this country that really frightens me...and I don’t think that I
have the patience or the energy to put up with the bigotry that comes with
that fight.

John also talked about his perception of how people outside his family would react to
him parenting a child:

My main worry is how judgmental people might be, you know, and
bullying and all that. I’m sure I could raise a kid within a family unit but
it’s the outside world that’s the problem.

Some men talked about how they felt that society’s attitudes had made them feel
about themselves with respect to parenting:

You know, I grew up thinking that I was a criminal, and that is a very
hurtful and damaging thing. I know not everyone who lived before
gayness became legal feels like this but it was drummed into me so
much...and I just feel that I could never have children while I was a
criminal, you know – who wants a criminal for a father? (Mark)

Societal attitudes have influenced me a great deal. It has made an impact
on my thinking because I don’t think it would be the best thing for the
child...I think that the whole media thing has shaped my thinking...
Maybe I’ve just accepted that gay people aren’t supposed to have
children. Maybe if I was heterosexual, things would be different. I think
that society may have had some kind of an effect. (Chris)
Interestingly, at the beginning of his interview, Chris stated that he had never wanted to have children and felt that he had benefited greatly in his life from not having children in terms of more resources, time for his career and less responsibility. At first Chris said that he had not explicitly thought about why he did not want children in the first place but, as the above quotation suggests, it seems that he may have internalised some of society’s attitudes to the point where he thought of himself and other gay men as essentially unsuited to parenting. Dev talked about the difficulties he had when he ‘came out’ because he had internalised the idea that gay men do not parent. He talked about having to give up the idea of having children and experiencing this as a loss.

It was in the process of coming out because that is the first thing that people would assume in terms of sexuality – you know, clichéd thing about your mother will never be a grandmother, so that was a significant thing for me in terms of thinking about coming out. That was one of the things that would be a loss really in my life. And at that time I hadn’t really considered that there was an option so it was that I would not have children. There didn’t seem to be a viable option to be a parent and gay.

This shows how, for some gay men, the two identities of father and gay man are incompatible because of conditioning by society, especially men who belong to an older generation. It suggests how some gay men may internalise homophobic attitudes that affect their life decisions.

*Perceived possible effects on a child of living in a gay parented family.*

Some of the participants expressed concern about the possible effects on a child of living in a gay parented family. A link is drawn between this box (top right) and the previous box because it seems that the concerns that the participants had about children living in gay parented families echoed to some extent the societal and media prejudices outlined above. In other words, it seemed that the societal prejudices that the participants may have internalised, and those that are a reflection of the real world, were expressed when the participants talked about how they imagine having their own child would be.
John talks about his concern that the child would be bullied at school and how he might feel responsible:

What if he gets bullied? What if it goes really wrong, do you have to swap schools or how do you deal with this sort of thing? You would have to make the kid really really strong from the start and teach it how to cope with all this kind of thing. But you might find that the child can’t cope with it so...but then I also suppose that kids can get bullied over anything but I won’t want to give fuel. I wouldn’t want to cause someone else’s pain and misery and I just thought about my own needs and look what happened. I would go insane with worry.

This seems to show how, for John, the perceived societal pressures and effects on the child make the thought of parenting too stressful to contemplate. The image portrayed here is one of struggle as he imagines having to teach the child how to live in a hostile world. Other men talked about the differences between a gay parented family and a heterosexual family in terms of the effects on a child of living with parents of one gender:

The only problem I can see is that if a child is raised by a gay man or two gay men they may not have the influence of a female and I worry that the child may miss out of knowing how to deal with or interact with women...I don’t think that actual sexuality of the parent makes a difference but the gender issue might make a difference. (Oscar)

The interesting point about these quotations is that they all contain aspects of arguments commonly used by people who argue against gay parenting. Clarke (1999) collated a list of such arguments and it included contentions such as lesbian and gay parenting is abnormal; the ‘gay lifestyle’ is incompatible with parenting; children need a mother and a father and children in gay households suffer because of the stigma. These comments can be found in the transcripts of the participants in this research. This suggests that these men have internalised such arguments against gay
parenting to the extent that it has prevented them from becoming parents in any form (adoptive or biological).

Gains, losses and ambivalence.
The participants reflected on how they felt they had gained and what they thought they may have missed by not having children (see box named ‘Gains, Losses and ambivalence’ in the third row down in the model). Overall, most participants felt that they had gained some form of freedom and independence, such as freedom to concentrate on a career or time and money to spend in an independent way. At the same time, some men reflected on what they felt they had missed and these reflections were often painful and vivid in emotional content. The data from all ten participants was complex since they all showed ambivalence in this area. The overall impression created within the transcripts was one of the majority describing positive aspects of a life without offspring at an intellectual level but, from some men, a sadness and regret at a deeper, emotional level. It was interesting that when the men were asked about their lives without children in the present, many of them talked about the pleasures of being free of responsibility and other restraints associated with parenting. However, some men went on to reflect on what their lives would be like if they had children and it was here that some of the painful affect was evident. One explanation for this could be that many of these men do indeed live fruitful and full lives (as can be seen by their relatively high occupational status) but this does not mean that there might not also be, for some, an underlying sadness connected to living without children of their own.

Nearly all the participants commented on the financial gains of living without children.

You certainly gain in terms of finances. We have more lavish holidays than people with children...I think we can spend a lot more on ourselves. You don’t have to think about school fees...I can also work much longer hours than people with children, I can put much more into my career. (Chris)
As Chris mentions, the extra free time means that more effort can be put into careers and this can lead to a sense of satisfaction as debts are paid off and money can be saved. Many of the men talked about being “too selfish” with their money and time to have children. However, it was unclear whether they saw themselves as intrinsically too selfish or had become accustomed to an individual way of life and could not imagine giving parts of it up in order to accommodate a child.

I’m very selfish with my time, which is probably why I’ve never had any children. If I had got married and had children I don’t think that I would be who I am today. I would not have blossomed into the man I am today. I wouldn’t have been as spiritual, I would probably have been cynical, I would not be with the same woman probably. I would probably never have gone to Wall Street, which enabled me to travel to England. (Peter)

Many men reflected on the responsibility of looking after a child. Some stated that this was an area of parenting that they were pleased to have avoided. It seemed that, for some men, part of the joy of having relationships with friends’ children, but not actually parenting, was the lack of ultimate responsibility that was involved:

I think that I shirk the responsibility of knowing that it’s not just me that I have to take care of or it’s not just me, my partner and the cat, you know - it’s someone else as well. (Chris)

At the other end of this spectrum, however, some felt that they were being denied the chance to be responsible parents and that this denial felt especially unfair when they perceived some heterosexual parents as irresponsible.

It annoys me that there are all these people that just breed and abandon their children in the street and I can’t have a child...that’s bad. Anger and frustration come from this. (Nedim)
In the same way that Nedim sees the lack of responsibility differently to the other participants, some viewed freedom, the ability to be selfish and the financial gains as losses or painful features of life without children. These men talked about their lives as being empty and without substance.

Supposedly I’m free, but at the same time I’m empty. Sometimes I think there is nothing substantial in one’s life if you don’t have anything like that [children]. (Nedim)

It [having children] was something so important to me and I had always been told that they are a thing to look forward to so thinking about that not being part of my life [] left me with a feeling of emptiness. I think that having children would have grounded me, given me a focus to my life. (Dev)

An interesting point here is that the liberating and painful features of a childfree life for different men are essentially the same, namely a feeling of freedom in terms of money and time and an ability to concentrate on the self. It seems that it is the meaning that is attributed to these factors by each individual that causes the perception of whether they are positive or negative.

Some men felt that they would gain a sense of belonging to a family unit by having children. The family unit was described as being a warm, close social group of people that unconditionally accept and love you and are geographically close to one another. It seems that the men who had had a good experience of this when they were young felt that it was an important aspect that was missing from their lives and that has not been replicated by friends or other family. It seems that children are special to this feeling of family bonding:

I like the idea of the family unit, of having children, and having children in the house. (Bob)
But I am envious of people’s time with their children and the family unit. (John)

I thought that a family home with kids, I always loved relatives visiting us or us visiting relatives, we didn’t have so much distinction between young and old people and sometimes we’d mix with all ages and the whole family environment was brilliant and I’ve always wanted a younger brother and so I thought oh well one day I’m going to have a family like this with kids. (Nedim)

It seems that some of the participants saw financial gains and freedom in terms of time and career choices as being positive aspects of living without children. At the same time, however, some men spoke about a desire to belong to a family unit or a wish to have the distraction or responsibility of children in order to make their lives feel less empty.

_Culture and ethnicity._

Some men talked about the influence of their childhood, families of origin and their culture on their thoughts and feelings about living without children. Duncan described his parents as “loving and good parents” and suggested that he feels regretful that he cannot replicate his own parents’ parenting skills:

> My parents were such loving and good parents, you know, they just they were strict and yet held us and showed us that they loved us. I would have liked to have passed on what they taught me about being a parent. I feel that they taught me how to be a good, strict but loving parent.

For some men, it seemed that having a biological child was important to their families of origin and this was seen as a cultural effect. Both Oz, a black African, and Dev, whose family originated from Turkey, suggested that the cultures in which they had grown up imbibed them with expectations of having their own children. This expectation had caused them some distress when they ‘came out’, as they were unable to assimilate the identities of gay man and father, and they felt that they had to choose
the identity of ‘gay man’ over their cultural identity. They also talked about their perception of their own parents’ disappointment that they would not have children of their own:

I grew up in Nigeria and family is very important there, you know. You respect your parents and you are expected to look after your brothers and sisters. Even as a child, I thought that I would have my own family one day and so when I realised or admitted that I was gay I suppose that I had to go through some grieving for the loss of the children I wouldn’t have. (Oz)

As a child, we had so many children around the house, we always had our cousins and everyone over all the time and there was always lots of noise. So I suppose I find it depressing sometimes that I live on my own without any of the noise of family. I think that my parents worry about me living on my own...they don’t really understand it and they think I must be lonely...I didn’t really ever think that I would end up like this – it’s not what I was used to as a child. (Dev)

Oh I know my mom is upset that I won’t have any children, you know, no grandchildren for her. I know that she finds that more sad than the fact that I’m gay. You know, she is from Jamaica and she always thought that she would have so many grandchildren and she does have others but I know she would like more. (James, African American)

It seems that some of the men were describing a sense of loss of cultural identity as they took on the identity of a gay man living without children. It is interesting that despite a sense of sadness at giving up the thought of having a child, none of the men talked about a possibility of repressing a gay identity in order to fulfil their cultural expectations of a heterosexual life with offspring.

A link is drawn between the box entitled “Culture” and that entitled “Desire to nurture more important than fathering a biological child” because the some of the participants
who talked, in positive terms, about the effects of large families of origins suggested that these experiences had left them with a desire to have a nurturing relationship with children and that this had encouraged them to take on roles such as godparents or mentors.

*Desire to nurture more important than fathering a child.*

When the participants for this study were recruited, the only two inclusion criteria were that they identified as gay and that they had not fathered a child. This may have given the impression that the research was primarily interested in the experience of not having a biological child. The interview schedule, however, did not explicitly make reference to biological or non-biological parenting (although none of the participants had experience of non-biological parenting). Despite this, all ten participants that were interviewed talked about a difference between fathering a child of their own and parenting a child to whom they would not be biologically related and all the participants suggested that they believed that they felt a nurturing urge rather than a desire to father a child. For example, when Oscar was talking about his desire to parent he stated that he felt an urge to nurture rather than a wish to pass on his genes:

> With me it’s not an urge to be a biological father it’s an urge to be a nurturing father that I have. I can be nurturing to my nieces and nephews, I can be nurturing to my mates, I can be nurturing to the kids that I used to teach, stuff like that. I don’t think it’s a genetic need to pass on my genes to a future generation, it’s more of a nurturing need.

With some of the men, this seems to have been a realisation that they have come to over time:

> I suppose up until about ten years ago I had always assumed that it would be my child and now I feel that it would be as important if it was a child that needed my care and love. (Bob)
Earlier in the interview, Bob had talked about the impact of wanting to have a child on his gay identity development. He suggested that he only finally assimilated a gay identity ten years ago because it was then that he began to believe that it could become possible for gay men to adopt children. Before that, he had been reluctant to give up the idea that he would father a child in a heterosexual relationship, although he said that at a deeper level he understood that that possibility was unlikely. Once he began to believe that he might be able to adopt a child, he began a process whereby his priorities changed. Instead of concentrating on fathering a child, he began to consider what it was about parenting that was important to him. In other words, it seems that the ideas of nurturing, loving, forming an attachment and passing on cultural information became more important than the passing on of genetic information. This process whereby the urge to nurture overwhelmed the desire to have a biological child was described by all the participants. For example, Luke said:

I’m not too much concerned about being a biological dad. What is important to me is the sense of parenting, the sense of nurturing, teach them the names of all the trees and flowers, finding starfish in the rock pools and making them better after they have cut their knee. I know how much my parents mean to me and I would like to give someone else that feeling.

It could be that due to societal prejudices or internalised homophobia that have made parenting seem unlikely or difficult to these men, they have been left to think about their desire to parent in a deeper way than heterosexual men or women need to do. Through having this time, and perhaps through an internal dialogue with heterosexist attitudes to parenting, they may have examined their motives for parenting in a more comprehensive manner and come to the conclusion that it is an urge to nurture not an urge to procreate that they are feeling. It is possible that some men who expressed a desire to parent are using this discourse as a reaction formation to avoid painful affect surrounding the knowledge that they may not father a child.

As the model shows, there is a link between the desire to nurture and the gains of life without offspring. This link was made by participants who stated that they preferred
to be able to have nurturing relationships with children that were not their own (godchildren, for example). Some participants said that they found that their desire to nurture was not being fulfilled as they did not have their own child and it made their feeling of loss more poignant.

Many of the participants who have either chosen not to parent or who cannot for various reasons see themselves parenting talked about ways in which they felt they were expressing their parenting or nurturing urges (see the box at the bottom of the model). Duncan, Oscar and Eric talked about working with children:

I work in schools and I get close to some of the children I teach piano to, I get very close to. (Duncan)

It was during this time [coming out] that I decided to become a teacher. There are a lot of gay people in teaching and I’m sure that this is a sublimation of wanting to be a parent. I think it was for me. I had a lot of desire to help kids, and I came to the decision that I couldn’t be a parent and so I’ll teach instead. (Oscar)

Yes I do, and as such I joined the Essex Youth Service as a volunteer to help out at youth clubs, that way I can help and care for kids, and feel generally useful. It is like a surrogate family. (Eric)

Chris was one of the few interviewees that did not express a desire to parent stating that he enjoyed the freedom of having more time and money to spend on himself and his partner. He did, however, suggest that their cat was a surrogate child to him and his partner and that their bond with the cat was strong:

We call ourselves his Daddies, it’s almost like the only thing that we won’t be doing is sending him to school...we spend a lot of time playing with him...we think he’s a very well brought up cat.
Peter made a distinction between procreation and passing something of yourself (cultural rather than genetic) on to the next generation:

Some people have children to carry on the human race, well other people are doing that. But I think another part of having children is imparting a little bit of you on them. They don’t have to be biological children to do that. You know, mould another person onto being something good, you don’t have to be a biological parent to do this. It’s a great feeling to pass this on to a young person and it doesn’t matter if this person isn’t my child. Anyone’s a parent just not always a biological parent.

The relationships that these men are describing seem to be concerned with teaching, caring for and being attached to a child (or a pet). It seems that not only do these men feel that a nurturing bond with a child is more important than a genetic bond but that they have found satisfaction in expressing this nurturing urge, at times to the point of basing their career or much of their leisure time around activities that allow such expression.

[I feel that I have benefited from being able to take the time to immerse myself in a world that is a step removed from my own experience. I have been able to think at length about the nature of the construct of sexual identity, to examine my assumptions, prejudices and understanding of same sex sexualities and how these may affect my work with gay or lesbian clients. I have also wondered about the intense feelings that it raises in society and it is here that there have been some disappointments. Usually, when I tell people about my research it sparks a great deal of interest and lively conversation. Sometimes, unfortunately, people have reacted in a negative, prejudiced way. At these times, I find myself having to gather strength to attempt to begin a discussion and elucidate the heterosexist assumptions of traditional family life. I have found, however, that some people are not interested in discussions and I have found this view of the world depressing. When reading research about gay and lesbian parenting and affirmative psychology, it is easy to begin to think that the
world is changing in a positive way, but sometimes real life seems to be far removed from academia. Indeed, I was struck by how little the participants in this study knew about gay parenting issues. John said that he would love to hear from anyone who was parenting as he felt too isolated at present, with his desire to parent, to contemplate a life with children.

Overview

Whilst research into gay parenting is important, it seems that many gay men in Britain are living without offspring and this research aims to begin an investigation into the experiences of such men. The model presented attempts to offer one understanding of the experiences of the participants in this research. The top line of the model looks at the impact of societal attitudes on the participants and their reflections upon what they feel it might be like for a child to live in a gay parented family. These two boxes are linked as it seems that some participants may have internalised attitudes normally seen as part of homophobic or anti gay parenting discourse, or that they are reflecting societal prejudices and these attitudes and beliefs seem to be represented in their worries and concerns about a child living in a gay parented family. The third line of the model looks at the gains and losses that the participants felt were a result of living without offspring. These are linked because the data here was complex with ambivalence and differing levels of affect suggesting that most of the participants felt some sadness at not having offspring while at the same time where able to feel the benefits in other parts of their lives. The fourth line of the model reflects that all the participants stated that they felt they had an urge to nurture a child rather than procreate. This is seen as a gain by some men because they described nurturing relationships with other significant children in their lives while other participants saw this in terms of loss as they suffered a frustrated desire to nurture. The final line of the model looks at how some men have found ways to express their desire to nurture.

The concerns expressed about the effects on a child of living in a gay parented family are interesting when compared to available research literature. Recent research investigating children living in lesbian and/or gay parented families suggests that
these children feel that they experience positive benefits (Tasker, 2002). Patterson (1997) posits that children of gay and lesbian parents show no developmental differences to those brought up in families with heterosexual parents. While this may indeed be the case, it is interesting that this kind of positive research has not filtered through to the men in this study. It may be that the research has been conducted on groups or families living in areas that are more liberal than the social contexts of these men. If this is the case, the validity of such research needs to be questioned.

The distinction that the participants made between a desire to nurture and fathering a biological child is interesting from the viewpoint of evolutionary psychology and attachment theory (Bowlby, 1988). Modern evolutionary psychology suggests that human mental suffering revolves around the dynamics of social relationships. Gilbert (2000) outlines various “social mentalities” which he describes as motivational psychological mechanisms, or in other words, behaviours which make us feel better. One of these social mentalities involves care-giving behaviours and can be seen as coming under the more general umbrella of attachment behaviours (which encompass both care-eliciting and care-giving behaviours). It could be said that the men in this study are describing their desires towards care-giving behaviours and that this is more important to human behaviour and happiness than passing on genetic material.

A different way of looking at this desire to nurture is to see it in terms of Erikson’s (1968) notion of generativity. Erikson (1968) posits that in order to successfully negotiate a certain stage in life (the generativity versus stagnation stage), between the ages of 25 and 50, people need to develop a way of passing something of themselves on to future generations. This is usually resolved in parenting but can find expression in more creative, cultural ways. The participants described nurturing relationships that also include an element of teaching, moulding and passing on skills to future generations that could be argued to be addressing the resolution of generativity. In a study looking at the desire to parent among gay men, Beers (1996) found that gay men who parented children that were not biologically related to them showed high resolution of generativity. He suggested that this reinforced Erikson’s concept that the transmission of ideas, values and culture to another generation is the important factor in parenting rather than ensuring the survival of one’s genes. This notion can
be combined with the idea that it is the expression of attachment based behaviours that provides a sense of security rather than genetic procreation. These ideas reinforce some of the participants’ views that their preferred way of life is to have a number of significant children with whom they have nurturing relationships.

It is impossible to hypothesise about cause and effect from this data set and so this model is restricted in that it only offers links between the categories in the model. However, a tentative question that arose from the data concerns the impact of the internalised homophobic, or anti gay parenting discourses and whether these attitudes and discourses were related to the process that led to these men to live without offspring. A further limitation of the study concerns the sample which largely consists of men who had given serious consideration to issue of gay parenting and for whom having no children was a noticeable absence in their lives. It would be interesting to expand on this study by using participants who had differing opinions about their lives without offspring. The present sample was well educated. Barret & Tasker (2002) report that typical samples of gay men in parenting research contain participants who are highly educated and from unrepresentatively high income brackets. If time had not been a constraint in this study, it would have been interesting to theoretically sample participants from other socio-economic backgrounds.

From a therapeutic point of view, the fact that these men may have internalised homophobic attitudes towards gay parenting suggests that working with such client groups using an affirmative psychological model may be complicated. Broadly speaking, affirmative psychology aims to place gay, lesbian or bisexual identity as equally positive as heterosexual identity (Davies, 1996). This may become difficult, however, if the client, like these men, have internalised homophobic or heterosexist attitudes. Clark (1987) has suggested that that affirmative psychology should concentrate on reliving and working through experiences of oppression and attempting to undo societal conditioning. It could be said that the participants in this research may benefit from a therapeutic approach that encourage exploration of the effects of societal conditioning.
The theory generated in this study should be seen as localised to the participants and should be seen as expanding the knowledge base from which counselling psychologists and other psychotherapeutic workers can inform their practice (Corrie & Callahan, 2000). It is hoped that it will spur other researchers to continue to investigate this area, perhaps by using a sample from a wider socio-economic background, or investigating the effects of internalised homophobia on a person’s decision to live without offspring.
References


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Information sheet for participants

**Title:** Enforced childlessness, childfree choice and other possibilities: a grounded analysis of gay men’s reflections on life without offspring.

**Author:** Frances Gillies – Counselling Psychologist in Training, PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

**Supervised by:** Dr Adrian Coyle and Dr Martin Milton

My name is Frances Gillies and I am currently undertaking a doctoral training in Psychotherapeutic and Counselling Psychology at the University of Surrey. For my doctoral research, I am interested in interviewing gay men who have never fathered a child. At the moment, there appears to be lots of research into gay men as parents. While I feel that this is important and necessary work, I also feel that there are many gay men who have not had children (either through choice or through circumstances) but we know very little about these men’s situations and how they feel about them. If you are a gay man who is not a biological father, I would be interested in interviewing you and hearing your reflections on living without children of your own.
My interest in this area comes from both personal and professional experiences. Personally, during a recent pregnancy, I began to talk to gay male friends about their wish for or their lack of wish for their own children. Professionally, as a trainee counselling psychologist, I have worked with gay clients who have found it difficult to imagine being a parent and who were experiencing some unhappiness because of this. I felt that, as a heterosexual female psychologist, I had little understanding about how it feels to be gay and to have to deal with the issue of having, or not having, children. Although there is now some research which has looked at the experiences of gay men who are fathers, we know very little about what it’s like for gay men not to have children. I felt that if I were to conduct research on this issue, it might help therapists who find themselves working with gay male clients.

If you were to take part in this research, it would involve a face to face interview with me which would last about an hour. We could arrange to meet at a time and place convenient to you. The interview would be taped and later transcribed by myself. I will take all measures to ensure confidentiality so that there would be no identifying information in the transcript. After the interview is transcribed, the tape will be erased. When I have analysed the transcripts, I will produce my findings in the form of a research report: some of your responses may be reproduced in this report but no individual will be identifiable to anyone else. I would appreciate participants’ input at the final stages of writing the report in order to see if the findings ‘ring true’ to those who took part and I would also be happy to send you a copy of the final report. However, there is no need for you to be involved after the interview if you would rather not.

If you are interested in participating in this study, please call me on 01483 689176 or email psm1fg@surrey.ac.uk or write to me care of the PsychD in Psychotherapeutic & Counselling Psychology, Department of Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.
Dear Ms Gillies

**Enforced childlessness, childfree choice and other possibilities: A grounded analysis of gay men’s reflections on life without offspring (ACE/2003/20/Psych)**

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and the following conditions are met:

- That, for safety reasons, you will not meet with the participants in their own homes.
- That you sign part 12 of the attached Protocol Cover Sheet.

For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at [http://www.surrey.ac.uk/Surrey/ACE/](http://www.surrey.ac.uk/Surrey/ACE/).

This letter of approval relates only to the study specified in your research protocol (ACE/2003/20/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

I should be grateful if you would confirm in writing your acceptance of the conditions above, forwarding the signed Protocol Cover Sheet for the Committee’s records.

Contd...
Date of approval by the Advisory Committee on Ethics: 26 March 2003
Date of expiry of approval by the Advisory Committee on Ethics: 25 March 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
    Dr M Milton, Supervisor, Dept of Psychology
    Dr A Coyle, Research Tutor, Dept of Psychology
Appendix C

Interview schedule

Thank you for being here today and agreeing to take part in this interview. I would like to talk to you about your views and feelings about being a gay man who is living without children. I will start by asking you to read through and answer some simple background questions and then we will move on to the main interview. If any of the questions do not seem relevant to you please tell me and we can expand or move on as you wish. If there is anything you wish to add at any time please do so.

(Hand the background information sheet and a pen to the participant to complete)

Thank you for filling that in. If you are ready we can begin the interview.

I would like to begin by asking you about your family and people who you feel are close to you.

1. Contextual Questions
   How old are your parents?
   Do you have siblings?
   How old are they?
   Which of them have children?
   How old are they?
   Are there any other people who feel like family to you?
   Do any of them have children?
   Are there any other significant children in your life, such as godchildren or children of previous partners that you are still in touch with?

2. Parenthood and Lifespan
   (Give all the participants the time-line.)
   This is a time-line. It is meant to represent your life, past, present and future and we can use it to help you identify when certain things happened or occurred to you and what else might have been going on at those times. I will ask you a few questions and we can use the time-line when you are answering.
I’m wondering if you’ve ever thought about being a father?

**If Yes**
Using the time-line as a guide:
At what points in your life have you considered the idea of you and fatherhood?
What do you think was going on in your life at each of these times that influenced your thoughts about you and fatherhood?
What has attracted you to fatherhood at different times?
What has put you off fatherhood at different times?
Over time, how have your relationships with the significant children you mentioned earlier changed?
In what ways, if any, do you see your thoughts about you and fatherhood changing in the future?

**If No**
Using the time-line as a guide:
How, over time, have you reached this conclusion?
(If participant repeats that he has never thought of the issue before, can prompt further explorations by questions such as “I’m wondering why this issue seems irrelevant to you?” or “If you were to think about it now, how do you feel about you and parenthood?”)
What, if anything, might make you change your views in the future?

3. **Parents, Family and Friends**
(If the participant’s partner has a child/children) In what ways has your relationship with your partner’s child affected how you feel about you and parenthood?
Have you and your partner discussed the possibility of parenting as a couple?
**If yes** How do you think your partner views the idea of you as a couple becoming parents?
Have you and your partner discussed the possibility of you becoming a father?
**If yes** How do you think your partner views the idea of you becoming a father?
Have you and your partner discussed the possibility of him becoming a father?
If yes How do you think your partner views the idea of himself becoming a father?
In what ways, if any, do you feel that this subject has affected your relationship?
How do you think your parents would feel about you becoming a father?
In what ways, if any, have their attitudes or views affected your feelings about you and fatherhood?

4. General
What do you feel you have gained by not having children?
What do you feel you have missed by not having children?
How do you imagine your day to day life would be affected by having a child?
In what ways, if any, do you feel that your sexual orientation affects your feelings about having a child?
Whether or not you are personally interested in having a child, how do you feel about gay men raising children?
Can you tell me how your gay male friends feel about gay male couples parenting?
Is there anything else you would like to add?
How do you feel about the topic after taking part in this interview?
What makes you say that?
How are you feeling now?
How did you find the questions? Were they relevant to you or are there other questions that you would have liked to have been asked?
Is there anything that I could do or say to make this procedure more comfortable?
Thank you very much for taking part in this interview.
Background information

The following information is collected so that people who read the final report can know more about the people who have taken part. However, none of this information will be used to identify you as this research is completely confidential.

1. How old are you? ______________

2. How would you describe your ethnicity?

Choose one section from (a) to (e) then tick the appropriate box to indicate your cultural background.

(a) White
□ British
□ Irish
□ Any other White background, please write in below ____________________________

(b) Mixed
□ White and Black Caribbean
□ White and Black African
□ White and Asian
□ Any other mixed background, please write in below ____________________________

(a) Asian or Asian British
□ Indian
□ Pakistani
□ Bangladeshi
□ Any other Asian background, please write in below ____________________________
(d) Black or Black British

□ Caribbean

□ African

□ Any other Black background, please write in below

________________________________________

(e) Chinese or Other ethnic group

□ Chinese

□ Any other, please write below

________________________________________

3. What is your highest qualification? (please tick appropriate answer)

None

GCSE/O level/CSE

A level

Diploma

Degree

Postgraduate degree

4. What is your current job, or of you are not working, what was your last job?

________________________________________
5. Which is following descriptions best applies to your current sexual feelings?

- Exclusively homosexual
- Mainly homosexual but with a small degree of heterosexuality
- Mainly homosexual but with a substantial degree of heterosexuality
- Equally homosexual and heterosexual
- Mainly heterosexual but with a substantial degree of homosexuality
- Mainly heterosexual but with a small degree of homosexuality
- Exclusively heterosexual

6. Which of the following descriptions best applies to your current or most recent sexual activity?

- Exclusively homosexual
- Mainly homosexual but with a small degree of heterosexuality
- Mainly homosexual but with a substantial degree of heterosexuality
- Equally homosexual and heterosexual
- Mainly heterosexual but with a substantial degree of homosexuality
- Mainly heterosexual but with a small degree of homosexuality
- Exclusively heterosexual

7. How would you describe your current gay relationship status?

- No regular partner
- One regular partner only
- One regular partner with casual partners also
- More than one regular partner
- More than one regular partner with casual partners also
- Other (please specify)
Appendix D

Consent form

Title: Enforced childlessness, childfree choice and other possibilities: a grounded analysis of gay men’s reflections on life without offspring.

Author: Frances Gillies – Counselling Psychologist in Training, PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

Supervised by: Dr Adrian Coyle and Dr Martin Milton

- I the undersigned voluntarily agree to take part in the study on............
- I have read and understood the Information for Participants sheet. I have been given a full explanation by the researcher about the length, purpose and nature of the interview and what I will be expected to do. I have been given an opportunity to ask questions and have understood all the answers provided.
- I agree to comply and co-operate with the interviewer during the interview. I will inform the interviewer if I feel distressed during the interview and the interview will be terminated at my request.
- I understand that all personal data relating to participants is held in the strictest confidence and in accordance with the Data Protection Act (1998).
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.
• I acknowledge that I will not receive payment for participation in this study.
• I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer.................................................................(BLOCK CAPITALS)
Signed..................................................................................
Date.................................................................

Name of researcher.............................................................(BLOCK CAPITALS)
Signed..................................................................................
Date.................................................................
Appendix E

Transcription of Interview with Duncan

(I = Interviewer P = Participant)

I: Are your parents still alive?

P: yes they are.

I: How old are they?

P: I think my mother’s seventy five and my dad’s seventy seven.

I: and have you got any siblings?

P: I’ve got one of each, yeah.

I: how old are they?

P: My brother is coming up to 54 in a couple of days time and my sister is 51.

I: ok... so you’re the baby?

P: (Laughs) I’m the baby, yeah.

I: and have they got children?

P: my brother’s got five children by two marriages and my sister’s got two children.

I: do you have any other people who feel like family to you?

P: yeah I do. Where I’ve just come from, a family who moved in across the road a few years ago and who I’ve got very close to. Err, and nearly always in my adult life I’ve had a surrogate family who’ve I’ve been close to and um they’re the current surrogate family.

I: so what’s your relationship like with your parents?
P: with my parents it’s very good now. They moved down to X about five years ago but I’ve been alienated from them since my teens really. I mean I’ve gone to see them once or twice a year but we’ve not been close really because well to put it briefly I started my first gay relationship when I was fifteen with a teacher at school which, you know, when they found out which they found out quite soon, caused quite traumatic problems and the way he and I got out of it was to simply lie our way out of it. They knew I was lying and I knew they knew I was lying but they didn’t know what to do so that caused problems between us. Then when I went away to university I had a new relationship and actually they really liked M and M came to visit and we shared a bed and Mum brought us tea in bed and this was when I was nineteen when still at that point the age of consent was 21 so it was illegal and um I still never accepted that they had come to terms with it. It took me another twenty years to accept that they really were accepting it. I mean they still used to say “maybe one day there’ll be a nice girl” all that sort of stuff but really they’d come to terms with accepting that I was going to have gay relationships even if they hoped that there was another bit of me that would come out....but it took me because our relationship was so awful in my mid-teens it took me a long time to forgive them I suppose. And um so that process of repairing the relationship probably happened about seven or eight years ago. And um...

I: and what precipitated that?

P: Therapy! (Laughs) On my part. It was, that took quite a long time. Ten years ago I went briefly to a Jungian therapist and on the way to the first session....the reason I’d gone there was because I’d been in love for far too long with this bisexual guy who had strung me along since university and I wanted to learn how to fall out of love with him and I thought that a therapist would be able to teach me that and I thought I know that she’s going to say that this has all got to do with my parents and I know
this has got nothing to do with my parents and I got there and she asked me some completely innocuous question certainly not about my parents and within about a minute of answering I was talking about my parents...and fortunately I realised that I've got to do something about that relationship with my parents before I can sort anything else out. It wasn't until I went to another therapist with a completely different style, an hypnotherapist and she just plucked techniques from all over the place and it wasn't just that she said you've got to sort things out with your parents it's just in talking to her I became well I restored my self esteem you know I was really in a state of self loathing and so getting me over that hole enabled me to admit that I love my parents. And then a couple of years after we had sorted things out they said oh we're thinking of moving to X. I had been in X for thirteen years and they moved in a minute way and it’s good.

I: do you have relationships with your nephews and nieces?

P: not a lot, my brother lives in the States and so all his children live there and I have very little contact there. I don’t really get on with my brother. He always found my gayness difficult to accept. With wonderful irony his oldest son is gay. I did think that serves him right. I feel a bit bad that I haven’t been able to be there for him but I was always worried that my brother would say that I had made him gay or something.

I: have you got any other children that are significant to you such as godchildren?

P: yes. Well I suppose the first one....when I was at university umm when I was twenty I was sharing a house with my boyfriend at the time, M, and a couple of other people J and P. P was on the same music degree course as I was. And she got pregnant from P which was a mistake and she was under a lot of pressure to have the baby adopted while she was pregnant and she went through all the process. Initially she was under pressure to have an abortion this was before I knew she was pregnant - I wasn't that close to her at first - I mean literally M and I were driving around B in a friend’s car and we saw her standing in the street looking pregnant in the summer holidays and we said what’s going on and she said I’ve got nowhere to live.. she was
looking for somewhere to live and so she and P came to live with us. So she was under pressure to have the baby adopted and I grew very close to her and got very interested in the whole pregnancy thing. P the father was withdrawing more and more into cannabis as a way on not coping with it and um and so to a large extent I took on the father role really. To the point when on the night we went to the maternity hospital P’s mother was there and she drove us and the nurse couldn’t work out which of us was the father and er was saying well would the father like to attend the delivery and I was thinking oh please please I really want to go but he chose to go and I don’t think that it was appropriate for me to go anyway.

I: how did you find the pregnancy?

P: I was fascinated by it. Oh, what I haven’t explained is that at about seven months she said to me “I can’t give this baby away” and so I was the first person to know that and I gave her a lot of emotional support through that. So when the baby was born, E. I went into see her about three hours after she was born and I’ve had this experience twice in my life. I felt I suppose what was parental bonding. I hadn’t expected it, I mean I knew I would be interested in the baby but I had quite a strange experience of feeling as I looked into the cot of feeling drawn in. It was a very physical thing, it was though, I mean I don’t have spiritual beliefs but it was like my spirit or my soul was rushing into this little baby. And er I felt totally in love with her and bonded to her instantly. (Starts to cry) Extraordinary feeling, it makes me want to cry.....and so then I was very much in loco parentis for the next year. About a year that I lived with them I did a lot of the parenting. And then I had another year when I was living with J’s sister and so I saw a lot of them but it wasn’t quite the same.

I: So after a year you moved out?

P: yeah.
I: How did it feel moving away from them?

P: It was alright because I knew that I was still in the same city. Yeah that was ok. Then I went to London which was more of a wrench but it felt quite natural. And then, so I was in London and the links started to weaken and then I studied in Canada for a while and after that I was I came back to England and I didn’t have any roots and I lived with them for about a year and a half. And that’s how I came to move to X because J was doing teacher training and I had got very close to E again and didn’t know what I was going to do with her life and I said to J if she was to get a job I could go with her and house husband. And so we did that for a while. So even more so than when she was a baby I was doing all the day to day parenting you know the house work the bath the bed time reading all that business. Until she was about six. And then J could afford to buy a house and it felt natural that we should move together and what made that easier was that my sister had been widowed young and with her two children she’d come to visit us and she came to live in D and so I became a parent for her children as well. That was only for about seven months. Yeah so I got close to them I suppose. But what is a sadness to me is that I haven’t stayed close to E.

I: do you see her much now?

P: yes I do in fact I saw her last week. She’s got a five year old of her own. So…

I: so, do you feel parental towards her now?

P: a bit but in the meantime J had long terms relationships and I could feel my role lessening and then what complicated the issue was that I fell out with J so I didn’t have the motivation to see J which meant that I didn’t see E. But I have been thinking that I want to get close to E again especially now she has her own child. I have seen
him about once a year since he was born and he's a very sweet little boy. So I do want to be closer to them.

I: and you said that you had another experience with a baby?

P: yeah a second time. Well, now I have to explain a bit of history about P – another P. In my second year in a chamber choir there was this really handsome guy who I got friendly with and I pursued and finally managed to have a physical relationship with him. He’s bisexual but predominately heterosexual but he and I had a physical relationship off and on while he was having relationships with women for about seven years. Then he met his partner C and she knew about me and she’s always been really good to me. She treated me with such respect and consideration that I couldn’t carry on. Although it’s a bit complicated in that some time later I did recommence our relationship and it’s almost as if I had to do that in order to close our relationship. Anyway, they had children and it’s the first of their children. When C got pregnant at first I felt really threatened by it and I thought well this will really cement their relationship and where will I fit into that relationship. But I saw the baby a couple of hours after he was born and again that thing happened and it was so unexpected. I mean with E I had been very involved with the pregnancy and I thought I felt like I knew her already. With M yeah I had spent a lot of time with P and C but I didn’t expected to feel anything for the baby.

I: do you think that it happened because it was P’s baby?

P: I don’t know. They are the only two new born babies that I’ve seen so maybe it’s just seeing new-borns...I don’t know. But again it was an overpowering sense of attachment to this child and they were fantastic and welcomed me being a third parent in a way. I did a tremendous amount of caring for M and baby sitting and um then I moved closer to M because I couldn’t bear not to see him every day. It was really
strong – I just had to see him as often as I could. And um I mean again really that strong sense of attachment the need to see him all the time did wear off. I’m not sure how long it took. C had another baby Mi a couple of years later and I made arrangements to go away for the summer and I inconvenienced my friends considerable because I wanted to stay for the birth and achieve that same sense of attachment to the second and although I went to see her just after she was born it didn’t happen. So explain that one I don’t know why. And I am very close to both of them and M is seventeen but I haven’t seen them for three months and they only live eight miles away.

I: I wonder if there was anything else going on in your life that you can think of when these two babies where born?

P: I don’t know. I suppose I didn’t have other relationships going. Actually that’s not true I was infatuated with P. I don’t know I can’t explain it. I suppose I was strongly attached to J and to P so maybe there’s something in that. I mean it was up to me to help her keep her baby.

I: Have you ever thought about yourself becoming a father?

P: I have because I was forced to think about it. When I was about thirty, I had a dream which I have put into a song. The dream was that I was on Clifton suspension bridge and the bridge was swaying in an exciting way and all that happened was that there was a little boy on the bridge on he ran to me and I picked him up and held him to me and it was an overwhelming sense of love you know for this child and it was an ecstatic dream and I woke up thinking “oh my god is this me I want to have children?”. I had kind of discussed it but hadn’t thought it through a lot. And in fact I told this to a therapist and I said “does this mean I want to have children?” and she said “not necessarily it may be your inner child – you need to love and protect your
inner child” which made a lot of sense to me. But the other time I was really faced with the issue was about eight years ago when a friend of mine came down from London and she’s got a troubled past and she was a heroin addict and a prostitute before I knew and amazingly got herself sorted out. I’ve known her about eighteen years. And she has a confused sexuality – she has had strong relationships with men and with women. And er she did say “how would you feel about fathering a baby for me” and we talked about it. And I thought well if we did that I would want to be involved in bringing up the baby, I’m not willing to be just a sperm donor and we talked about the practicalities and about where we would live and organise it. So I said let me think about it a bit and I said if I’m obsessing about it that means that I want to do it. And she went back to London and I completely forgot about it. It was almost like there was an active forgetting because it was so complete it was unreal. Weeks later something reminded me and I had to ring her up and say “sorry it’s not for me”.

I: Did you think about the practicalities of how you would go about the conception?

P: We would have done that through artificial insemination. That doesn’t bother me at all. I don’t think that it was that I had doubts about R’s stability or may be it was that but I don’t think that it was who was suggesting it it was more that I didn’t need to be a father. I think that too many people have children too casually.

I: so that came along after you have had these other experiences with the other children?

P: yeah

I: do you have a feeling that those experiences satisfied some kind on paternal feeling?
P: yeah I do and I also work with children a lot. I work in schools and I get close to some of the children I teach piano to I get very close to. There’s one family where I teach the two sons and I’ve been teaching M since he was six and they treat me as family when I see them.

I: Do you think there’s anything in the future that may change your mind about wanting to parent?

P: I don’t think so. I can’t imagine it happening. I suppose, I think the only thing maybe is if I found a long term partner who is very keen on the idea of parenting, I suppose that could change my mind. But you know I’m getting on a bit to have a child or anything.

I: Do you think you have missed anything by not fathering a child?

P: yeah, but it’s not anything that I feel particularly regretful about because I think that I’ve gained a lot because I mean that there are lots of children that I’m close to that I haven’t even mentioned. And um...

I: So what do you feel you have gained?

P: well a certain amount of freedom because I’m not responsible for any of them. Um but also to carry on being creative you have to be in touch with your own child so I am quite childlike in a lot of ways and I think staying close to children and mucking about with them and being silly helps to retain that. I’m not great at discipline so in a way I like to be able to parent sometimes but stay a child at other times. Also, I find teenagers much much harder to relate to and I know that’s why I became more distant from E and why I have from M because I don’t know what you talk to teenagers about. Although M isn’t the classic teenager, he has always been very sweet. Up until a couple of years ago he would still come and sit on my lap and he was six foot two by that time which was amazing. He’s turned out to be a lovely person.
I: Have you any idea about how your parents might feel about you becoming a father?

P: If I was to become a father with a male father, I’m not sure what they would think. I think they are pretty open minded now about complicated relationships now. I don’t think it’s anything they think about and it doesn’t affect me. They’ve got seven grandchildren already.

I: How do you feel, in general, about gay men raising children?

P: It’s not something I’ve witnessed really.

I: How about just the idea of it?

P: In a way I have quite a traditional sense that the ideal way is to have the mother and father in stable relationship. I do think there’s a lot to be gained from having the two sexes. I believe in equality but also the differences in the two sexes and the child can take things from each. But I think that in our society there are so many different types of family and arrangement that I think that if a child can have two parents who ever they are who love it and each other or at least get on with each other then your doing pretty well and it doesn’t matter whether the parents are both male or both female or whatever. You know, stability and love are what matters most. And it’s probably better to have two parents than a single parent. You know, if you are prioritising, then I would say that heterosexual happy couple then next two parents of same sex and then next single parents.

I: How do you think your gay male friends see gay male couples parenting?

P: I don’t have many gay male friends. So I don’t suppose I’ve ever discussed it, really. What I should say is that on two other occasions I have been asked to father a child. Some friends of mine, a straight couple who are fairly alternative asked, she had a gay couple who are were looking for someone to father a child about five years
ago. But they were strangers but I was not willing to do that. I wouldn’t of done it because I had the potential of knowing them because that would have meant that I would have seen the child but not have a role in parenting. I did actually meet the child that she did have eventually with another person. Knowing them and not being involved in the child would be too difficult. Donating sperm totally anonymously I could almost imagine doing even with the possibility of the adult child seeking me out. I think I wouldn’t mind doing that.

I: And you said there was another one?

P: There was another R only a couple of years ago. But I replied straight away that I’d been through that before and I know that it wasn’t for me. And she’s now got a partner and is pregnant. I could imagine adopting an older child, but I think that it’s extremely unlikely partly because I think that it’s unlikely that I’ll be with a long term partner. I think I’ve got too old and stuck in my ways to get to do that. And I think by the time I felt that our relationship was stable enough I would be in my fifties and I just think that would be too old.

I: OK. I think that I have come to the end of my questions for now. How are feeling about the issue of parenting after this interview?

P: It’s interesting to explore it. I don’t feel sad or anything. I think on this issue in my life I’ve done the right thing. When I was fourteen, my mother got pregnant unexpectedly and she had a termination, she was forty and didn’t feel able to cope with having another child although they’ve always wanted four children but at that age they just couldn’t face the idea of having another baby and um I do sometimes think about that baby and how old it would be now.

I: how did you find the interview and the questions?
P: I felt very comfortable with it. It's a topic I'm interested in um and it's I'm really please that you're exploring that particular topic. I've always been interested in gay men and children because I've always been close to children and throughout my adult life I've been a third parent to one child or another. I do wonder about how many other gay third parents are there around. I know that the families that I've been close to have often valued me as a release valve you know a way that makes their relationship easier. I don't know how it happens, I stay out of any arguments or tiffs but I can joke about it and that eases things.

I: is there anything else you would like to add or ask?

P: not that I can think of at the moment.

I: Ok, well thank you very much for giving up your time to take part.
Differences Between Being a Gay Father and a Gay "Uncle"

Card Thirty Six - Differences Between Gender Instincts Towards Parenting

Card Thirty Two - Losing the Desire to Parent

Card Thirty One - Possible Effects on Child of AI

Card Twenty Nine - Impact of Experiences of Coming Out Identity as a Father

Card Twenty Eight - Impact of Friends Having Children

Card Twenty Seven - Parenting as an Alien Concept

Card Twenty Three - Practicalities of Conception

Card Eight - Biological Relatedness

Card Nine - Salient Factors of Parenting

Card Ten - Incidences of Thoughts About Parenting

Card Eleven - Conditions Necessary for Parenting to Occur in the Future

Card Twelve - Impact of Perceived Societal Attitudes/Media

Card Fourteen - Perceived Views of Own Parents/Family

Card Sixteen - Perceived Features of Life With Children

Card Fifteen - Salient Features of Life Without Children

Card Four - Influence of Own Childhood

Card Five - Impact of Desire to Parent

Card Six - Attitudes to Gay Parenting

Card Eight - Biological Relatedness

Card Nine - Salient Factors of Parenting

Card Ten - Incidences of Thoughts About Parenting

Card Eleven - Conditions Necessary for Parenting to Occur in the Future

Card Twelve - Impact of Perceived Societal Attitudes/Media

Card Thirteen - Specialness of Gay Parenting

Appendix F. Shows the original category names in the boxes. The lines drawn between boxes show the links between the categories.
Appendix G

History of cards

Original Card Names
Card One – Belonging to a Family Unit
Card Two – Responsibility
Card Three – Family Structure
Card Four – Influence of Own Childhood/ Culture
Card Five – impact of Desire to Parent
Card Six – Attitudes to Gay Parenting
Card Seven – Impact of Perceived Societal Changes
Card Eight – Biological Relatedness
Card Nine – Salient Factors of Parenting
Card Ten - Incidences of Thoughts About Parenting
Card Eleven – Conditions Necessary for Parenting to Occur in the Future
Card Twelve – Impact of Perceived Societal Attitudes/Media
Card Thirteen – Specialness of Gay Parenting
Card Fourteen – Perceived Views of Own Parents/Family
Card Fifteen – Salient Features of Life Without Children
Card Sixteen – Perceived Features of Life With Children
Card Seventeen – Gay Politics
Card Eighteen – Perceived Possible Effects on a Child of Living in a Gay Family
Card Nineteen – Experiencing a Parental-Type Bond With a Child
Card Twenty – Relationship with Another Person Effecting Relationship with Significant Child
Card Twenty One – Contact With Significant Children
Card Twenty Two – Defining the Relationship to a Significant Child
Card Twenty Three – Practicalities of Conception
Card Twenty Four – Working With Children
Card Twenty Five – Relationships to Significant Children Changing Over Time
Card Twenty Six – Being Introduced to the Idea of Fatherhood by Partner/Family/Friends
Card Twenty Seven – Parenting as an Alien Concept
Card Twenty Eight – Impact of Friends Having Children
Card Twenty Nine – Impact of the Experiences of Coming Out On Identity as a Father
Card Thirty – Impact of Attitudes of Friends to Parenting
Card Thirty One – Possible Effects on Child of AI
Card Thirty Two – Losing the Desire to Parent
Card Thirty Three – Reasons Given to Self for Not Being a Parent
Card Thirty Four – Finding Teenagers Unattractive
Card Thirty Five – Social Benefits of Not Having Children
Card Thirty Six – Differences Between Gender Instincts Towards Parenting
Card Thirty Seven – Passing Something On To The Next Generation
Card Thirty Eight – Differences Between Being a Gay Father and a Gay “Uncle”
Card Thirty Nine – Possessing Childlike Qualities That Enable Him to Relate to Children
Card Forty – Not Realising That Living Gay Lifestyle Would Effects Desire to Parent
Card Forty One – Coming to the Realisation That He Might Not Be a Father
Card Forty Two – Incompatibility Of a Gay Lifestyle and Being a Parent
Card Forty Three – Sexuality Overriding Other Identities/Desires
Card Forty Four – Contemplating a Future Without Children
Card Forty Five – The Imagined Effects on Mental Well-Being of Having a Child
Card Forty Six – Effect of Culture on the Desire to Parent
Card Forty Seven – Parenting a Pet
Card Forty Eight – Expressing Parental Urges

First Analysis
Card Seven was too similar to Twelve and so was amalgamated.
Card Seventeen abandoned due to only one quote
Card Nineteen abandoned due to only one quote
Card Twenty abandoned due to only one quote
Card Twenty Four became a subset of Card Forty Eight
Card Twenty Five abandoned due to only one quote
Card Twenty Six abandoned due to only one quote
Card Thirty abandoned due to only one quote
Card Thirty Three abandoned due to only one quote
Card Thirty Four abandoned due to only one quote
Card Thirty Five abandoned due to only one quote
Card Thirty Seven amalgamated with Card Forty Eight
Card Thirty Nine abandoned due to only one quote
Card Forty abandoned due to only one quote
Card Forty One abandoned due to only one quote
Card Forty Two amalgamated with Card Eighteen
Card Forty Four abandoned due to only one quote
Card Forty Five abandoned due to only one quote
Card Forty Six became a subset of Card Twelve
Card Forty Seven became a subset of Card Forty Eight

Second Analysis
Card Two title changed to Appetite for the Responsibility of Children with a subset added concerning unfairness of not being aloud to be responsible when heterosexual parents are seen to be irresponsible.
Card Three title changed to The Importance of Having Heterosexual Parents with some quotes moved to Card Eighteen the Effects on Child.
Card Five Abandoned as viewed as unimportant to present research.
Card Six abandoned due to lack of importance
Card Eight title changed to The Low Importance of biological Relatedness for better fit with data.
Card Nine Abandon due to lack of specificity of category
Card Ten abandoned due to lack of importance and relatedness with other cards
Card Eleven can become Being rich enough and Card Eleven A can become Importance of having a long term partner. Add Card Twenty Seven as another subset.
Card Thirteen changed title to Potential Superiority of Gay Parents for greater fit with data
Card Fourteen became Importance of Childlessness to Gay Man’s Family for better fit with data

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Card Fifteen split into liberating features and painful features
Card Eighteen split into parts – Concern that child may be bullies, Protecting the child from prejudice, child’s sexuality, effects of living without a female influence, perceived instability of gay relationships. Cards Twenty One all abandoned due to lack of examples and interesting links.
Card Twenty Two changed to Describing the Relationship to a Significant Child
Card twenty Three changed to Reflections on the Practicalities of Conception
Card Twenty Seven amalgamated with Card Twelve
Card Thirty One becomes subset of card Eighteen
Cards Thirty Two and Thirty Six abandoned
Card Thirty Eight abandoned
Card Forty Three abandoned as potentially too big an issue for this research.

Final Core Categories
Core Category One – Gains and Losses of a Childfree Life
Includes Card One – Belonging to a Family Unit
   Card Fifteen – Salient Features of Life Without children
   Card Sixteen – Perceived Features of Life with Children
   Card Two – Reflections on the Prospect of Being Responsible for Children
   Card Four – Influence of Own Childhood on Desire to Parent

Core Category Two – Attachment and Generativity
Includes Card Forty Eight – Expressing Parenting urges
   Card Twenty Two – Describing the Relationship to a Significant Child
   Card Eight – The Low Importance of Biological Relatedness

Core Category Three – Social Attitudes and Internalised Homophobia
Includes Card Twelve – Impact of Perceived Societal Attitudes/Media
   Card Thirteen – Potential Superiority of Gay Parents
   Card Eighteen – Perceived Possible effects on a child of living in a gay-parented family
   Card Three – The Importance of Having Heterosexual Parents
Core Category Four – Culture and Ethnicity
Includes Card Four – Influence of Own Childhood/ Culture
Card Fourteen – Importance of Childlessness to Gay Man’s Family

Cards Seen as Important but Left Out Due to Lack of Space
Card Eleven – Life Changes Necessary for Parenting in Future
Card Thirty Two – Losing Desire to Parent
Card Forty Three – Sexuality Overriding Other Desires/ Possible Identities.
instructions for authors

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   • an introductory footnote with authors’ academic degrees, professional titles, affiliations, mailing and e-mail addresses, and any desired acknowledgment of research support or other credit;
   • a header or footer on each page with abbreviated title and pg. number of total (e.g., pg. 2 of 7).

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Investigating psychologists' and psychotherapists' social representations of gay male parenting.

Abstract

Issues surrounding gay male parenting have recently received greater interest in both the social and academic arenas. Research has suggested that, for some gay men, such issues are emotionally complex and painful. There is little research, in Britain, looking at therapeutic practitioners' views or opinions of gay parenting and how these might be affecting their practice with gay men who present with parenting issues. Using social representation theory as a framework, this study aimed to investigate how psychotherapists and clinical and counselling psychologists understood gay male parenting and whether there was any connection between the nature of the social representations held by practitioners and personal variables such as age, gender, reported sexuality and reported social contact with gay men. Cluster analysis failed to find any groups that could be said to represent social representations. A conclusion was drawn that the questionnaire designed in this study failed to measure any social representations that might have been held by participants. Further analysis suggested that therapist identification as 'non-exclusively heterosexual' and social contact with gay men led to significantly more agreement with positive statements about gay male parenting.

Key words: children, gay, quantitative, social.
Introduction

Throughout history, gay men have fathered children and fulfilled parental roles. Parenting for a gay man, however, often meant living in a heterosexual relationship or at least not having an openly gay identity. Indeed, today many gay male parents have had children within the context of heterosexual relationships/ marriages prior to 'coming out'. Recent developments in societal thinking (Weeks, Heaphy and Donovan, 2001) and research on gay and lesbian parenting issues from America (Armesto, 2002; Baum, 1996; Beers, 1996; Bigner, 1999; Crawford and Soliday, 1996; Laird, 1993; McIntyre, 1994; McLeod and Crawford, 1998; Patterson, 1992, 1994, 1995, 1997, 2000; Rooney, 2002; Sbordone, 1993) and from Britain (Barrett and Tasker, 2002; Clarke, 1999, 2000, 2001, 2002a, 2002b; Golombok and Tasker, 1994; Hargaden and Llewellyn, 1996; Harris and Turner, 1986; James, 2000; Saffron, 1996; Tasker, 2002; Weeks, Heaphy and Donovan, 2001) has meant that issues concerning gay men choosing to become parents have received interest in both academic and social arenas.

No British surveys have attempted to discover how many gay men are involved in parenting. Bryant and Demian (1994) estimated, through their surveys of gay communities in the USA, that one in ten gay men identify as fathers. With the growing social focus on gay male parenting generally and in gay communities specifically during the intervening decade, it is reasonable to speculate that the figure may be higher today. There are many ways in which a gay man might be involved in a parenting role. As mentioned above, some gay men may have children from a
previous heterosexual relationship. Gay men are also seeking to become parents by fostering or adopting children (James, 2000; McCann and Tasker, 2000). Research suggests that there is a growing number of gay men who have become involved in parenting as openly gay men or who are planning to become parents (Dunne, 2001). When gay men define their “families of choice” (as opposed to their blood relatives), wider networks of care-giving responsibilities become apparent (Weeks, Donovan and Heaphy, 1996) such as co-parenting a partner’s children.

Despite this potential rise in the numbers of gay men becoming parents, the majority of gay men, especially in Britain, are remaining childfree (Hargaden and Llewellin, 1996). There are many reasons why a gay man might be living without children of his own. The most obvious reason would be that the man has made a considered decision in favour of a life without children of his own and feels that he benefits from this decision (for example, in terms of having more disposable income and greater freedom). Another reason could be that the logistics of setting up a surrogacy arrangement or finding a suitable (often lesbian) co-parent may seem too difficult or daunting (see Touroni and Coyle, 2002, on the potential difficulties of this from a lesbian perspective). A man may feel that his social context is too prejudiced against gay parenting for him to feel comfortable with the idea of himself parenting and he may worry about the effects of social attitudes on a child. It may be that he is from a generation for whom having children was not an option for gay men or he may be someone with HIV or AIDS which could affect his decisions concerning his future. Homophobic articles in the media have portrayed gay men who show an interest in children as bad role models in terms of orienting the child’s sexuality towards homosexuality, which is seen as harmful for the child (Clarke, 1999). At other times,
the media have suggested that gay men who have contact with children only do so for paedophilic motives (Gamson, 1998). These factors may contribute towards encouraging a gay man not to give serious consideration to the possibility of having a child, even if he experiences strong parenting urges. Despite this, research has suggested that the desire to parent may be relatively common among gay men. Beers (1996) and Sbordone (1993) have both measured the desire to parent in gay male samples and both found that about 50 per cent of their sample of gay men without offspring expressed this desire.

Most of the research concerning gay male parenting issues concentrates on the possible effects on children living in gay parented families (Parks, 1998). There is little psychological research looking at either the desire to parent in gay men or the effect on gay men of living without children of their own. One possible reason for this could be the assumption that gay men are not interested in parenting (Barrett and Tasker, 2002) and so the possibility that it might be worth exploring this issue does not arise. In a qualitative study, Gillies (2003) interviewed gay men who were living without children of their own and found that their experiences and emotional responses to their childfree lives were ambiguous and complex. Some of the participants expressed a strong desire to nurture a child but they also felt a pressure from society to remain childfree. Other men expressed a sense of freedom from the responsibilities of childcare although a few men reflected that this may be their way of making the best of a situation that they felt was forced upon them by a society that generally disapproves of gay male parenting. Some men stated that they felt pressured by society to stay childfree and at the same time undervalued by a societal pro-natal bias (Gold and Wilson, 2002). While these findings are localised to the men
that participated in the study, it suggests that, for some gay men, issues surrounding parenting or living without children are relevant, emotionally complex and sometimes painful. While research suggests that gay men parent in similar ways to heterosexual men (Tasker, 2002) gay fathers may have to contend with additional marginalizations. On one hand, their parenting can leave them feeling excluded by other gay men. On the other hand, they may feel stigmatised, because of their sexuality, within heterosexual society.

It would seem, then, that parenting issues, such as those described above, may be topics that could arise for some gay men in the therapeutic context. While some of the issues may be similar to those that arise for heterosexual clients (such as emotional reactions to infertility or the daily stresses of childcare), there will be some aspects of gay parenting that will be context specific. In other words, a therapist may need to have some understanding of the social pressures and prejudices that a gay man might come across that would make any issues surrounding parenting or not parenting emotionally painful for that man. In recent years, 'lesbian and gay affirmative psychotherapy' (Milton, Coyle and Legg, 2002) has attempted to provide guidelines for a way of working with clients that encourages a non-discriminatory, contextually aware attitude for therapists working with gay and lesbian clients. While this is a positive step towards counteracting negative therapeutic experiences encountered by lesbian and gay clients (Annesley and Coyle, 1995) it seems that most psychotherapeutic training courses address issues of working with gay clients briefly, if at all (Milton and Coyle, 1998). This suggests that gay parenting issues may be given little attention at training level and leads to the question of how psychologists
and psychotherapists working in Britain are conceptualising gay parenting issues and how their practice with this client group is affected.

Some idea of attitudes towards gay parenting can be gleaned from existing research. Some of the following research has investigated attitudes to lesbians and lesbian parenting. While it is acknowledged that parenting issues for gay men and for lesbians will be different, it is possible to get some understanding of attitudes towards "the other" in terms of sexuality and parenting. Palma (1996) found that counsellor trainees held negative attitudes towards lesbians and gay men. Jordan and Deluty (1995) reported that 11% of their sample of clinical psychologists used therapeutic techniques to attempt to change sexuality. Annesley and Coyle (1995) found that their clinical psychologist participants held positive attitudes towards lesbianism but were more ambivalent towards lesbian parenting. In the same way, Crawford, McLeod, Zamboni and Jordan (1999) found that psychologists held negative views of gay parenting because of the concern about the perceived stigmatisation that gay families encounter. There is no research in Britain looking at psychologists' or psychotherapists' attitudes towards gay male parenting. However, an expectation of differences in attitudes arises from the respective training programmes underlying the development of each branch of therapeutic practice. Counselling psychology is committed to affirmative practice that moves away from the medical model and towards a belief in therapy as a collaborative endeavour (British Psychological Society Division of Counselling Psychology, 2001). A liberal humanistic framework, which informs some psychotherapy training, places emphasis upon the similarities between heterosexuals and lesbians and gay men and hence has the shortcoming of avoiding the specific social context of lesbian and gay sexualities and surrounding
issues (Clarke, 2002; Kitzinger and Coyle, 1995). This can mean that debate about
issues that are pertinent to the experiences of lesbians and gay men are ignored.
Historically, psychoanalytic theories have regarded homosexuality as a pathology
(Klein, 1932). While in more modern psychoanalytic literature there has been a move
away from these views (O’Connor and Ryan, 1993), some psychoanalytic therapists’
practice with lesbian and gay clients is still informed by these traditional
psychoanalytic views of homosexuality. Finally, there is some evidence that suggests
that personal qualities such as specific group memberships predict attitudes towards
lesbian and gay issues. Herek (1988) suggested age, gender and participants’ level of
personal social interaction with lesbians and gay men were all variables that underlie
the shaping of attitudes towards lesbians and gay men.

The above research offers some understanding of individuals’ potential attitudes
towards gay parenting. Contemporary theories of attitudes emphasise the
intrapersonal psychological processes involved in the acquisition, maintenance,
structure and content of the attitudes (Gaskell, 2001). This is at the expense of
explanations involving social influences. Social representation theory (Moscovici,
1961) assumes that groups of people share representations of social phenomena and
that these shared social representations allow sense to be made of the world and for
that sense to be communicated. Writers such as Jaspars and Fraser (1984) attempt to
bring the two concepts of attitude and social representation into relation with each
other by considering social representations as structured and widely shared sets of
social attitudes. Other authors argue that this confounds the social and individual
processes and suggest that social representations are collective processes that
underpin individual attitudes (Doise, Clémence, Lorenzo-Cioldi and Kaneko, 1993;
Farr, 1993; Gaskell, 2001). While the study of attitudes towards gay parenting is important, the effects of social influence, social communication and prejudices may be ignored. Since many of the difficulties that gay parents might encounter will be related to social influences, it is felt that a psychological framework that involves social processes would be most appropriate for studying issues surrounding gay parenting.

Moscovici characterised social representations as:

System(s) of values, ideas and practices with a twofold function; first, to establish an order which will enable individuals to orient themselves in their material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history. (Moscovici, 1973, p. xiii)

From this definition, it can be understood that social representations will affect the way in which a person will behave. It can also be seen that social representations are used by people to locate themselves within a social group. This has specific importance for the study of how therapists might understand gay parenting issues as it suggests that the type of social representation that is held could affect the type of therapeutic intervention offered to a client.
Moscovici (1984) argued that the purpose of social representations is to make the unfamiliar familiar. In order to do this, unfamiliar phenomena are drawn in, or anchored, into existing psychological categories. This is essentially a process of classification and naming. The process of anchoring will affect the way in which the social representation is structured. At the same time, social representations will be projected outwards onto the world. This process of objectification means that we begin to see the world according to our understanding.

Throughout the report, reflections on the interaction between self and the research process are offered in italics and parentheses.

*Research Aim*

The aim of this research is to investigate psychotherapists', clinical psychologists' and counselling psychologists' social representations of gay male parenting. Before the processes (anchoring and objectification) of social representations can be investigated, it is necessary to first establish the presence of one or more social representations (Fife-Schaw, 1993). Some social representation research begins with the assumption that specified groups of people will hold social representations. Fife-Schaw (1993) suggests that research data should be examined for clusters which in turn can be used to group the participants. In other words, the social representations should be found first and these should be allowed to form the group of people that hold them. The research will also examine the content of any uncovered representation(s) and will look at possible links between participants' personal attributes and the representation(s). Since there is no existing research in this area, this should be seen as exploratory rather than a definitive piece of work.
Moscovici defended the idea that social psychology should be governed by a "methodological polytheism" (Moscovici, 1981) in which particular methods are selected because they are appropriate to a specific inquiry, rather than accepting that any one method should be given priority in all circumstances. Social representation research involves a mixture of qualitative and quantitative research methodology (Breakwell and Canter, 1993). It was felt that a quantitative approach was suitable for the purposes of investigating the presence and content of social representations.

This research is seen as important as it is informed by Moscovici's (1981) assumption that social representations are the basis for much of our social interaction. In this case, the aim is to begin a discussion concerning how practitioners' social representations of gay male parenting might affect their therapeutic relationship with clients.

The study will be exploratory but the following hypotheses can be developed on the basis of previous relevant research:

1. It is hypothesised that significantly fewer practitioners will rate parenting as an issue that is likely to arise in therapy with gay men than those who do rate it as something that is likely to arise.

2. It is hypothesised that there will be a significant relationship between the type of training received by practitioners and the nature of the social representations held by practitioners. More specifically, it is hypothesised that psychoanalytically trained practitioners will hold more negative social representations that other
practitioners; and that counselling psychologists will hold more positive social representations than other practitioners.

3. It is hypothesised that there will be significant relationships between participants' age, gender, reported sexuality and levels of personal social interaction with gay men and the nature of the social representations held by practitioners.

My choice of social representation theory as a framework for this study was also partly connected to my interest in evolutionary psychology. Evolutionary psychology sees human beings as social animals that are affected, at a mental level, by social and group processes. For example, depression is seen as an adaptation to negative group pressures and anxiety is seen as an adaptive response to a potentially dangerous social situation. Pathological mental distress is seen to come about when these adaptations are no longer serving a useful purpose, or in other words, have become maladaptive. My conceptualisations of clients' presenting problems are often coloured by an underlying interest in each client's social context and the possible effects of this context on the individual's functioning. It seemed, therefore, interesting to use a framework for studying gay parenting that allowed analysis at a social or group level.

A concern that I had, about using social representation theory as a framework, emerged as I began to investigate the social representation research literature. As mentioned in the introduction, the area is characterised by "methodological polytheism" and while this may seem to be of benefit to an experienced researcher, it left me feeling insecure as I desperately tried to pin down appropriate research methods. When I first began to think about designing a quantitative piece of research,
I had expected the experience to be one of methodical planning and organisation. Instead, I have felt that this piece of work was running through my fingers as I tried to grasp hold.

**Method**

In order to survey a wide range of practitioners’ social representations, a postal questionnaire was developed and used. Eight participants were interviewed, the interviews were transcribed and analysed and resultant data were transformed into the questionnaire. The questionnaire was then sent out to 200 potential participants and the results were statistically analysed.

**Questionnaire development**

An aim of the study was to investigate the content of social representations and it was felt that an attribute checklist followed by a questionnaire encompassing personal attributes was a precise way to elicit and measure social representations’ content (Fife-Schaw, 1993). Semi-structured, face to face interviews were conducted in order to develop this questionnaire. Participants for the qualitative interviews were recruited through the researcher’s work placement. The only inclusion criterion for participants was that they were qualified psychotherapists, counselling or clinical psychologists. Copies of a letter containing details about the research aims and the structure of the interview (see Appendix A) were left in staff pigeonholes. Eight participants replied and all were interviewed (for a transcript of an interview see Appendix B) using an interview schedule as a guide. The purpose of the interviews was to elicit the participants’ understanding of different situations where a gay man
might be in a parenting role and to uncover statements that the participants made about some or all of these scenarios of gay parenting. With this in mind, an interview schedule (see Appendix C) was drawn up to guide the interviewer in these directions.

After receiving their information letter, potential participants contacted the researcher by phone or email. A date was set up for the interview that was convenient to both parties. The interviews all took place in consulting rooms in the psychology department of a hospital. Some of the participants worked within the department and all were known within the department so the interviews were not completely confidential in that other staff members may have seen that the meeting was taking place. The consulting rooms were, however, soundproofed. At the start of the interview, each participant was asked whether they would like any more information about the project and was then asked to sign a consent form (see Appendix D). The interviews lasted for approximately half an hour. The interviews were tape recorded and later transcribed by the researcher. The tapes were then erased and the transcripts were given code numbers so that the participants could not be identified from the transcripts.

The resultant transcripts were then analysed by the researcher. Firstly, data that appeared to describe different ways in which a gay man might be in a parenting role were extracted and made into a list titled “Scenarios of gay parenting”. Secondly, any units of data that were considered to be attitudes, views or opinions about gay parenting were collected and made into list titled “statements about gay parenting”. Nine scenarios (single gay man fathering and raising a child; gay man with a gay partner fathering and raising a child; donating sperm to a lesbian mother and co-
parenting the child; single gay man adopting a child; gay man with a gay partner adopting a child; single gay man fostering a child; gay man with a gay partner fostering a child; gay man co-parenting gay partner’s children; gay man co-parenting children from previous heterosexual relationship) and 22 statements (e.g. “Is an issue that might arise in therapy”; “Is a positive advance in societal thinking”) were collected from the transcripts. The scenarios were then placed in a column at the left-hand side of the page and the statements were placed in a row along the top making a matrix of boxes for participants to fill. A five-point scale was used (1 = Strongly Agree, 2 = Agree, 3 = Undecided, 4 = Disagree, 5 = Strongly Disagree) so that participants could fill the boxes with a number of their choice.

The personal attributes questionnaire was developed to collect basic demographic information about participants as well as other information about group memberships such as theoretical orientation, sexuality and whether or not the participant had social contact with gay men. The questions about group memberships were informed by Herek’s (1988) research that suggested that age, gender and participants’ level of personal social interaction with lesbians and gay men were all variables that underlie the shaping of attitudes towards lesbians and gay men and by other research mentioned in the introduction, which suggests that therapeutic training affects attitudes towards lesbians and gay men (e.g. Crawford et al., 1999).

The questionnaire was piloted at the researcher’s work placement and revised accordingly. It was suggested that fostering and adoption were not significantly different and so fostering was dropped leaving the number of scenarios at seven. It was also suggested that the questionnaire took too long to complete so two statements
were removed that were seen to be similar to other remaining attributes. This meant that the matrix contained 140 cells. (See Appendix E for the final version of the questionnaire).

Participants

200 potential participants were selected from both the British Psychological Society’s Register of Chartered Psychologists (BPS, 2002) and the United Kingdom Council of Psychotherapists’ National Register of Psychotherapists (UKCP, 2003) using a random sampling technique (Fife-Schaw, 2000). The participants did not need to meet any other criteria for inclusion.

Procedure

The participants received a copy of the questionnaire, an information letter (see Appendix F) and a stamped addressed envelope. No consent form was sent as the information letter stated that completion and return of the questionnaire would be taken as consent. This meant that all questionnaires returned were anonymous.

Data Analysis

Hierarchical cluster analysis and frequency tables were used to explore whether any groups of variables existed that might represent social representations. For hypothesis 1, frequency tables were used to examine the participants’ responses to statement “Is an issue that might arise in therapy.” A Kruskal-Wallis test followed by Mann-Whitney tests were used to investigate hypothesis 2. In hypothesis 3, Scatter plots and Spearman’s correlation were used to compare age with each scenario/statement.
and Mann-Whitney tests were used to compare each scenario/statement with gender groups, reported sexuality and social interaction with gay men.

[During the development of the questionnaire, I felt more at home. On reflection, I realised that this may have been due to the qualitative nature of the data collection. I have found that I prefer using qualitative to quantitative research methods. I find face to face interviews rewarding and interesting, whereas conducting research on an anonymous sample seemed soulless to me. When I received completed questionnaires, I found that I was looking through the demographic questionnaire first, trying to find out who this person was. Despite enjoying the experience of collecting the data for the questionnaire development, I felt inexperienced and full of doubt as I designed the questionnaire. On reflection, I feel that the time pressure I felt myself to be under encouraged me to pilot the questionnaire less than would have been useful.

The data analyses shown in this report were not my original plan. I had hoped to take any clusters that I found and conduct a correspondence analysis to visually display the relationships between the scenarios of and statements about gay parenting. This analysis would have permitted the scenarios and statements to be plotted in their component spaces and hence offers an idea of the content of each representation. Finally, to make any links between the participants' personal attributes and the representation they hold, a multi-nominal logistic regression would have been run. It was hoped that this would offer insight into how and/or why participants held particular social representations. These would have seemed a more appropriate battery of statistical tests according to the requirements of a doctoral level piece of
research. However, the results of the cluster analysis suggested that I had to rethink my statistical plan. This left me feeling dispirited. Because of the large number of variables, the statistics actually took a long time and yet the results were disappointing. I felt that in a different position, I could have abandoned the questionnaire and started again, yet due to the pressures of the course I had to decide how to make the best of the data I had.]

Results
Sample characteristics
There were 44 (69%) female participants and 20 (31%) male participants. 63 (98.4%) of the participants described themselves as white; one (1.6%) chose the Chinese description. The mean age was 54.8 with a standard deviation of 12.4 and a range of 33-78.

36 (56.3%) participants described themselves as exclusively heterosexual; 11 (17.2%) participants described themselves as heterosexual with a small degree of homosexuality; 6 (9.4%) participants described themselves as heterosexual with a substantial degree of homosexuality; 6 (9.4%) participants described themselves as exclusively gay; 4 (6.3%) participants described themselves as gay with a small degree of heterosexuality; 1 (1.6%) participant reported as equally gay and heterosexual.

27 (42.2%) held a counselling psychology qualification; 12 (18.8%) held a clinical psychology qualification; 10 (15.6%) were UKCP registered psychotherapists; 7
(10.9%) held analytic qualifications; 4 (6.3%) held a diploma in psychosynthesis; 2 (3.1%) held a sex therapy qualification; 1 (1.6%) held a cognitive behavioural qualification; 1 (1.6%) held a humanistic qualification.

Since the number of participants was small in each group, for the purposes of statistical analysis, these groups were collapsed so that participants holding analytic and UKCP registered qualifications became one group. The participant holding the cognitive behavioural qualification joined the group of clinical psychologists meaning this group contained 17 (26.6%) participants; the humanistic participant joined the group of counselling psychologists meaning this group held 13 (20.3%) participants and the psychosynthesis and the sex therapy qualifications were joined into one group (named the ‘others’ group) meaning this group held 6 (9.4%) participants.

52 (81.3%) participants stated that they had friends who had let them know they were gay; 12 (18.8%) stated that they did not have friends who had let them know that they were gay.

Cluster Analysis

In order to uncover one or more social representations held by the participants, hierarchical cluster analyses were run. In the first instance, a cluster analysis was performed in order to see if the participants fell into clusters. The results of this cluster analysis suggested that there were no groups. Secondly, a cluster analysis was performed to see if the variables fell into groups. The results suggested that there were no clusters. Thirdly, cluster analyses were performed on each of the scenarios of
gay parenting to see if the 20 statements fell into groups or clusters. Seven cluster analyses were performed and the results suggested that there was no evidence to group any of the statements together. For the remainder of the analysis, therefore, each scenario/statement combination was treated as a separate variable.

Hypothesis 1. It is hypothesised that significantly more practitioners will rate parenting as an issue that is not likely to arise in therapy with gay men than those do who rate it as something that is likely to arise.

58 (90.6%) of participants responded ‘agree’ or ‘strongly agree’ to “Single gay man fathering and raising a child” and “Is an issue that might arise in therapy”. 4 (6.3%) were undecided and 2 (3.1%) disagreed. 58 (93.5%) participants responded ‘agree’ or ‘strongly agree’ to “Gay man with a gay partner fathering and raising a child” and “Is an issue that might arise in therapy”. 4 (6.3%) were undecided and none disagreed although 2 did not answer the question. 50 (83.3%) participants responded ‘agree’ or ‘strongly agree’ to “Donating sperm to a lesbian mother and co-parenting the child” and “Is an issue that might arise in therapy”. 10 (15.6%) participants were undecided. 56 (90.3%) participants responded ‘agree’ or ‘strongly agree’ to “Single gay man adopting a child” and “Is an issue that might arise in therapy”. 2 (6.3%) were undecided and 4 (6.3%) disagreed. 52 (83.9%) participants responded ‘agree’ or ‘strongly agree’ to “Gay man with a gay partner adopting a child” and “Is an issue that might arise in therapy”. 8 (12.5%) were undecided and 2 (3.1%) disagreed. 52 (83.9%) participants responded ‘agree’ or ‘strongly agree’ to “Gay man co-parenting gay partner’s children” and “Is an issue that might arise in therapy”. 6 (9.4%) were undecided and 4 (6.3%) disagreed. 53 (85.5%) participants responded ‘agree’ or
‘strongly agree’ to “Gay man co-parenting children from previous heterosexual relationship” and “Is an issue that might arise in therapy”. 6 (9.4%) were undecided and 3 (4.7%) disagreed.

Hypothesis 2. It is hypothesised that there will be a significant relationship between the type of training received by practitioners and the nature of the social representations held by practitioners. More specifically, it is hypothesised that psychoanalytically trained practitioners will hold more negative social representations than other practitioners; that counselling psychologists will hold more positive social representations than other practitioners.

For “Single gay man adopting a child” “Is a positive advance in societal thinking”, the counselling psychology group’s mean response was 2.43 (.87) and a Mann-Whitney test suggested that it was significantly different to the clinical psychologist group’s mean response which was 3.46 (.05) (p=0.007). Thus, it seems that the counselling psychology group was significantly more likely to agree than the clinical psychology group. For “gay man with a gay partner adopting a child” and “is a positive advance in societal thinking”, the counselling psychology group’s mean was 2.14 (.89) and a Mann-Whitney test suggested that it was significantly different to the clinical psychology group’s mean which was 3.3 (.34) (p=0.002). Thus, it seems that the counselling psychology group was significantly more likely to agree than the clinical psychology group.
For “single gay man fathering and raising a child”, “gay man with a gay partner fathering and raising a child”, “single gay man adopting a child”, “gay man with a gay partner adopting a child”, “gay man co-parenting gay partner’s children” and “gay man co-parenting children from previous heterosexual relationship” and “might affect child’s sexuality”, the clinical psychology group’s mean response was 3.00 (.35) and Mann-Whitney tests suggested that these were significantly different to the ‘others’ group’s mean response which was 4.33 (.03) (p=.04). Thus, it seems that the clinical psychology group was significantly more likely to be undecided and the ‘others’ group was significantly more likely to disagree.

Hypothesis 3: It is hypothesised that there will be significant relationships between participants’ age, gender, reported sexuality and levels of personal social interaction with gay men and the nature of the social representations held by practitioners.

Age

Scatter plots and Spearman’s correlation were use to compare age with each statement. This was little evidence to suggest any association between these variables. Any significant result found was under r =+/-.3 and was therefore considered too weak to report.

Gender

Mann-Whitney tests suggested that the mean response for female participants for “single gay man fathering and raising a child” and “unnecessary for the happiness of the gay man” (3.53 (.13)) was significantly different to the mean response for males (2.80 (.05)) (p=.01). A Mann-Whitney test suggest that the mean response for female
participants to “gay man with a gay partner fathering and raising a child” and “against the teaching of my religion” (4.64 (.92)) was significantly different to the mean response for males (3.87 (.93)) (p=.002).

**Sexuality**

Mann-Whitney tests suggested that there were significant differences between the responses of the ‘not exclusively heterosexual’ group and the ‘exclusively heterosexual group’ to various scenarios and “unfair on child”, “is a positive advance in societal thinking” and “might affect the child’s sexuality”. Table 1 shows the mean responses and the p values for the significant Mann-Whitney tests.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Not exclusively heterosexual group. x (sd)</th>
<th>Exclusively heterosexual group. x (sd)</th>
<th>P values for Mann-Whitney tests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single gay man fathering and raising a child/ Unfair on child.</td>
<td>3.96 (.92)</td>
<td>2.92 (.96)</td>
<td>.008</td>
</tr>
<tr>
<td>Gay man with a gay partner fathering and raising a child/ Unfair on child.</td>
<td>4.21 (.73)</td>
<td>3.58 (.87)</td>
<td>.000</td>
</tr>
<tr>
<td>Donating sperm to a lesbian mother and co-parenting the child/ Unfair on child.</td>
<td>4.04 (1.07)</td>
<td>3.03 (1.14)</td>
<td>.001</td>
</tr>
<tr>
<td>Single gay man adopting child/ Unfair on child.</td>
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<td>3.08 (1.05)</td>
<td>.004</td>
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<tr>
<td>Gay man with gay partner adopting a child/ Unfair on child.</td>
<td>4.11 (.87)</td>
<td>3.28 (.76)</td>
<td>.001</td>
</tr>
<tr>
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<td>3.58 (.02)</td>
<td>.007</td>
</tr>
<tr>
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</tr>
<tr>
<td>Scenario</td>
<td>Mean (SD)</td>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Donating sperm to a lesbian mother and co-parenting the child/ Is a positive advance in societal thinking.</td>
<td>2.18 (.98) 3.06 (.14)</td>
<td>.002</td>
<td></td>
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<tr>
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<td>2.25 (.88) 3.17 (.11)</td>
<td>.001</td>
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<tr>
<td>Gay man with gay partner adopting a child/ Is a positive advance in societal thinking.</td>
<td>2.07 (.81) 2.81 (.06)</td>
<td>.006</td>
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</tr>
<tr>
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<td>.017</td>
<td></td>
</tr>
<tr>
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<td>3.93 (.94) 3.25 (.05)</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Gay man with gay partner adopting a child/ Might affect the child’s sexuality.</td>
<td>3.93 (.94) 3.19 (.03)</td>
<td>.006</td>
<td></td>
</tr>
<tr>
<td>Gay man co-parenting children from previous heterosexual relationship/ Might affect the child’s sexuality.</td>
<td>4.11 (.78) 3.42 (.13)</td>
<td>.017</td>
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</tr>
</tbody>
</table>

**Gay friends**

Mann-Whitney tests suggested that there were significant differences between responses of the ‘yes’ group and the ‘no’ group to various scenarios and “unnatural”, “concerns surrounding this issue will be the same as for a heterosexual man” and “might affect the child’s sexuality”. Table 2 shows the mean responses and the p values for the Mann-Whitney tests.
Table 2. Shows the mean and standard deviation responses for the ‘yes’ group and the ‘no’ group to various scenario/statements. The p values are for Mann-Whitney tests.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes group. x (sd)</th>
<th>No group. x (sd)</th>
<th>P values for Mann-Whitney tests.</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3.42 (.90)</td>
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<tr>
<td>Gay man with a gay partner fathering and raising a child/ Unnatural.</td>
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<td>3.42 (.65)</td>
<td>.004</td>
</tr>
<tr>
<td>Donating sperm to a lesbian mother and co-parenting the child/ Unnatural.</td>
<td>4.29 (.03)</td>
<td>3.42 (.16)</td>
<td>.006</td>
</tr>
<tr>
<td>Single gay man adopting child/ Unnatural.</td>
<td>4.19 (.97)</td>
<td>3.00 (.40)</td>
<td>.004</td>
</tr>
<tr>
<td>Gay man with gay partner adopting a child/ Unnatural.</td>
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<td>3.08 (.87)</td>
<td>.000</td>
</tr>
<tr>
<td>Gay man with a gay partner fathering and raising a child/ Concerns...</td>
<td>2.65 (.42)</td>
<td>4.00 (.34)</td>
<td>.004</td>
</tr>
<tr>
<td>Donating sperm to a lesbian mother and co-parenting the child/ Concerns...</td>
<td>2.71 (.98)</td>
<td>4.00 (.34)</td>
<td>.006</td>
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<tr>
<td>Gay man co-parenting children from previous heterosexual relationship/ Concerns...</td>
<td>2.60 (.53)</td>
<td>3.92 (.30)</td>
<td>.008</td>
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<td>2.50 (.79)</td>
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<td>2.59 (.12)</td>
<td>.000</td>
</tr>
<tr>
<td>Donating sperm to a lesbian mother and co-parenting the child/ Might affect the child’s sexuality.</td>
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<td>2.79 (.64)</td>
<td>.001</td>
</tr>
<tr>
<td>Single gay man adopting a child/ Might affect the child’s sexuality.</td>
<td>3.77 (.98)</td>
<td>2.58 (.79)</td>
<td>.001</td>
</tr>
<tr>
<td>Gay man with gay partner adopting a child/ Might affect the child’s sexuality.</td>
<td>3.73 (.99)</td>
<td>2.58 (.79)</td>
<td>.001</td>
</tr>
<tr>
<td>Gay man co-parenting gay partner’s children/ Might affect the child’s sexuality.</td>
<td>3.81 (.97)</td>
<td>2.75 (.86)</td>
<td>.001</td>
</tr>
<tr>
<td>Gay man co-parenting children from previous heterosexual relationship/ Might affect the child’s sexuality.</td>
<td>3.96 (.03)</td>
<td>2.67 (.77)</td>
<td>.000</td>
</tr>
</tbody>
</table>
By the time I had analysed the results, I was feeling ambiguous. On one hand, I felt that there were some interesting differences in responses to certain statements by different groups. In particular, I was struck by how both the 'no' group and the 'exclusively heterosexual' group had suggested that they were undecided about whether gay parenting might affect the sexuality of the child. This was pertinent to me as, during my qualitative research in the second year, I had had many conversations with gay men who wanted to parent a child and who felt angry about the heterosexist assumption that they would be able to influence the sexuality of any child they cared for. One man pointed out that most gay men were born into heterosexual families and they still identified as gay. The other part to this assumption that seemed to make some of these men angry is the assumption that a child identifying as gay is a bad thing.

The other side of my ambiguous feelings was the disappointment at being unable to have a discussion with social representation theory as a framework. Not only had I hoped to be able to look at the communication of ideas about gay parenting at a social/group level, I was also concerned about the asymmetry of the report. I feel that some of my disappointment may be evident in the tone of the report.

Discussion

The aim of this study was to investigate psychotherapists’, clinical psychologists’ and counselling psychologists’ social representations of gay male parenting. The primary aim was to uncover the presence of any social representations and the content of these
representations. Additionally, any links between participants' age, gender, reported sexuality and their amount of social contact with gay men were also explored. In the following discussion, the results presented in the previous section will be discussed with attention given to possible interpretations and a discussion on the possible reasons for the lack of statistically significant results.

Design of the questionnaire

As mentioned in the introduction, this study began at the exploratory stage. The questionnaire was designed to allow the data to be analysed by cluster analysis. The use of participants that were representative of the sample that would complete the questionnaire was a way of using 'key informants' (Gilchrist, 1992) to develop the statements and scenarios in the questionnaire. It is recognised that this limits the participants who completed the questionnaire to those statements and scenarios. It could be that the participants held social representations that were different in content and were not covered by the statements taken from the qualitative interviews. However, it was hoped that the researcher's knowledge of the literature concerning gay male parenting enabled an informed analysis of the transcripts of the interviews.

Response rates and demographics of participants

The response rate for the questionnaire was 32%. While a low response rate can be expected in a postal questionnaire (Fife-Schaw, 2000) it could also be attributed to the design of the questionnaire and to the content. The questionnaire was piloted and shortened according to feedback. However, there were 140 cells in the matrix with a five point Likert scale to enable sensitive decision making. This may have seemed daunting to some potential participants especially when members of both of the
professional lists used are often presented with postal questionnaires from researchers. The subject of gay male parenting could be seen as irrelevant to some potential participants. It may be that some non-responders rated the questionnaire as unimportant either as a research topic in general or to their own interests.

Of those that did respond, there was a bias towards female respondents (69% females, 31% males). This may reflect the gender bias that exists in the professions of psychology and psychotherapy as suggested by a greater prevalence of female applicants for related training courses (Universities & Colleges Admission Service, 2003). Female participants also tend to be more co-operative than male participants in responding to postal questionnaires (Fife-Schaw, 2000). It is interesting, however, that the subject of this research was gay men and yet the gender bias was towards women. This may reflect an unwillingness among some men to discuss matters concerning gay men or it may reflect a disinterest in the subject of gay parenting as a potential therapeutic issue.

There was also a marked ethnicity bias as there was only one non-white respondent. In a qualitative study looking at gay men's experiences of living without children, Gillies (2003) found the desire to parent was influenced by the participants' ethnic background. It seemed that there was an interaction between ethnicity, sexuality and a desire to parent. Some men reported how their culture of origin was pro-natal and that had led them to believe that their own offspring would be an important part of their lives. These men reported some emotional distress when they felt that their sexuality precluded life with their own offspring and that the effects of their culture of origin exacerbated this distress. The ethnic bias in the present study was, therefore, a
surprise. It may reflect an ethnic bias in the population from which the sample was taken. It also flags up the fact that in random sampling techniques for postal questionnaires there is no way of knowing the demographics of the potential sample.

**Social representations of gay parenting**

This research investigated the presence and content of social representations. The idea was that if one or more social representations could be found, further research could be conducted in the future into the processes of social representations - anchoring and objectification - and the social aspects of sharing and communication. Hierarchical cluster analysis was used to assess if there were any groups within the data. The results suggested that there was no evidence of any groups existing either in terms of participants or of variables. The aim of this study was to uncover any clusters in the data and to assume that any clusters could be representative of social representations. Since no clusters were found, one conclusion to be drawn is that this sample did not hold any social representations of gay parenting. A different assumption could be made that the lack of clusters does not reflect a lack of social representations of gay parenting in the population but is rather a sign that the questionnaire failed to measure any social representations. One reason for this could be the design of the questionnaire. The statements and scenarios were intended to elicit an indication of the participants' views, attitudes and thoughts about gay parenting. It seems, from the cluster analysis, that responses to each statement and scenario were sufficiently different to the next that none could be easily grouped together. One interpretation of this is that each statement and scenario combination held sufficient information to be seen as being a social representation of its own but this appears to be a rather speculative interpretation. Another point may be that the
questionnaire failed to engage participants in a way that elicited access to their social representations. The demographic biases and low response rates suggest that the questionnaire failed to engage some members of the targeted sample. There could also be an effect of participants feeling that there was a correct answer, or in other words, a 'politically correct' answer to some of the statements. (One participant wrote on the returned questionnaire, "Is this a test of my personality?"). It could be that those targeted participants who held more negative social representations did not complete and return the questionnaire whereas some of those that did felt obliged to answer in a positive manner. One effect of training as a therapist can be that we begin to see ourselves as, or that we ought to be, free of prejudice or negative attitudes. While this is good in theory, a worry is that it could prevent ongoing self-reflection and a tendency towards denial of our social representations and their effects on our behaviour. It also can prevent open inspection of the existing social pressures and prejudices that minority groups come under and that need to be understood by therapists in order to be helpful to our clients.

It seems that a parsimonious interpretation of the results would be to assume the lack of clusters were not a sign of a lack of social representations of gay parenting in the sample, but rather, at this stage as a failure of the questionnaire to measure any such social representations. It does, however, set the tone for the reading of the results of this research, which should be one of caution. Because of the lack of clusters found, this research should be seen as containing information that may spark further research in the area. In this vein, the rest of the analysis was conducted with a view towards examining views and opinions of the sample on issues relevant to gay parenting. The difference between 'views and opinions' and social representations is that there is no
assumption of a social process by which a group of people come to understand or think about a phenomenon. In other words, this research is only able to offer a flavour of the participants’ feelings or views towards gay parenting and it is not able to suggest where these have come from or how they may have come about. If clusters had been found, the theory of social representations – and how they are communicated and acquired – could have informed our understanding of how these participants had come to hold the representations that they did. Without the framework of the theory upon which to hang results, assumptions about psychological processes cannot be made. Therefore, while this research offers a glimpse of relationships between responses and statements, it should be taken merely as offering insight into the flavour of views or opinions held but without understanding of social or psychological process underlying these views.

Gay parenting as a likely issue to arise in therapy

Hypothesis 2 suggested that practitioners would not rate parenting as a likely issue to arise in therapy. This hypothesis was generated partly from the attitudinal literature described in the introduction. Palma (1996), Jordan and Deluty (1995), Annesley and Coyle (1995) and Crawford et al. (1999) all suggested that practitioners held negative views and attitudes towards gay and lesbian parenting. If a practitioner holds a negative attitude, it seems less likely that that practitioner has been inclined to be reflective about that issue. Since there appears to be little interest in the research literature about gay male parenting and linked affect (Dunne, 2001; Gillies, 2003) it would follow that some practitioners might not have contemplated gay male parenting as a potential issue for therapy. The results from this study, however, appear to disprove this hypothesis. It seems that for all seven scenarios, between 83% and 93%
of participants agreed that gay male parenting might be an issue that arises in therapy. This may suggest that the respondents to this survey are aware of the potential for difficult affect that might arise for some men. It may, however, show that the participants are aware that any issues can be painful for different people depending on the phenomenology of the client and that to refuse to admit that an issue might be painful would seem untherapeutic.

Relationship between practitioners' training and type of social representation held.
Hypothesis 3 suggested that the type of training a practitioner received would affect the type of social representation held. Because of the lack of clusters found, the analysis looked at any relationship between practitioners' training and their responses to the statements. Initial Kruskal-Wallis tests showed only a few significant differences found between the groups of practitioners suggesting that as a whole this hypothesis was not supported. This suggests that the responses made by participants may not have been influenced by their therapeutic training. One interesting significant difference found between the “clinical” group and the “others” group was that for all seven scenarios and statement “Might affect the child’s sexuality”, the “others” group was significantly more likely to disagree while the clinical group remained undecided. Research suggests that there is no evidence of either biological or non-biological parental sexuality affecting a child’s sexuality (Patterson, 1997; Tasker, 2000). Some of the participants in the “others” group were sex therapists and it could be that this group was more aware of the research in sexual identity formation or that they had worked with more clients presenting with issues surrounding sexuality.
Relationship between age, gender, reported sexuality, personal interaction with gay men and social representations of gay parenting.

Hypothesis 4 suggested that age, gender, reported sexuality and personal interaction with gay men would affect the type of social representation held by each practitioner. Again, the analysis here was changed to looking at relationships between these variables and responses to the statements. This hypothesis was informed by Herek’s (1988) investigation into attitudes towards lesbians and gay men. Only two significant differences were found between male and female participants whereas there were many significant differences found between groups reporting different sexualities. This suggests that gender of the participants did not have an effect on their responses to the statements whereas their sexuality did have some effect. This could be interpreted as suggesting that, for this sample, the construct of gender contains little meaning with respect to thinking about gay parenting. It seems, however, that the construct of sexuality does have meaning to these participants and seems to affect the way they think about or understand gay parenting. For example, for many of the scenarios and statement “Unfair on child”, the “exclusively heterosexual” group was significantly more inclined to remain undecided whereas the “not exclusively heterosexual” group was more likely to disagree. Research suggests that children who are parented by non-heterosexual families consider the effects of living in these families as beneficial (Gillespie, 1999; Tasker, 2000). It seems, however, that not having the experience of identifying as “not exclusively heterosexual” leaves participants feeling more negative towards gay parenting from the point of view of perceived effects on the child. This negative thinking was also shown by the results suggesting that the “not exclusively heterosexual” group were significantly more likely to agree with some scenarios and “Is a positive advance in
societal thinking” whereas the “exclusively heterosexual” group were significantly more likely to be undecided. Finally, the “exclusively heterosexual” group were, like the “clinical” group, significantly more likely to be undecided about most of the scenarios and “Might affect the child’s sexuality”. Again, this suggests that a lack of experience with non-exclusively heterosexual sexualities could lead therapists to assume a more negative views of gay parenting.

Finally, having experience of social interaction with gay male friends appears to play a part in the type of view participants hold of gay parenting. The “yes” group was significantly more likely to agree with the statement that having a child “should be a fundamental right for a gay men”; they were significantly more likely to disagree with the statement that, for many of the scenarios, gay parenting is “unnatural”; the “no” group was significantly more likely to agree that all of the scenarios, “might affect the child’s sexuality”. This taken together suggests that having the experience of a gay friend could lead to a more positive understanding of gay parenting. The “yes” group was also significantly more likely to disagree, for many scenarios, that the “concerns surrounding this issue will be the same as for a heterosexual man”. This suggests that this group had some understanding of the added social political pressures that gay men who want to parent might be under. This also suggests that the liberal framework, upon which some therapeutic training programmes are built, is not necessarily appropriate when considering social and political issues affecting minority groups.
Relevance for counselling psychology

Counselling psychologists are encouraged to work within the therapeutic relationship using the self as a therapeutic tool (Woolfe, 1996). This means that practitioners need to be reflective and have an understanding of, among other things, what underlying views, prejudices or assumptions they might hold and how these might be affecting their relationships with clients. Counselling psychology is committed to critiquing the medical model of the client-helper relationship in which the "other" is sometimes pathologised. In terms of gay parenting, some of the results above suggest that participants with less experience of gay parenting issues tend to hold more negative views of gay parenting issues. In terms of training and practice, this research would suggest that practitioners and their practice might benefit from further awareness of gay parenting issues. This could happen at the training level and could include training in affirmative therapy (Milton and Coyle, 1998) which advocates the therapist having knowledge about the political and social environments of gay and lesbian clients.

Conclusion

This research was an exploratory attempt to find what social representations practitioners might hold concerning gay male parenting. Cluster analysis failed to find clusters that could be said to represent a social representation. This may have been due to a lack of social representations held by the participants or a failure in the design of the questionnaire to appropriately measure such social representations. A decision was made to continue the analysis in order to look at relationships between participants and their responses to the statements in order to have some measure of their views or opinions towards gay parenting issues. There were significant
differences between various groups of participants and their responses to various scenario/ statement combinations and it is hoped that these results will spark further research in this area and further interest at training level in gay parenting issues.

[Despite the disappointing results of this study, I feel that I have come out with a greater understanding of quantitative research methods. I still feel that I prefer to use qualitative methods but that is more to do with my enjoyment of 'being with' people (clients or participants) and because I feel that in the future qualitative methods may be a more useful way of conducting research that is clinically relevant to process issues in counselling psychology. I feel that I began this project with some naivety and probably a little too much enthusiasm with not enough careful attention to detail. From the point of view of a learning exercise, I feel that it has been a steep learning curve. I have a greater understanding of the importance of the design phase and how a well designed and carefully piloted study might go further to reducing the feelings of insecurity I felt during this process.]
References


Information sheet for participants

Title: Psychotherapists’, clinical psychologists’ and counselling psychologists’ understanding of gay male parenting.

Author: Frances Gillies – Counselling Psychologist in Training, PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

Supervised by: Dr Adrian Coyle – Senior Lecturer, Department of Psychology, University of Surrey.

My name is Frances Gillies and I am currently undertaking a doctoral training in Psychotherapeutic and Counselling Psychology at the University of Surrey. For my doctoral research, I am investigating psychotherapists’ and psychologists’ understanding of and attitudes towards gay male parenting. I intend to develop a questionnaire that will be used as a tool to investigate the content of any attitudes or views held by the participants. In order to develop that questionnaire, I would like to talk to psychotherapists, clinical psychologists and counselling psychologists about their views, attitudes and thoughts about gay men being in parenting roles.
If you were to take part in an interview, it would involve a directed conversation with me at a time and place convenient to you and would last about half an hour. The interview would be taped and later transcribed by myself. I will take all measures to ensure confidentiality so that there would be no identifying information on the transcript and all information relating to participants will be kept according to the Data Protection Act (1998). After the interview is transcribed, the tape will be erased. Some of your responses may be reproduced in the final questionnaire but no individual will be identifiable to anyone else. If you do not wish to take part you do not need to give a reason and you may withdraw from the study at any time.

If you would like to receive a copy of the research report, please email me (see email address below) your name and address and I will send you a copy of the report when the research has been completed at the end of 2004.

If you are interested in participating in this study, please call me on 01483 689176 or email psm1fg@surrey.ac.uk or write to me care of the PsychD in Psychotherapeutic & Counselling Psychology, Department of Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.

Thank you very much for your time.
Appendix B

Transcript of interview with participant for questionnaire construction.

Key: R = Researcher  P = Participant

R: Thank you for being here today and agreeing to take part in this interview. I understand that you have read the information letter and so you will know that I would like to talk about your feelings about and attitudes towards gay men taking on parenting roles. Before we start, is there any more information about the study that you would like to hear?
P: No, not at the moment. Something might come up later on.
R: Ok. That's fine, just ask anything you like as we go. What I'd like to do is ask you some questions but I would really like your views and opinions so I see this as more of a conversation than an interview.
P: Ok, that sounds good.
R: So, let's start. In what ways do you imagine a gay man might take on a parenting role?
P: Well, I've been thinking about this since I got your letter. It's an interesting subject as there is so much gossip and press about it. I realise that there are some men who are travelling to the States to have babies through surrogate mothers and I suppose that these babies can be genetically related to one of the men. Then you hear about gay couples wanting to adopt or foster children. I had a client the other day who was complaining that she had heard that there were so many gay couples wanting to adopt children that heterosexual couples were being denied children. I don't know if that's true, I mean I don't actually know if gay couples adopting children is legal here.
R: So the instances that you can think of are surrogate mothers where the child may or may not be genetically related to the gay man and adopting and fostering as part of a gay couple?
P: Yes. Those are the ones that come to mind.
R: What do you feel might be the positive aspects of those situations?
P: Well, I'm not sure about that. I mean...well, the situation that I was thinking about is that couple who went to the States and used a surrogate mother there. I mean, it just seemed that they might have been using that baby as a way of publicising gay rights or something and I'm just not sure that I like that. I know that this is not a politically correct thing to say but I do feel...well, uncomfortable that a baby is put into the limelight like that.

R: So you feel that a negative point of that situation in particular was that the baby might not benefit from being in the public eye?

P: Yes, and that their motives for adopting the baby were not purely for wanting a child.

R: Ah, right so your concern was that they were using the child as a publicity stunt?

P: Yeah, I could be wrong but that's how it came across in the press.

R: Ok, so that's a concern about that situation. If we just hypothesise for a moment and imagine a gay man uses a surrogate mother to have a child of his own and that his motives are fuelled by a desire to parent a child, can you see positive aspects of that situation?

P: Oh yes, well, I mean at least that child will be born because it was wanted and as we know what children need more than anything is love. So, you know, as long as the father was a loving parent I can see that this is a good thing and probably more than most of our clients have had.

R: Can you see any negative aspects of that situation?

P: Well, my concerns would be that the child does not have two parents. I mean if the surrogate mother did not have anything to do with the child, that might be sad for the child when it grows up. I mean, we have clients, don't we, that do not know their roots because they were adopted or whatever and this lack of stability, or rather, identity can worry some people, can't it?

R: So you wonder if the not knowing the biological mother might have a negative affect on the child's well-being later in life?

P: Yes, you know, I'm just basing that idea of the experiences I have had with clients working through issues surrounding them having being put up for adoption by their biological parents.

R: Is there anything that comes to mind when you think about the sexuality of the father?
P: With respect to the child's...?
R: Yes, or just in terms of the situation...any good or bad points from that?
P: No, funny enough, I haven't been thinking along those lines at all. I really don't think that our parents' sexuality per se affects us. Not very Freudian am I? (Laughing). But seriously, I feel that it is how our parents are about sexuality in general that affects our own sexual identity.
R: I'm not sure what you mean, could you expand a little...?
P: Yeah, what I mean is that if your parents are repressed or they tell their little girl that men are bad and sex is bad and have sexual feelings are bad and dirty, the likelihood is that that child will grow up feeling that it shouldn't enjoy sex. Whereas, if your father was a bit camp or your mother turned out to be a lesbian but they were happy with their sexuality and were able to pass that relaxed and happy attitude on, I feel that this would encourage a child to enjoy their sexuality and not have problems with it...I certainly don't think that sexuality is inherited, but I do think that being comfortable with your own sexuality and the way you express it can be encouraged by good parenting.
R: Ok. So it sounds like the sexuality of the parent does not worry you as such but the issues that worry you are attachment based?
P: Yes, that's exactly it really. I think that the issues that concern me are the same for any children that do not know their biological parents.
R: Ok. That's helpful, thank you. Can we move on now and think about issues that might arise in therapy? I was wondering if you have any thoughts about what issues might arise in therapy if you were working with a client who was gay and he began talking about parenting issues? You may have had some experiences of this?
P: Well, I have had some actually. I worked with a client last year who was a teenage boy and he was trying to come out. I worked with him for a year or so while he was deciding whether he would do it or not.
R: Would you mind talking about the issues that he brought up concerning parenting?
P: No, I mean this is confidential so...well, let me think properly...I think that he was just mentioning that he...what was it...well, oh yes, well in fact I remember thinking my god, I didn't think about parenting in such an explicit way at his age but I suppose it was brought home to him earlier. Basically, I think that he had started to think about the fact that he felt that his mother would be upset because he might not have
children if he was gay. And that really got him thinking about the fact that he might actually want to have children one day and we had to work on his anger about this for a while.

R: Can you tell me what you felt his anger was about?
P: Well, I understood it that he felt that he would not have children because he was gay and he was angry because he might want to and he felt this to be unfair.

R: I'm wondering why he felt being gay would prevent him having children?
P: Well, I suppose I thought...well, thinking about it now...well, I just assumed that he meant because biologically he would not sleep or have a relationship with a woman but thinking about it now, maybe he felt it was a social thing. Maybe he was angry with society.

R: Thinking now, do you feel that you were able to help him unpack this issue?
P: Well, I did at the time but...maybe not...I'm not sure.

Pause

R: I'm wondering how this makes you feel now when you contemplate what issues might arise in therapy for a gay man contemplating parenting?
P: Well, I suppose that it makes me think that I might not understand the difficulties that a gay man might have. That perhaps by not having lived that kind of experience I might not be in a position to make assumptions about what could be painful.

Pause

R: Is there anything else that you would like to add?
P: Pause. Not really, although it has been interesting to think about it like this. When I read your letter I thought that I had my views, you know and I still think that the issues are... that the attachment issues are worrying and that there is something to think about to do with not knowing your parents but otherwise...

R: Is there anything that you would like to ask me or clarify?
P: I was wondering why you are doing this research, I mean why this topic interests you in particular.

R: This piece of research follows on from some conversations I had with participants in previous research. I spoke to gay men about their experiences of living without children of their own and in some instances it seemed that it was a painful issue. This led me to wonder if therapists were prepared for such issues to arise in therapy if they were working with a gay male client.
P: Well, good luck with the research.
R: Thank you and thank you for taking part.
Appendix C

Interview schedule

Thank you for being here today and agreeing to take part in this interview. I would like to talk to you about your views and feelings about gay men taking on parenting roles. The interview will take the form of a conversation as I am interested in your personal and professional views, attitudes, understanding of and thoughts about gay men parenting.

1. In what ways do you imagine a gay man might take on a parenting role?

Taking each instance in turn and introducing other instances that the interviewee may not have thought of:

2. What do you feel are the positive points about this situation?

3. What do you feel are the negative points about this situation?

Elaborate on these points by asking questions such as “What makes you say that?” “Do you have an understanding of what that idea is related to?”

4. What kinds of issues, related to parenting, do you feel a gay man may present with in therapy?

5. How might you work with these issues?

Is there anything else that you would like to add? Are there any questions you would have liked me to ask? Is there anything you felt I did not understand? Is there anything that you would like to discuss further?

Thank you for taking part in this interview.
Consent form

Title: Psychotherapists’, clinical psychologists’ and counselling understanding of gay male parenting.

Author: Frances Gillies – Counselling psychologist in training. PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

Supervised by: Dr Adrian Coyle and Dr Chris Fife-Schaw.

- I the undersigned voluntarily agree to take part in the study on............
- I have read and understood the Information for Participants sheet. I have been given a full explanation by the researcher about the length, purpose and nature of the interview and what I will be expected to do. I have been given an opportunity to ask questions and have understood all the answers provided.
- I agree to comply and co-operate with the interviewer during the interview. I will inform the interviewer if I feel distressed during the interview and the interview will be terminated at my request.
- I understand that all personal data relating to participants is held in the strictest confidence and in accordance with the Data Protection Act (1998).
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.
• I acknowledge that I will not receive payment for participation in this study.
• I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer..........................................................(BLOCK CAPITALS)
Signed.............................................................................
Date.................................................................

Name of researcher......................................................(BLOCK CAPITALS)
Signed........................................................................
Date.................................................................
INSTRUCTIONS

The following pages contain 7 scenarios where a gay man might be in a parenting role. There are also 20 statements about gay parenting. Please could you take each scenario in turn and rate, using the scale below, your agreement or disagreement with each statement. For example, if you ‘strongly agree’ that ‘fathering and raising a child as a single gay man’ ‘should be a fundamental right for a gay man,’ put 1 in box 1A. If you are ‘undecided’ whether it is ‘unnatural’, put 3 in box 1B and so on.

Please use the following scale:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>1</td>
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<td>3</td>
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<tr>
<td>Scenario</td>
<td>Statement A</td>
<td>Statement B</td>
<td>Statement C</td>
<td>Statement D</td>
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<td>1 Single gay man fathering and raising a child.</td>
<td>Should be a fundamental right for a gay man.</td>
<td>Unnatural</td>
<td>Against the teachings of my religion.</td>
<td>Might be a loving environment for a child.</td>
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<td>2 Gay man with a gay partner fathering and raising a child.</td>
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<td>3 Donating sperm to a lesbian mother and co-parenting the child.</td>
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<td>4 Single gay man adopting a child.</td>
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<td>5 Gay man with a gay partner adopting a child.</td>
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<td>6 Gay man co-parenting gay partner’s children.</td>
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<td>7 Gay man co-parenting children from previous heterosexual relationship.</td>
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<td>Statement H</td>
<td>Statement G</td>
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<td>Is an issue that might arise therapy.</td>
<td>Selfish.</td>
<td>Deprives a heterosexual couple.</td>
<td>1. Single gay man fathering and raising a child.</td>
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<td>7. Gay man co-parenting children from previous heterosexual relationship.</td>
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<td>1</td>
<td>Unnecessary for the happiness of the gay man</td>
<td>Unstable environment for the child.</td>
<td>A child might benefit from living in an unconventional family</td>
<td>Could be emotionally painful issue for a gay man.</td>
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<td>Single gay man fathering and raising a child.</td>
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<td>8</td>
<td>Gay man co-parenting children from previous heterosexual relationship.</td>
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<td>Scenario</td>
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<td>Scenario</td>
<td>Statement Q Against God’s wishes</td>
<td>Statement R Useful to society</td>
<td>Statement S Child might feel different from peers in a negative way</td>
<td>Statement T Might affect child’s sexuality</td>
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</table>
Below are some questions about you. The following information is collected so that people who read the final report can know more about the people who have taken part. However, none of this information will be used to identify you as this research is completely confidential.

1. How old are you? __________

2. Male Female (please circle one)

3. How would you describe your ethnicity?

Choose one section from (a) to (e) then tick the appropriate box to indicate your cultural background.

(e) White
   □ British
   □ Irish
   □ Any other White background, please write in below _______________________________

(b) Mixed
   □ White and Black Caribbean
   □ White and Black African
   □ White and Asian
   □ Any other mixed background, please write in below _______________________________
(c) Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background, please write in below

(f) Black or Black British
- Caribbean
- African
- Any other Black background, please write in below

(g) Chinese or Other ethnic group
- Chinese
- Any other, please write below

4. Which of the following descriptions best applies to your sexuality at the moment?

- Exclusively homosexual
- Mainly homosexual but with a small degree of heterosexuality
- Mainly homosexual but with a substantial degree of heterosexuality
- Equally homosexual and heterosexual
- Mainly heterosexual but with a substantial degree of homosexuality
- Mainly heterosexual but with a small degree of homosexuality
- Exclusively heterosexual
5. Please state your psychotherapeutic orientation.

6. Have any of your female or male friends, relatives, or close acquaintances let you know that they are homosexual?

Yes  □
No   □

Thank you very much for taking the time and trouble to fill in this questionnaire. If you have any comments or queries, please do not hesitate to contact me (see the information sheet for contact details).
Information sheet for participants

Title: Psychotherapists', clinical psychologists, and counselling psychologists' understanding of gay male parenting.

Author: Frances Gillies – Counselling Psychologist in Training, PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

Supervised by: Dr Adrian Coyle – Senior Lecturer, Psychology Department, University of Surrey.

My name is Frances Gillies and I am currently undertaking a doctoral training in Psychotherapeutic and Counselling Psychology at the University of Surrey. For my doctoral research, I am interested in psychotherapeutic practitioners' understanding of, and attitudes and views towards, gay male parenting. There has been lots of research recently, mostly in America, looking at gay men as parents but it seems that in Britain it is a subject that has only very recently gained much publicity. I am interested in how therapists are making sense of the concept and whether this will affect our professional thinking and practice if the subject was to arise with a client.
I appreciate that this topic may or may not be of interest to you, and that your time is probably limited, but I would greatly appreciate your input and I hope that this questionnaire will be relatively simple and quick.

If you wish to take part, it would involve you filling out the attached questionnaire, putting it into the self-addressed envelope provided and posting it back to me. It should take about 20 minutes to complete. If you complete the questionnaire, I will assume that you have consented to the study and so there is nothing to sign. Your questionnaire will be treated as confidential and there will be nothing on it to identify you. All information about participants will be kept according to the Data Protection Act (1998). If you do not wish to take part you do not need to give a reason and you may withdraw from the study at any time.

If you would like to receive a copy of the research report, please email me (see email address below) your name and address and I will send you a copy of the report when the research has been completed at the end of 2004.

If you would like further information please do not hesitate to call me on 01483 689176 or email psm1fg@surrey.ac.uk or write to me care of the PsychD in Psychotherapeutic & Counselling Psychology, Department of Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.

Thank you very much for your time.
05 April 2004

Ms F Gillies
Department of Psychology
School of Human Sciences

Dear Ms Gillies

Psychotherapists', clinical psychologists and counselling psychologists' social representations of gay parenting (EC/2004/14/Psych)

I am writing to inform you that the Ethics Committee has considered the above protocol, and the subsequent information supplied, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, the Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (EC/2004/14/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Ethics Committee: 05 April 2004
Date of expiry of approval by the Ethics Committee: 04 April 2009

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, EC
    Dr A Coyle, Supervisor, Psychology
NOTES FOR CONTRIBUTORS

Initial manuscript submission. Submit three copies of the manuscript (including copies of tables and illustrations), to Sandra Suurmeijer, Faculty of Social Sciences, Tilburg University, P.O. Box 90153, 5000 Le Tilburg, The Netherlands.

Authors must also supply:
• an electronic copy of the final version (should normally apply, see section below);
• a Copyright Transfer Agreement with original signature — without this, we are unable to accept the submission; and
• permission grants — if the manuscript contains extracts, including illustrations, from other copyright works (including material from on-line or intranet sources) it is the author's responsibility to obtain written permission from the owners of the publishing rights to reproduce such extracts using the Wiley Permission Request Form. Permission grants should be submitted with the manuscript.

Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time. Submitted material will not be returned to the author, unless specifically requested.

Electronic submission. The electronic copy of the final, revised manuscript should be sent to the Editor together with the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect (and TeX or one of its derivatives). Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. Write on the disk the software package used to create them; we illustrate packages such as Excel or Powerpoint.

Manuscript style. The language of the journal is English. All submissions including book reviews must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3 cm all round. They should not normally exceed 7,000 words in length, or equivalent in text, references and tables, and should include a word count where possible. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

• The title page must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page, as the Journal of Community & Applied Social Psychology operates a "blind" reviewing system.
• Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).
• Supply an abstract of up to 200 words for all articles, except book reviews. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
• Include up to ten key words that describe your paper for indexing purposes.

Short Papers of no more than 2,000 words in length (or equivalent in text, references and tables) are encouraged. Research papers, Innovations in practice and Communication and commentary are all welcome in the Short Paper section. Submissions will be reviewed in the usual way but it is anticipated that the reviewing and publication process will be of shorter than average duration than for longer papers. Abstracts for Short Papers should be of around 50 words.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.
Example: According to Irene Taylor (1990), the personalities of Charlotte...

B. If the author is named in the text, only the year is cited.
Example: According to Irene Taylor (1990), the personalities of Charlotte...

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.
Example: In a 1989 article, Gould explains Darwin's most successful...

D. Specific citations of pages or chapters follow the year.
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.
Example: Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983) ... Alcock and Thornhill (1983) also demonstrate ...

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by et al. (meaning "and others").
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas et al., 1997).
When the reference is to a work by six or more authors, use only the first author's name followed by et al. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.
G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example:
Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example:
Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas ...