A Portfolio of
Academic, Therapeutic Practice,
and Research Work

Including an investigation of
‘Developmental Experiences of Persons with
Multiple Sclerosis:
The Lack of a Holding Environment’

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Submitted for the degree of Practitioner Doctorate
(PsychD) in Psychotherapeutic and Counselling
Psychology

University of Surrey
August 2000
Acknowledgements

I would like to thank the members of the counselling psychology course team, Dr. Adrian Coyle, Dr. Martin Milton, and Dr. Jill Owen for their help and guidance throughout my three years of training. Special thanks are extended to Mr. Ricardo Draghi-Lorenz, my third year research supervisor, and Professor Jenny Brown, my first year research supervisor, along with all my placement supervisors for their inspiring support. I am grateful to Mrs. Kay Hambleton and Mrs. Marion Steed for all their kindness and assistance. I also wish to express my gratitude to my fellow trainees, for their tremendous support. Finally, I would like to thank all the participants in my research and my clients throughout my therapeutic training, who have enabled me to learn from them.

I am indebted to my family for their love and support throughout this experience. This portfolio is dedicated to my husband John, for his holding, inspiration, and encouragement.
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Introduction to the Portfolio

This portfolio consists of a selection of work that has been carried out as part of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It is comprised of three sections which represent the academic, practice, and research components of the training.

Anonymity Statement:

The confidentiality of clients and participants has been protected throughout this portfolio. Whenever client or participant material is referred to, therefore, names have been replaced with pseudonyms and any identifying information has been changed or omitted to preserve the anonymity of those involved.
Introduction to Academic Dossier

This dossier consists of four papers selected from work submitted for the following courses: Theoretical Models of Therapy; Advanced Theory and Therapy; Year 3 Options; and Issues in Counselling Psychology.
MELANIE KLEIN:
A PIVOTAL FORCE IN THE EVOLUTION OF
PSYCHOANALYTIC THEORIES
OF HUMAN DEVELOPMENT
MELANIE KLEIN: A PIVOTAL FORCE IN THE EVOLUTION OF PSYCHOANALYTIC THEORIES OF HUMAN DEVELOPMENT

Introduction

Melanie Klein is a pivotal force in the evolution of psychoanalytic theories of human development. Born in Vienna in 1882, her interest in Freud's work flourished when she moved to Budapest and underwent personal analysis with Sandor Ferenczi, the principal Hungarian analyst of that time and a colleague of Freud's. While in analysis with him (1912-1919) she developed her interest in the analysis of children, and Ferenczi encouraged her to pursue its study (Cooper, 1996). She read her first paper to the Hungarian Psycho-Analytic Society, 'The Development of a Child', in 1919 and was subsequently invited to further psychoanalytic practice and research in Berlin by Karl Abraham, then President of the Berlin Psychoanalytic Society (Symington, 1983). Even though she intended to remain loyal to Freud and presented her work as an extension of his theories, her contributions to the Berlin Society (1921-1925) generated much controversy and, after she ultimately settled in England (1926-1960), culminated in a major ideological schism within the British Psychoanalytic Society (Greenberg & Mitchell, 1983). This paper will discuss some of the ways in which Klein's ideas departed from Freud's structural model and have been instrumental in the development of object relations theory.

The primacy of object relations

Klein reformulated Freud's concept of drives as structureless and tension producing phenomena, which become secondarily attached to objects for gratification purposes, to incorporate objects as a constitutive part of their nature. Her theory assumes that, from the outset of human development, anxiety is generated by conflict between the life and death instincts. Klein posited that the latter is "experienced as the fear of an uncontrollable overpowering object" (1946: 4). For example, the human baby is subject to different experiences and stimulations as the inter-uterine environment changes continuously throughout the processes of conception, pregnancy and birth (Piontelli, 1992). Klein (1930) believed that the infant's threatening experience of helplessness and dependence on the mother for the satisfaction of its vital needs
underlies its aggressive motives for possession, control and destruction. In this manner, Greenberg and Mitchell (1983) have emphasised that unlike Freud, who regarded the life and death instincts as properties of biological tissue, Klein considered these forces to have a phenomenological basis in experience. Innate and unconscious phantasies and anxieties bound up with specific relations with specific others, therefore, comprise the building blocks of mental processes in her theory.

The analysis of very young children convinced Klein "that there is no instinctual urge, no anxiety situation, no mental process which does not involve objects, external and internal; in other words object relations are at the centre of emotional life" (1952: 257). In her theory, intrapsychic representations of aspects of relations with other persons are comprised of 'bad' and 'good' objects. Bad objects arise from the primitive and aggressive drive to deflect the death instinct from self-destruction. Their harsh and persecutory feelings of hate, destructiveness and envy are projected on to relations with specific others in the outside world. Good objects, on the other hand, represent the life instinct and are introjected from positive experiences with primary caregivers and the surrounding environment. For example, Klein stated that "feelings of love and gratitude arise directly and spontaneously in the baby in response to the love and care of his mother" (1964: 65). Klein likened the formation of the superego to an "assembly of internalised objects" (1940: 330). Contrary to Freud, whose writings give it a developmental date of four or five years, Klein observations led her to believe that the superego unfolded during the second year of life at the latest (see Hinshelwood, 1998). Her model characterises the earliest stages of object relations as a blending of perceptions of real objects in the external world with projected images.

A relational 'position' model
Klein (1928) considered that Freud's psychosexual 'phases' were not distinctly sequential and that various stages overlap and merge into each other. In turn, she replaced the concept of stage with that of object relationship (Moore & Fine, 1990). Klein proposed an alternative model of human development oriented in two basic 'positions' of mental life. Each of these refer to a combination of drives, defences, and relations to objects. The 'paranoid-schizoid' position (Klein,1957) represents the first and most primitive form of mental functioning. The term 'paranoid' is used to describe the intense state of anxiety over the threatened, fantasied annihilation by persecutory
internal objects. 'Schizoid', on the other hand, refers to the process in which the infant gradually learns to defend itself against persecutory anxieties by introjecting good experiences and separating these from bad feelings, which are consequently projected outwards. This process is accompanied by the tendency to idealise good objects and denigrate bad ones: "in the very earliest stage every unpleasant stimulus is related to the 'bad', denying persecuting breasts, every pleasant stimulus to the 'good', gratifying breasts" (Klein, 1935: 305-306). Splitting, projection and introjection are essential processes through which the infant begins to separate good from bad and organise the perceptions and emotions which constitute its internal world (Klein, 1932). This achievement is a precondition for the child's potential to tolerate ambivalence.

Klein (1935) suggested that by time the infant is three to four months of age it should develop in rudimentary form the capacity to integrate love and hate for objects and reconcile their good and bad parts. She believed this process occurs as the infant begins to experience its mother as a whole object and realise that the mother which generates good feelings, associated with successful feeding and nurturing, and bad feelings, associated with frustration, aggression and loss, is one and the same person. The recognition that the frustrating and hated object is also the one that nourishes and is loved generates the onset of the 'depressive position'. The developing capacity to tolerate ambivalence leads to a shift from the persecutory anxiety pervading in the paranoid schizoid position to feelings of guilt and concern that aggressive impulses may destroy the object now recognised as needed, important and loved.

Klein likened the passage from the paranoid-schizoid position to the depressive position with the resolution of the Oedipal stage, which she believed occurs in the earliest stages of infancy (see Hinshelwood, 1998). It requires the child to accept its temporary exclusion from the parental couple and tolerate the phantasy of the 'primal scene' (Bateman & Holmes, 1995: 64). However, Klein contended that Freud had:

not given enough weight to the crucial role of these feelings of love, both in the development of the Oedipus conflict and in its passing ... the Oedipus situation loses in power not only because the boy is afraid ... but also because he is driven by feelings of love and guilt to preserve his father as an internal and external figure (1945: 389).
It would seem that Klein emphasised the child’s growing concern for the object and its welfare over the fear of castration as central to the resolution of the Oedipus complex. Like the depressive position, therefore, she appears to imply that this development involves the child’s acceptance of dependence on the parental couple.

It is true that the paranoid schizoid and depressive positions may be seen as phases of development. However, Moore & Fine (1990) explain that the term ‘position’ emphasises that the phenomenon described are not simply manifestations of a passing stage. For example, Segal (1973: ix) has stated that these represent “a specific configuration of object relations, anxieties and defences which persist throughout life”. Thus, the depressive position never fully supersedes the paranoid-schizoid position. Defences against depressive conflict, which can be characterised by the realisation and acceptance of the interdependent and mortal implications of our human condition, tend to generate regression to paranoid-schizoid mechanisms. There is, therefore, a constant oscillation between the two positions (Bateman & Holmes, 1995), although the predominance of the paranoid-schizoid is associated with mental unrest.

**Notions of normal and disturbed development**

Feelings of guilt and sadness associated with the depressive anxieties are an integral part of what Klein considered normal development (Klein, 1948). The infant gradually learns to cope with these anxieties by means of 'reparation', a concept that includes all efforts to spare the object from harm, particularly from the damage threatened by its own psychic conflict. Reparation characterises the triumph of love over hate, otherwise represented as the triumph of the life instinct over the death instinct. It epitomises the potential for holding the object together with its good and bad parts. On the other hand, the continuing prevalence of destructive impulses generates envy, a hatred directed toward good objects that transforms them into denigrated and worthless objects. In this manner, unresolved paranoid-schizoid mechanisms tend to account for disturbed interpersonal development. They can in some cases ultimately elicit despair about "being dominated by destructive impulses and about having destroyed oneself and one's good object" (Klein, 1960: 266). A case example seems necessary to illustrate these dynamics.
When Mr. Leonard Smith began therapy, his wife had left him a few months earlier. He explained that he had had frequent outbursts of anger throughout their marriage, in which he would lash out at her and treat her with contempt. Now he felt bad about his offensive behaviour but said that, at the time, he never experienced any feelings of guilt. In the course of therapy, it emerged that loving his wife had felt too threatening for him and, in turn, he would inadvertently turn to “hating” her. The breakdown of their marriage and her loss had impelled him to want to work through the underpinnings of his paradoxical behaviour and its destructive impulses.

When I inquired about his childhood, Leonard told me that he was born illegitimate. His mother had abandoned him shortly after birth. He lived in an orphanage for the first year of his life and then in various foster homes until adulthood. Such information suggested that the lack of stability throughout his development had probably prevented him from introjecting sufficient and reliable good object experiences. His overriding fear of loving his wife, for example, intimated that harsh and persecutory feelings continued to prevail upon his internal world. In turn, Leonard’s tendency to turn to “hating” her appeared to convey the predominance of ongoing paranoid schizoid mechanisms, characterised by his lack of guilt and concern about repairing the effects of his destructive impulses.

In Klein’s theory, splitting and projecting are considered primitive defence mechanisms. These can persist throughout life when an individual like Leonard seems to lack a good and secure internal object to enable him to manage anxiety, frustration and loss (Klein, 1932). Its establishment in the core of the ego presupposes the triumph of love over hate in the depressive position. Nonetheless, Leonard’s intention to work through his destructive impulses suggests a growing concern for the Other, now recognised as needed, important, and loved, which hints at the movement towards the depressive position.

**Contributions to clinical practice**

Among the numerous defence mechanisms described in Klein’s model, she is well known for her development of the concept of ‘projective identification’ (1946). Klein depicts this activity as a phantasy in which bad parts of the infantile self are split off from the rest of the self and projected into the mother or her breast. Projection is the
mental mechanism in which the infant feels that its mother has 'become' the bad parts of itself and projective identification is the specific phantasy expressing it (Moore & Fine, 1990). This automatic and unconscious mental process can continue throughout the lifespan. Klein emphasised its interactive aspect, in which the recipient of the projection may be induced to feel or act in ways that originate with the projector.

An example of my experience as the recipient of projective identification occurred in my clinical work with Ms. Miranda Jones. At the assessment session, she revealed that she had always felt like a "a doormat". She reported that her parents had raised her "like an animal," providing basic needs such as food and shelter, without ever attending to her in more meaningful ways. The next few sessions were characterised by long periods of silence. What was supposed to be a shared enquiry process felt more like 'pulling teeth'. Miranda appeared generally resistant to therapeutic engagement, steering away from making eye contact and speaking very little. When I would try to probe her thoughts, she would respond with 'dead end' replies. It was as if she was preempting the possibility of anything good to unfold from the therapy. Her defensive behaviour made me feel like I had been 'shoved into a corner'. When I heard myself speak, I discovered that what I intended as tentative communications sounded more like tense, quasi staccato statements.

Upon discussing my reactions with my supervisor, she encouraged me to use the concept of projective identification as a means to reflect on my feelings. This helped me to discern that the overwhelming sense of oppression and frustration, which characterised my experience of feeling ‘shoved into a corner’, seemed to have much in common with Miranda’s ongoing experience of feeling like “a doormat”. In the next sessions, I realised that I had become “identified” with the bad parts of herself. My own painful identification with Miranda’s difficulties, nonetheless, provided me with invaluable insights about the very hostile and persecutory feelings which appeared to prevail upon her internal world. This experience enabled me to empathise with her difficulties better and use my feelings to inform my transference interpretations. In turn, Miranda began to trust me to assist her to explore and work through the unresolved affects, stemming from her developmentally deficient experience, that she seemed to transfer on our therapeutic relationship.
Klein's development of projective identification challenged Freud's notion of countertransference as simply an emotional reaction to overcome, comprised of the analyst's own complexes and internal resistances arising from a patient's transference (Hinshelwood, 1994). The interpsychic dynamic of projective identification affirmed that the therapeutic relationship does not consist of the presence of feelings in the client and their absence in the therapist. Rather, Heimann (1950) put forward that the analyst's countertransference represents one of the most important research tools for understanding the patient's unconscious. In turn, this view reinforces the imperative for therapists to reflexively examine and evaluate their feelings and reactions to clients.

Klein's developmental concepts have also been used to crystallise the dynamics of transference interpretations. For example, Money-Kyrle (1956) put forward that the analyst's role involves introjecting the patient's experience and then reprojecting it back to the patient. He likened this process to 'metabolization', in which the analyst's understanding gives the patient's experience a more communicable form. This process is geared to enabling the patient to (re)introject the 'metabolised' experience, along with insights for understanding themselves better.

**Difficulties and limitations with Klein's model**

Notwithstanding Klein's theoretical and clinical contributions, her model still contains its difficulties and limitations. Three main areas that seem particularly controversial are Klein's belief in the death instinct; her assumption of far-reaching constitutional knowledge and imagery; and her presupposition of considerable cognitive capacities in the infant at or shortly after birth (Greenberg & Mitchell, 1983). Modell (1968) and Kernberg, (1980) have cast light on the lack of clarity regarding the relationship between phantasy and character formation in her writings. For example, Symington (1986) has explained that mechanisms, such as projection and introjection, are emphasised at the expense of the emotional quality of the object. Furthermore, Greenberg and Mitchell (1983) have stated that Klein may have gone to great lengths to conceptualise object relation equivalents of Freud's structural concepts at the cost of evolving her own theory. This is manifested in statements throughout her writings, such as "the incorporated object at once assumes the functions of a super-ego" (Klein, 1932: 184n) and "the first internal good object acts as a focal point in the ego" (Klein, 1946: 6).
Klein's object relations theory offers a new and creative reformulation of Freud's drive/structure model, yet remains ultimately faithful to the classical view that all significant aspects of mental life are internally derived. Klein's belief that good experiences with parents transform the child's bad objects into more favourable whole objects, for example, implies that the origins of mental illness rest in the child's own aggression, which may or may not be able to be modified by nurturing. She seems to fall short of considering that problematic features in the parents' own personalities, along with the reality of dysfunctional environments, may cause the development of bad objects and the genesis of emotional disturbance in the child. Likewise, Kleinian psychotherapy maintains that external events are not of primary importance (Cooper, 1996), while it is well known that these events can exacerbate or alleviate distress.

Finally, Klein's account of the two basic 'positions' of mental life has also generated debate. In particular, she does not develop a notion of what a middle ground between the paranoid-schizoid and the depressive position might be like. Steiner (1993) has, in turn, coined the 'borderline position' to identify the mental condition of an internal 'bad parent' object who punishes and persecutes, while combining elements of revenge and triumph over the object. Symington (1986) has proposed the 'tragic position' to suggest what might follow the 'depressive position'. This condition implies the realisation that the human condition is fraught with extenuating circumstances (such as war, economic crisis, unemployment) beyond an individual's control. These, in turn, are likely to impinge upon the formation of one's internal world, experience of parental care, and subsequent development.

**Conclusion**

Klein's shortcomings nonetheless inspired the pursuit of theory, research and practice in areas that she failed to address or did not adequately explain. Subsequent theorists, like Winnicott and Bowlby, left Freud's structural model behind and proceeded to recognise the importance of the 'holding environment' and the 'secure base' for generating positive emotional development. Just as Freud continues to be seen as a seminal figure for introducing the study of psychoanalysis, therefore, Klein represents a pivotal force in revolutionising its outlook. Her influence generated a major ideological schism within the British Psychoanalytic Society during the 1930s and 1940s, upon which three groups were formed: the 'A Group', loyal to Anna Freud; the
'B Group', loyal to Klein, and the 'middle group', consisting of Winnicott and others who did not ally themselves with either side. The emergence of these factions reflects the beginnings of pluralism and diversity among British psychoanalytic theorists. None possess the 'truth' but each has offered its own models and metaphors for which to come to know the mysterious processes of human development.
REFERENCES


IN COGNITIVE THERAPY, THERAPEUTIC CHANGE IS NOT DEPENDENT ON THE THERAPEUTIC SYSTEM OF DELIVERY, BUT ON THE ACTIVE COMPONENTS WHICH DIRECTLY CHALLENGE THE CLIENT'S FAULTY APPRAISALS. DISCUSS.
IN COGNITIVE THERAPY, THERAPEUTIC CHANGE IS NOT DEPENDENT ON THE THE THERAPEUTIC SYSTEM OF DELIVERY, BUT ON THE ACTIVE COMPONENTS WHICH DIRECTLY CHALLENGE THE CLIENT'S FAULTY APPRAISALS. DISCUSS.

Introduction
It would seem that this essay question has been inspired by the longstanding perception that cognitive therapy overlooks the importance of relational factors in favour of technical skills. This idea may derive from the fact that, contrary to their humanistic and psychoanalytic counterparts, cognitive therapists are famous for using tools and techniques, as 'the active components which directly challenge clients' faulty appraisals'. Beck and his colleagues' repeated assertion that the therapeutic relationship is a necessary but not sufficient condition for change (Beck et al., 1979; Beck et al., 1993) has, in turn, continued to seem at odds with psychotherapeutic approaches which use the therapeutic relationship as a central mechanism of change. This paper seeks to explore that in cognitive therapy, therapeutic change is dependent on relational aspects, between client and therapist, pertaining to the 'therapeutic system of delivery'. Yet, the view that the therapeutic relationship is not in itself sufficient for generating change tends to vary in accordance with whether a 'rationalist' or 'constructivist' approach is implemented. Before beginning this exposition, a brief review of the cognitive paradigm seems necessary.

Cognitive paradigm
The 1970s witnessed a 'cognitive revolution' (Mahoney & Arnkoff, 1978) in psychology, which inspired greater interest in the relevance of cognitive processes to therapy. Bandura's pioneering research of social learning theory, for example, demonstrated the capacity to understand the phenomena of modelling from a cognitive rather than strictly behaviourist perspective (Bandura, 1977; Rosenthal & Bandura, 1978). Mahoney, in turn, drew attention to the significance of cognitive processes, such as expectation and attribution, in conditioning an individual's management of their own behaviour (Mahoney & Arnkoff, 1978). During this time, Beck (1976) and his colleagues (Beck et al., 1979) put forward what is now commonly regarded as the original model of cognitive therapy. It conceptualised psychological disturbance as the
result of some malfunction in the process of interpreting and evaluating experience.

Beck's research (1963, 1964) into depression indicated that this condition was associated with a form of 'thought disorder', in which the depressed person repeatedly distorts incoming information in a maladaptive way. Beck termed the resulting frequent and disruptive cognitions 'negative automatic thoughts' (NATs). In depression, NATs habitually convey a negative view of the self, the world, and the future (Beck, 1976). Beck posited that these self-defeating thoughts aggravate depressing mood and, in turn, perpetuate the vicious cycle of negative affect and cognition. Further research applied Beck's propositions to other emotional disorders. Clark (1986), for example, presented a model of panic, which emphasises the way in which catastrophic misinterpretations of bodily symptoms create a vicious cycle of anxiety leading to more bodily sensations and more panic. These and other investigations on psychological disturbances, including hypochondriasis (Salkovskis & Warwick, 1986), obsessive compulsive disorder (Salkovskis et al., 1995) and personality disorders (Beck et al., 1990) provide evidence that each of these diagnostic groups selectively filters information in a slightly different way, that is associated with perpetuating their distress.

NATs are considered symptomatic of deeper cognitive structures, known as schemas. Beck (1967) put forward that schemas contain beliefs which represent individuals' understanding of themselves, their world and others. Healthy schemas reflect stable, adaptive, and relativistic core beliefs whereas dysfunctional schemas reflect extreme, rigid and absolute core beliefs. More recently, cognitive interpersonal therapists (Safran & Segal, 1990; Liotti, 1991; McGinn & Young, 1996; J.S. Beck, 1996) have elaborated the schema concept to incorporate self-other interactions which originate from early attachment relationships. An individual with a secure developmental history, for example, may develop the core belief that 'other people may be beneficent, neutral, or malevolent toward me' whereas an individual with an abusive or deficient developmental history may develop the core belief that 'other people are untrustworthy'. Maladaptive beliefs, often expressed as rigid rules, pessimistic attitudes and conditional assumptions, predispose negative ways of construing experience. Schemas vary in the extent to which they are active at any given time. They tend to be triggered by events which threaten a person's sense of security and, in turn,
channel all stages of processing (Beck et al., 1990). The self-protective tendencies of dysfunctional schemas, however, trigger cognitive distortions and behavioural strategies which incline individuals to think or act in ways that maintain the problem.

Cognitive theory emphasises the modification of dysfunctional patterns of interpreting and evaluating experience. Its multilayered conception of the human apparatus, comprised of physiological symptoms, automatic thoughts and affects at the bottom, and core beliefs and assumptions at the top, has inspired the emergence of a variety of different therapeutic models within the cognitive paradigm. These can be broadly categorised as either ‘rationalist’ or ‘constructivist’. Rationalist approaches (Beck et al., 1979; Beck & Emery, 1985) such as cognitive behavioural therapy (CBT), assume that psychological disturbance results from irrational or distorted ways of seeing the world. Their problem-oriented practice generally reflects ‘bottom-up’ work (Wills & Sanders, 1997), which tends to begin by focusing on therapeutic change at the symptom relief level. ‘Constructivist’ approaches (Guidano & Liotti, 1983; Liotti, 1986), such as cognitive interpersonal therapy (CIT), on the other hand, reject the correspondence theory of truth and its corollary assumption that beliefs that fail to correspond to objective reality are, by definition, dysfunctional. They stress an understanding of the cognitive elements arising from each person’s interpersonal experience which are, in turn, associated with the construal of their own subjective reality (Pilgrim, 1997). Constructivists’ practice generally reflects ‘top-down’ work (Wills & Sanders, 1997), which tends to begin by exploring the developmental origins of clients’ maladaptive schemas. The next sections will each, in turn, respectively illustrate CBT and CIT renditions of therapeutic practice. Case material seeks to show that effective practice is dependent on the ‘therapeutic system of delivery’ regardless of the therapeutic approach implemented.

**Therapeutic change with cognitive behavioural therapy**

CBT is frequently associated with brief therapy, geared to achieving therapeutic change at the symptom relief level. This is often the most urgent and immediate point at which very distressed people need help. A client’s abnormal fears of going out and getting panic attacks, for example, may impede them from achieving tasks that are vital to their daily wellbeing, such as taking public transport, going to the supermarket, and maintaining medical appointments. CBT aims to enable clients to confront the NATs
which maintain their negative feelings and, in turn, interfere with their behavioural functioning. CB therapists, therefore, stress that the basic principles of their model be made accessible to clients so that they can learn a set of new skills to cope better with their problems. This requires the ‘therapeutic system of delivery’ to offer an elaborate, well-planned case conceptualisation of each client’s situation at the outset of therapy (Wills & Sanders, 1997).

A case conceptualisation seeks to provide clients with an account of their difficulties that is likely to increase their sense of understanding and control over their problems (Turkat & Maisto, 1985). This involves explaining to clients that it is their interpretation and evaluation of an event that is the major influence on their emotional response rather than the event per se (Moorey, 1996). In the case of the client who is afraid of going out and getting panic attacks, for example, a CB therapist is likely to put forward that it is their perception of major physical threat, combined with their underestimation of their ability to cope with the threat, that maintains their panic symptoms rather than the actual threat itself of going out. I have found that explaining the case conceptualisation is not a simple technical task, but instead incorporates the fundamental process of building a working alliance between the client and myself. As such, it should be based on the client’s subjective account of their difficulties and couched in their distinctive ideas, language and metaphors for them to feel heard and understood. In turn, it is equally important to convey warm and empathic feelings toward each client’s situation in order to come across as a coworker rather than a teacher. Effective delivery of the therapeutic system is associated with generating a bond between client and therapist in which they agree on a goal for therapeutic change and negotiate an agenda with relevant tasks for achieving that goal (Bordin, 1979).

An integral part of the process of achieving symptom relief requires clients to engage in ‘active components that directly challenge their faulty appraisals’. In CBT, these undertakings often occur separately from the therapeutic process. They generally include the accomplishment of self help tasks outside the therapy session, such as taking part in behavioural experiments, completing diaries of NATs and alternatives, and keeping weekly activity schedules. For the client who is afraid of going out and getting panic attacks, for example, this will involve encouraging them to reality test their anxieties by confronting rather than avoiding the feared situation. A mutually
agreed upon coping strategy to facilitate the process of experiencing their panic spiral subside may require the client to try to replace their NATs with more positive thinking. This behavioural experiment is nonetheless likely to feel threatening for the client who believes that they will have a panic attack when they go out. A large part of the client’s ability to engage in self-help activities, therefore, will depend on their confidence in the therapist and their treatment plan about the causes of the symptoms and the procedures for their resolution (Kazdin, 1986).

It is crucial for therapists to respond to clients who experience difficulty accomplishing self-help tasks in a warm and empathic manner (Burns & Auerbach, 1996). This creates a safe holding environment in which clients can feel comfortable to verbalise the thoughts and feelings which prevented them from engaging in the activities (Wills & Sanders, 1997). In my own clinical work, this is a recurring experience with clients. At the assessment session, for example, Mr. Paul Parry, a client with moderate Beck Depression Inventory (BDI) scores, and I agreed that he would keep weekly activity diaries. The following session, he confessed that he had not been able to attempt this task. As we endeavoured to uncover what had impeded him from trying it, he was able to talk about the activities that he had achieved. It emerged that he did not think these were ‘good enough’ to be recorded. This revelation made it possible for me to recognise and discuss with him how his NATs seemed related to his perfectionist assumptions which, in turn, appeared to perpetuate his self-defeating thoughts and low mood. This interaction enabled us to collaborate on reframing his high expectations with more realistic goals. Paul felt reassured of my support and understanding and appeared more inclined to value his own efforts better. In the following weeks, his decreased BDI ratings seemed associated with a growing sense of mastery over his dysthymia. This was also manifested by his completion of the weekly activity diaries.

Paul’s improvement illustrates that therapeutic change rests on the client’s confidence in the therapists’ commitment to the joint struggle against what is impeding them (Luborsky, 1976). This is consistent with research studies which demonstrate that the patients of therapists who were the warmest and most empathic improved significantly and substantially more than the patients of therapists with the lowest empathy ratings (Luborsky et al., 1988; Parloff et al., 1978). It would seem that a client’s introjection of
a positive therapeutic relationship acts as a precondition for modifying their negative patterns of evaluating and interpreting experience. Without the facilitating role of the ‘therapeutic system of delivery’, therefore, the ‘active components which directly challenge the client’s faulty appraisals’ would indeed become “gimmick-oriented” (Beck et al., 1993: 135).

**Therapeutic change with cognitive interpersonal therapy**

CI therapists emphasise that the individual's generic representation of self-other interactions predisposes them to develop clinical problems and must be modified to prevent the risk of relapse and generate enduring change. Safran (1990), for example, posits that interpersonal schemas are embedded within individuals’ distinctive cognitive-interpersonal cycles in which characteristic processes of construing experiences lead to characteristic behaviours and communications. These, in turn, may act as self-fulfilling prophecies which evoke schema consistent responses in others. CIT is associated with longer-term therapy frameworks, geared to assisting clients with pervasive interpersonal patterns of disruption to restructure their maladaptive core beliefs (Jacobson, 1989; Liotti, 1991; J.S. Beck, 1996; McGinn & Young, 1996).

CI therapists consider the therapeutic relationship a primary forum for generating a safe holding environment in which clients’ can learn to evaluate and test their dysfunctional interpersonal schemas. Safran has emphasised that therapists’ feelings and action tendencies, termed ‘interpersonal markers’, harbour some of the most important clues for discerning clients’ disruptive behaviours and communications. He incorporates Sullivan’s (1953) notion of the therapist as a participant-observer in the interaction with the client. This dynamic implies that therapists may experience clients’ ‘interpersonal pull’ like other people, yet use their feelings and reactions to identify specific events and themes that trigger problematic interpersonal patterns for the client. Rather than following their automatic inclinations to withdraw or retaliate, therefore, the task of therapists involves ‘metacommunicating’ with clients about their reactions to enable them to explore their own feelings and automatic thoughts. The following case example seeks to illustrate these ideas.
Mrs. Kadee Silvers, a woman who had undergone a transfemoral lower limb amputation, was experiencing depressive symptoms that seemed characterised by her overwhelming sense of social isolation. Ever since her amputation, she had difficulty maintaining friendships and relations with able-bodied people. At the assessment session, she appeared withdrawn, and hardly made any eye contact with me at the outset. I felt like she was rejecting me and, in the course of the session, resolved to comment on her reserved behaviour. She revealed that she felt uncomfortable to pursue therapy with an able bodied practitioner. I empathised with her and conveyed that I could understand her difficulty to relate with someone who had not undergone a similar traumatic experience. This acknowledgement enabled her to feel more relaxed and, in turn, she began to share her developmental history with me. Her parents had both died during her infancy. She was subsequently adopted by her aunt and uncle, who never told her that she was not their natural child. Kadee discovered the truth by accident as a young adult. Nonetheless, she explained that throughout her upbringing she never experienced a safe sense of emotional security. She reported that her aunt was habitually rejecting and, instead, loving to her three other siblings, whom she later discovered were her natural children.

Kadee explained that throughout her adulthood, until her amputation, she had been socially outgoing as a means to compensate for her inherent lack of trust and relatedness with others. As I listened to her story, it became increasingly apparent to me that her amputation had threatened her false sense of wellbeing and compelled her to revisit the awkward sense of feeling different that characterised her upbringing. Her assumptions conveyed that if she was different then she would be rejected, and such was the situation she feared with able-bodied people now. This enabled me to understand her rejecting interpersonal pull on me. The dysfunctional self protective behaviours and communications, which characterised her problematic cognitive-interpersonal cycle, instigated feelings of rejection in others out of fear of being rejected herself. In the course of therapy, I was able to use my interpersonal markers to make tentative metacommunications about the feelings and reactions she possibly provoked in others. She gradually realised that her interpersonal difficulties were not related to her disability as such but to her processes of interpreting experience which, in turn, could evoke schema consistent responses from others.
Clients are frequently unaware of the effects they have on others, or the manner in which they instigate these reactions. Through their metacommunications and capacity not to react in a complementary fashion, CI therapists seek to assist clients to identify and subsequently change aspects of their communication style that maintain their dysfunctional interactional cycle. The ‘active components which directly challenge the client’s faulty appraisals’ are, therefore, often integrated within the therapeutic system of delivery through the intersubjective interaction between client and therapist. The client’s experience with the therapist facilitates experiential disconfirmation of their dysfunctional schemas. Kadee’s development of trust in me, for instance, enabled her to challenge her maladaptive beliefs and helped her to work through her defence against trusting and relating with others. In CIT, therefore, the ‘corrective attachment experience’ (Liotti, 1991) contained in the therapeutic relationship can in itself be considered sufficient for generating change.

Conclusion
This paper has sought to illustrate that the role of ‘the therapeutic system of delivery’ transcends theoretical and conceptual differences within the cognitive paradigm. The view that the therapeutic relationship is a necessary but not sufficient condition for change, however, seems to primarily apply to rationalist approaches. Their realist epistemological underpinnings would appear to draw a line between the personal context of the therapeutic relationship and the supposedly objective content of the external world. In turn, they tend to view the modification of the client’s “faulty appraisals” as frequently and ultimately resting on empirical disconfirmation. Constructivists, on the other hand, tend to view the therapeutic relationship as a primary forum in which clients can learn to test and reevaluate their maladaptive schemas. The modification of a client’s phenomenological ways of construing their subjective reality can thus rest within the symbolic interaction with the therapist. Nevertheless, this does not mean that constructivists do not incorporate the use self help activities for clients, where appropriate, or that rationalists do not consider the therapeutic relationship as an essential ingredient for achieving change. Moreover, aspects of the rationalists’ ‘bottom-up’ practice and the constructivists’ ‘top-down’ practice can be integrated in a flexible manner that caters to the needs and difficulties of each individual client.
Finally, the development of CIT within the cognitive paradigm reflects a growing convergence with other theoretical approaches which use the therapeutic relationship as a central mechanism of change. CIT’s concept of interpersonal markers, for instance, incorporates many aspects of the psychodynamic concept of countertransference and, in turn, their use of metacommunications bears many resemblances to the psychodynamic use of transference interpretations. These overlapping skills and techniques reflect the integrative potential of cognitive therapy. The increasing recognition of the overriding value of relational practice seems to affirm today’s growing trend towards ‘beyond schoolism’ (Clarkson, ‘97), which maintains that ‘schools’, ‘orientations’ and ‘approaches’ will be less important than the experience of a positive therapeutic relationship for generating change.
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THE INTEGRATIVE INTERFACE
OF
OBJECT RELATIONS THEORY
THE INTEGRATIVE INTERFACE OF OBJECT RELATIONS THEORY

Introduction

Object relations theory maintains that a person's primary motivational drive is to seek a relationship with others. This psychodynamic model puts forward a system of psychological explanation based on the premise that the mind is comprised of intrapsychic representations of aspects of relations with other persons, known as internal objects, which are taken in from the outside (Moore & Fine, 1990: 131). Relational pattern stems from how a person's connections with their primary caregivers were expressed. Early relational experiences are internalised and provide a template for subsequent attitudes, reactions, and perceptions. The maturing person's ego and object become connected by affects which create a dynamic system of parts in relation, called the internal object relation (Scharff & Scharff, 1998: 121). People react to and interact with not only actual others but also internal others, psychic representations of significant persons in their developmental experience, which can influence both their affective states and overt behavioural reactions (Greenberg & Mitchell, 1983: 13-14). The practice of object relations theory is concerned with exploring the ways in which individuals interact with external and internal other people, and the relationship between their external and internal object worlds.

In this paper, I will focus on the contributions of Melanie Klein and Donald W. Winnicott, who are considered among the founding figures of British object relations theory (Moore & Fine, 1990; Scharff & Scharff, 1998; St. Clair, 2000). Their theories, or aspects of their theories, have profoundly influenced my psychological understanding of the following areas: (1) inter- and intrapsychic development; (2) problematic and enduring aspects of interpersonal relations and; (3) transference and countertransference dynamics in the therapeutic relationship. Due to the word length constraints of this paper, it will primarily focus on the first two areas. After reviewing them in the following section, I will draw out some theoretical convergencies with aspects of Bowlby’s attachment model, the cognitive interpersonal model, and the humanistic models. I will also explore how these three paradigms can be integrated to elicit a more holistic understanding of human behaviour. Implications for therapeutic practice will be briefly highlighted at the conclusion.
The contributions of Klein and Winnicott

Klein’s model of human development consists of ‘bad’ and ‘good’ objects. Bad objects reflect the infant’s internal persecutory anxiety about death and destruction. The ‘paranoid-schizoid’ position defines the state characterised by the harsh and persecutory feelings of bad objects, which are projected on relations with specific others in the outside world. Good objects, on the other hand, are introjected from positive experiences with parents and the surrounding environment (Klein, 1964). The interplay between good and bad object experiences begins with the infant’s experience of their mother, or caregiver, as a whole object who exudes good feelings, associated with successful nurturing, and bad feelings, associated with intrapsychic anxieties about abandonment (Klein, 1932).

The predominance of good object experiences establishes in the core of the ego a good and secure internal object (Klein, 1932). It has the the intrapsychic capacity to tolerate ambivalence and, in turn, integrate good and bad object experiences. This change from part object to whole object relationships represents the onset of the ‘depressive’ position, wherein the aggressive impulses pervading the paranoid-schizoid position are counterbalanced by guilt and attempts at reparation (Klein, 1957). If bad object experiences predominate over good ones, however, integration is experienced as the destruction of the little good one possesses. This perpetuates paranoid-schizoid mechanisms of splitting good from bad object experiences and projecting the latter outwards, as part of the individual’s attempt to rid themselves of everything that is felt to be bad and disruptive. There are always fluctuations between the two positions (Bateman & Holmes, 1995). The prevalence of the depressive is nonetheless associated with promoting development and maturity, whereas the prevalence of the paranoid-schizoid is associated with generating psychological disturbance (Segal, 1985).

Klein emphasises the role of innate, intrapsychic processes, whereas Winnicott emphasises the role of the environment. Parental availability and reliability provide a ‘holding environment’ for the infant to face the dangers of the external world, including frustration, aggression, and loss. The ‘good enough mother’ nurtures the establishment of a good internal object which enables the child to integrate the different aspects of its psychological experience. This process facilitates the
spontaneous expression of the child's 'true self', which has a 'me' and a 'not-me' clearly established (Winnicott, 1958a: 216). The lack of parental ego support, however, confronts the child "with a handicap in his own self-integrating task" (Winnicott, 1958b:150). This process tends to result in the prevalence of a 'false self', which is primarily concerned with defending itself against its feelings of overwhelming anxiety stemming from the failure of holding (Winnicott, 1965a). Even though most people have a social self that is tuned to outer reality and constructed from a certain amount of false sense structure (Moore & Fine, 1990: 209), its predominance generates a reactive form of living which may imply psychopathology (Winnicott, 1965b).

My integration of their contributions

My psychological understanding of the inter- and intrapsychic aspects of human development combines aspects of Klein and Winnicott's respective models. It considers interpersonal development as an interaction between the maturing person's innate, unconscious processes and their experiences with the external world. As such, this outlook acknowledges the role of inherited physiological factors which, at least in part, account for individual differences. The quality of the outside environment acts to facilitate or impinge individuals' unique potentials for personal growth and wellbeing.

Klein and Winnicott's respective models have converging concepts. Both consider the ego's establishment of a good internal object as the precondition for psychological integration. It signifies the increased organisation of the individual into a unit self (Winnicott, 1965c). Integration is associated with the true self and the depressive position and implies the capacity to differentiate 'self' from 'not self'. The reparative self object concerns that characterise the depressive position, for example, indicate the recognition that the object exists outside the self. The prevailing paranoid-schizoid mechanisms of projecting persecutory impulses on the outside world, on the other hand, suggests the lack of a clear differentiation between self and object. The paranoid-schizoid position can, in turn, be considered an expression of the false self. In the absence of psychological integration, both resort to a reactive form of living to protect the core self from its internal fear of fragmentation and destruction. The models of Klein and Winnicott, nevertheless, reconcile conflicting aspects from the developmental positions and the true and false selves into their respective notions of
the self. It is individuals with a predominance of the paranoid-schizoid position and/or false self who are prone to mental unrest.

In my clinical work, I use object relations concepts as “models” and “metaphors” (Clarkson, 1998:10-11) to elucidate certain types of deeply unconscious internal experience. In addition, I consider Klein and Winnicott’s emphases on the mother for healthy interpersonal development as primarily a reflection of the particular social and historical context in which their theories evolved. In my appreciation of their work, I prefer to regard the “good enough mother” as a metaphor for the parental availability and reliability of either or both caregivers, regardless of their gender. Nonetheless, Klein and Winnicott’s ideas have provided me with an interpretative framework to make sense of the client’s phenomenological experience. Its purpose is not to discern an “objectively discoverable ‘truth’” (Strawbridge & Woolfe, 1996: 619) but to help me obtain a better understanding of the inter- and intrapsychic processes which may constitute a client’s internal world. This paper will now explore how aspects of object relations theory have become integrated within my psychological understanding of aspects of attachment theory, as well as aspects of the cognitive and humanistic models respectively.

Integration with other psychological models

Object relations and Bowlby’s attachment theory

Bowlby’s attachment theory validates the object relations premise that a person’s primary motivational drive is to seek a relationship with others. His study of actual behaviours demonstrated that pleasure seeking was entirely secondary to the main goal of the infant’s instinctual behaviours, which was to seek attachment to the mother in order to secure survival (Bowlby, 1958). Bowlby’s findings reinforce Klein’s criticism of Freud’s notion of instincts as objectless (Klein, 1952/1975: 53) and Winnicott’s focus on the child’s relationship with the mother. His observation that the young of all species show aggression when their attachment needs are frustrated (Bowlby, 1973) can, for instance, be explained by Klein’s proposition that infants cope with the destructive impulses of bad object experiences by projecting them on the outside environment. Albeit some authors (Greenberg & Mitchell, 1983) consider that Bowlby conceived an alternative, instinctually based theory, his study of actual
behaviours appears to complement and provide experiential support for the interpsychic processes of object relations theory.

It would seem that Bowlby derived his idea of the ‘internal working’ model, which represents the development of interpersonal interactions relevant to attachment behaviours with primary caregivers, from object relations theory (Holmes, 1993). Like its counterpart, the internal working model characterises an imitation world of the self living and interacting with aspects of the environment and other people it knows or can imagine. Bowlby considered that its function was to transmit, store and manipulate information to make predictions for achieving set goals. This appears to incorporate the central postulate of object relations theory that early relational experiences are internalised and provide a template for subsequent attitudes, reactions, and perceptions. Bowlby may not have invented the concept of the internal working model, but his work seems to have rendered the issue that human beings have a ‘wired in’ propensity for maintaining relatedness to others (Bowlby, 1969) more accessible to other psychologists. Some cognitive theorists, for example, have conceptualised the internal working model in their own ‘language’ as the ‘interpersonal schema’ (Guidano & Liotti, 1983; Young, 1990; Safran, 1990; Safran & Segal, 1990).

Object relations and cognitive interpersonal theory

The interpersonal schema denotes a generalised representation of self-other relationships which guides both the processing of information and the implementation of action. It shares the theoretical interface with object relations and attachment models that interpersonal development is abstracted from early experiences with caregivers, whose internalised relations can determine the individual’s affective states and overt behavioural reactions. Maladaptive schemas are considered the result of dysfunctional experiences with parental figures. They tend to trigger negative thoughts that are reinforced by high levels of anxiety (Young, 1990). Characteristic behaviours and communications, in turn, frequently induce others to respond in a complementary fashion (Safran, 1990).

Object relations theory can assist efforts to work integratively by elucidating the internal processes which underlie cognitive and behavioural features of interpersonal functioning. It is likely, for example, that dysfunctional experiences with parental
Figures impinge psychological integration. In particular, the overwhelming anxiety features that are associated with maladaptive schemas seem symptomatic of the ego's absence of a good and secure internal object. Bad object experiences would, in turn, appear to be projected on the outside world in the form of self-defeating ways of construing experience. These negative cognitions tend to reinforce feelings of persecutory anxiety. Concomitant behaviours and communications can act as self-fulfilling prophecies which evoke schema consistent behaviours in others (Safran, 1990). For instance, I have found that clients frequently instigate feelings of rejection in others out of fear of being rejected themselves. This suggests the lack of differentiation between 'self' and 'not self' as the external world becomes a reenactment and concretisation of the ego's oppressive dynamics. Its reactive coping mechanisms, in turn, can overpower the possibility of good object experiences, to prevail over the fear of destruction. Hence, the maintenance of the vicious cycle of cognitive and behavioural distress.

*Object relations and humanistic theory*

Differentiation is also an essential part of humanistic theory, in which the child begins to distinguish 'self' from 'not self' in the phenomenal field. For Rogers (1959), it accounts for the development of the self-concept, which represents an organised, coherent and integrated pattern of self-related perceptions. This understanding of human development seems congruent with the tenet of object relations theory that psychological integration underlies the increased organisation of the individual into a unit self. In turn, the belief of humanistic theorists (Rogers, 1959; Maslow, 1987) that the structure of the self is shaped through interaction with significant others in the environment converges with the central postulate of Winnicott's model.

Rogers (1959) considered that the core conditions which underlie the development of the self concept are empathy, congruence, and positive regard. These would seem like the building blocks of Winnicott's holding environment. Maslow (1987) maintained that people who fail to develop their true potential are reacting to the deprivation of their basic physiological, safety and security needs. Their 'deficiency motives' sharply contrast with the 'growth motives' of those reared in a secure, friendly, and caring atmosphere. Deficiency motives aim at changing existing conditions that are felt as unpleasant, frustrating or tension arousing. As such, they seem to reflect
difficulties in tolerating ambivalence and, in particular, containing bad object experiences. Just like the reactive processes of the false self and the paranoid-schizoid position, therefore, deficiency motives can be understood, at least in part, as a defence against the absence of psychological integration and its overwhelming fears of fragmentation and destruction.

**Implications for therapeutic practice**

So far this paper has discussed the ways in which object relations theory has enhanced my understanding of intra- and interpersonal processes. It has sought to elucidate some theoretical equivalents and convergences between aspects of object relations theory and aspects of attachment theory, the humanistic and cognitive models respectively. For me, each of these therapeutic languages emphasises different yet interlocked aspects of our being whose integration nurtures a holistic appreciation of human development. Their overlapping concepts imply that they can, and often, are all alive in the process of therapy.

Even when practising cognitive behavioural therapy (CBT), an approach that seems antithetical to object relations theory, I try to remain attentive to the transference and countertransference dynamics between the client and myself during the therapeutic process. This endeavour has provided me with valuable insights about the quality of each client’s internal world, their relationship to their good objects and bad objects and, in this manner, enriched my awareness of their needs and difficulties. I might discover that before a client is ready to attempt some of CBT’s self help activities, for example, they may need to feel assured that I will not reject or abandon them. These primitive anxieties frequently have their roots in early experiences which can become embedded in an individual’s unconscious. This implies that rather than articulating their ‘deficiency motives’, clients often inadvertently project their bad feelings on the therapist. Reflexively examining and evaluating my feelings and reactions to clients has, in turn, assisted me to discern the latent meanings and messages contained in the transference, whether or not I proceed to interpret it. Many times, I have found that simply and tentatively acknowledging a client’s unspoken fears can go far in releasing their anxieties and bolstering their confidence in the therapeutic relationship as a safe holding place, regardless of the theoretical framework adopted.

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REFERENCES


EMBODIED BEINGS:
BODY-MIND ASPECTS OF PERSONS
WITH MULTIPLE SCLEROSIS
EMBODIED BEINGS:
BODY-MIND ASPECTS OF PERSONS WITH MULTIPLE SCLEROSIS

Introduction
The impetus to write this paper came from my psychotherapeutic work with a young woman with Multiple Sclerosis (MS). Having been diagnosed with the disease a few years earlier, at the time of our therapeutic endeavour, Ms. Gilda Gold seemed fully functioning with her symptoms apparently in remission. Throughout my work with her, however, I found it difficult, if not impossible, to ‘bracket’ her mysterious and debilitating disease from my understanding of her personhood. I say mysterious because, even though symptoms of MS may appear at any time between the ages of 15 and 50, a major issue relates to the frequency of its onset in young adults. People, between the ages of 25 and 35 (Allen & Goreczny, 1995), typically experience initial symptoms at a critical stage in their lives when they are “just formulating their identities” (Cobble, 1992: 141) and beginning to build families and establish careers (Minden, 1992). Reports indicate that MS affects about 50 to 60 individuals per 100 thousand (Maloney, 1985), and some convey that twice as many women as men have a diagnosis of MS (Kurtzke, 1983; Sibley, et al., 1984). The disease appears related to race and genetic factors, mostly among Caucasians, as reflected in its highest incidence reported between 65 and 45 latitude in the Northern and Southern hemispheres (Kurtzke, 1983).

To make matters even more intriguing, the etiology of MS remains unknown (Allen & Goreczny, 1995; Fischetti & Borgia, 1990). Some authors have hypothesised that MS results from an immunological response to some type of slowly progressive childhood viral infection (Sullivan et al., 1984; Sibley, 1990), but at this time researchers have not identified any virus that produces the effects seen in MS. The diagnosis of MS, which is based on evidence of brain lesions disseminated in time and space, and the exclusion of other conditions which may produce the same clinical picture, can be very difficult to ascertain (Baum & Rothschild, 1981; Scheinberg et al., 1984; Fieschi et al., 1997). Adding to this conundrum, a number of individuals, who are subsequently diagnosed with MS, initially seek treatment for psychiatric disturbances (Schiffer & Babigian, 1984; Minden et al., 1987). The apparent
convergence of affective and neurological symptoms has led some authors to emphasise the emotional features of persons with MS (Cottrell & Wilson, 1926; Wright & Trotter, 1968), and others to suggest that the illness may have its underpinnings in intensifying primitive and unresolved intrapsychic tensions that ultimately become somaticized through the body’s attacks on itself (Fischetti & Borgia, 1990). These views along with my own clinical work will be presented at a later stage in the paper. First, it would seem necessary to address the neurological workings of this debilitating disease.

What is multiple sclerosis?

MS attacks the myelin produced by the oligondrocytes within the central nervous system (CNS). The exact cause of this process, known as demyelinization, is not known. However, it seems to unfold when a breach occurs in the blood-brain barrier (BBB), which typically separates immune system cells from CNS cells. Raine (1990) has posited that immune system cells which breach the BBB attack elements of the CNS they misidentify as pathogenic agents. This produces scars or lesions (scleroses) of involved CNS cells by causing swelling and accumulation of fluid within the myelin sheath which subsequently causes loosening and/or separation of the typically tightly wrapped layers of myelin. The scarring, which can be located anywhere in the white matter of the CNS, causes a ‘short’ circuit of nerve impulses that normally travel down axons to adjacent nerve cells (Allen & Goreczny, 1995). While remaining continuously active in the CNS, serial MRI studies demonstrate that the scleroses come and go every few weeks, are multilevel and multisite, and can be partial or complete; thereby accounting for a fairly different clinical picture for each patient (Cobble, 1992).

Notwithstanding the apparent diversity in the symptomatology of MS, two prevalent categories that typify the disease course are relapse-remitting (RR) MS and chronic-progressive (CP) MS. Approximately 85% of individuals with MS exhibit a RR course (Sibley, 1990), characterised by periods of exacerbation, in which symptoms that are already present become more severe and/or new symptoms may develop, followed by periods of remission, potentially lasting from several months to many years, in which symptoms appear to become stable again with no further increase in severity. The other 15-20% of individuals with MS manifest a CP disease course, in
which neurological deficits produced by MS scarring progress steadily without periods of remission (Sibley, 1990). Both forms of MS contain a plethora of very disabling motor, sensory, perceptual, sexual, and cognitive dysfunctions. Some of the most troubling symptoms, such as impaired sensation and blurred vision, are invisible. Fatigue affects almost 90% of people with MS and is incapacitating for nearly 70% (Krupp et al., 1988). This paper will now review some psychiatric disturbances commonly found among persons with MS.

**Psychiatric disturbances**

Depression, anxiety, bipolar disorder, euphoria, emotional lability and psychosis may all occur in people with MS. Some of these disturbances can precede the onset of symptoms typically associated with neurological dysfunction as much as 20% of the time (Schiffer & Babigian, 1984). A study in New Zealand found that 16% of 91 people with MS were referred for psychiatric treatment during the time between the onset of their illness and the final diagnosis (Skegg et al., 1988). Similarly, a Danish study found that 12% of 366 people with MS required psychiatric hospitalisation for psychosis, depression, and alcohol or drug abuse (Stenager & Jensen, 1988). Clinicians have on several occasions overlooked the MS diagnosis and misdiagnosed patients as suffering from psychiatric disorders, the most common of which include depression, hysterical personality or conversion disorders (Skegg et al., 1988).

The prevalence of mood and affective disturbances in people with MS has led some authors (Minden et al., 1990) to continue to give considerable support to the statement made in 1926 by Cottrell and Wilson:

> The conclusion is, that no single symptom of the neurological series (nystagmus, tremor, scanning speech, paraesthesiae, spasticity, amaurosis, etc), occurs with anything like the same frequency in an unselected century of cases of the disease, and that the cardinal symptoms are not neurological, in its limited sense, but belong to the emotional, affective, and visceral spheres, and are constituted by 1) Change in mood; 2) Change in bodily feeling; 3) Change in emotional expression and control.
While there is growing evidence that some affective disturbances, such as euphoria and pathological laughing and weeping, result from the effect of disease activity on the neuroanatomical system (Minden & Schiffer, 1990; Minden, 1992), explanations for the presence of others are not as definitive. Bipolar disorder is curiously more prevalent in MS than would be expected in general population rates (Joffe et al., 1987; Schiffer et al., 1986). A number of controlled studies have also indicated that the lifetime prevalence rates for significant depressive illness, 42% to 54%, are higher for patients with MS than for patients with a variety of comparable medical and neurological diseases, although the cause of the depression remains unclear (Minden et al., 1987; Joffe et al., 1987).

Controversy persists as to whether affective disturbances are the consequences of damage done to the CNS; precipitants, along with stressful life events, of MS and future exacerbations of the disorder; normal reactions to the disease; or some combination of these three factors (Rabins, 1990; Schiffer, 1990; Warren et al., 1991). Despite the paucity of systematic research on this subject, I will review findings from two clinical investigations, along with my own work, in an attempt to elucidate and expand upon some emotional and intrapsychic aspects of persons with MS.

**Emotional and intrapsychic features**

In an investigation, based on 17 group therapy sessions with an average of 10 members per session, Wright & Trotter (1968) examined the emotional reactions of persons with MS to their disease and the consequences of these reactions on their interpersonal relations. They found that participants dealt with dependency and hostility either through repression or through regression to an exaggerated state of invalidism. Repression was seemingly achieved through the mechanism of denial and the use of other defences, such as reaction formation, projection, and introjection. For instance, people who adjusted defensively appeared to handle their hostility by a reaction formation consisting of an excessive need to ‘put their best foot forward’ and behaviour designed to please all people around them. On the other hand, it was observed that people who manifested aspects of regression expressed guilt feelings that their disease was somehow their own fault. Albeit these observations convey emotional and intrapsychic aspects which characterise the responses of individuals to their illness, it would have been interesting to observe the presence of any consistency.
Evidence of longstanding emotional and intrapsychic tensions has been elucidated in an Italian case study by Fischetti and Borgia (1990), based on psychoanalytic therapy sessions with a 17 year old patient called Giulia. While the therapeutic process began when her symptoms were in remission, Giulia conveyed profound depressive feelings, marked by an absolute incapacity to separate from her “terrible” mother. A collection of journal entries that she shared with the therapist entitled *A State of Mind* (Gore’s translation), written before the manifestation of her illness, described in detail her and her mother’s reciprocal physical and psychologically ‘biting’ relationship. Fischetti and Borgia hypothesise that Giulia internalised a negative experience of her mother ever since her weaning was halted at 7 months when her mother’s milk suddenly turned sour. They postulate that this primitive encounter unleashed her “cumulative trauma”. Even during the most vital and rebellious instances of her adolescence, for example, Giulia’s “raging”, “viscid”, and “cold-blooded” mother was able to prevail upon her internal world. The guilt Giulia feels about wishing her mother’s destruction, however, keeps her locked in the relationship. It appears to prevent her from achieving the crucial process towards adulthood of separation and individuation, which incorporates the capacity to recognise and distinguish ‘self’ from ‘not self’. Fischetti and Borgia contend that this unresolved developmental trauma ultimately seems repeated by Giulia’s MS with her body’s attacks on itself.

Contrary to her mother, Giulia describes her father as an absent figure and denies her need for his love and attention by omnipotently rejecting him. Giulia’s journal conveys the sense that she is constantly fighting against an angry and hostile world, personified by parents whom she feels have children merely to satisfy their whims as opposed to nurturing their personal growth. Her belief that she cannot rely on anyone but herself prevents her from accepting her need for care and assistance from others. Giulia transfers her anxieties about rejection and abandonment on the therapist, yet gradually learns that her own destructiveness is not strong enough to damage their relationship. For Fischetti and Borgia, MS is a psychosomatic illness with its roots in a mental incapacity to contain the destructive repercussions of stressful life experiences on one’s wellbeing. They believe that the hostile and persecutory dynamic of Giulia’s internal world becomes somaticized through her self destroying illness.
Personal clinical experience

I would have found Fischetti and Borgia’s findings curious, and at best interesting, if it were not for the fact that I encountered striking parallels with their case study in my psychotherapeutic work with Gilda. She was referred to the psychotherapy department by her psychiatrist, who indicated that she had been diagnosed with symptoms of depression. At the assessment session, she revealed that she hoped to work through “unresolved issues” about her personal relationships. Gilda explained that she had no sense of self. Her existence was inextricably tied to her relationships with others and, in particular, with her “overwhelming”, “opinionated”, and “bossy” mother.

Gilda’s revelation that the “only separation” she had ever achieved from her mother was that of being “250 miles apart” enabled me to understand how concrete her thinking was; she only seemed able to experience separation in measurable terms. Now that they were living together, her mother was impeding Gilda from making her own plans because, at the last moment, she could make her feel guilty about not being there for her. Gilda explained “it feels like she’s got me by the neck, strangling my throat while saying ‘I don’t like you but you’re still my daughter’”. She felt haunted and tormented by pangs of conscience about a recurring nightmare she had had ever since she was 14 years old. Gilda dreamt of climbing aboard a train and looking back to see that her mother had trapped her leg on the tracks and was about to be run over by the train. In my view, the nightmare appeared to convey the release of Gilda’s cumulative anger about not being able to break free from her mother short of destruction. Like Giulia, therefore, the guilt Gilda felt about wishing her mother’s demise seemed to keep her locked in a persecutory relationship which prevented her from achieving the pivotal process towards adulthood of separation and individuation. Rather than being able to distinguish between ‘self from ‘not self’, Gilda turned her aggressions inwards instead of directing them at her mother. This hostile intrapsychic dynamic, in turn, appeared to reflect the physical dynamic of her illness with her body’s attacks on itself.

The other striking parallel with Giulia’s case history was the experience of an absent father. Gilda considered herself “Daddy’s girl” until her parents’ separation when she was 14 years old. Her father subsequently left the country and Gilda had no contact with him until his remarriage 7 years later. She described this interim as an
isolating and lonely period. The devastating impact of her father’s abrupt departure seemed to have left a confusion in her mind about separation and abandonment which, in my view, confirmed an infantile trauma of separation as abandonment. Gilda tended to transfer her expectations about being abandoned on her relationships with others, finding it difficult to trust that she could be loved. This was also acted out in our therapeutic relationship, particularly around the time of our breaks in the therapy. Rather than actually experiencing her need for therapy in those breaks, she would project her abandonment on me by cancelling the sessions before and after the breaks. A crucial theme in helping Gilda work through her unresolved relational issues, therefore, included assisting her to realise that when there was a break in the therapy it did not mean that I was abandoning her. This gradually enabled her to accept her dependency on the therapy, manifested by the fact that she no longer avoided coming to the sessions before and after the breaks. This issue was also relevant in facilitating her to come to terms with the realities of her illness which would ultimately require a trustworthy dependence on others.

It would appear that the life experiences of Giulia and Gilda indicate longstanding patterns of the defences identified by Wright & Trotter as emotional reactions of persons with MS to their disease. Most noticeably, Giulia and Gilda’s inherent distrust in other people’s desire to care seemingly drove each of them to manage the perceived threat of dependency in their interpersonal relationships through repression, denial and hostility. This defensive behaviour can, in turn, have serious consequences for their illness by making it difficult to ask for help and accept the dependent implications of MS.

Implications for counselling psychology

The combination of emotional, psychiatric and neurological disturbances that seem to coincide among persons with MS suggests that the disease may result from a complex body-mind interaction, whose likelihood becomes aggravated by environmental and genetic factors. The commonalities observed between the emotional and interpsychic aspects of people with MS as reactions to their disease and as longstanding patterns predating their illness implies that some psychological disturbances may be precipitants of MS that become reinforced with its onset. The aggressive intrapsychic tension related to the difficulty in distinguishing between ‘self’ from ‘not self’, for
example, in many ways seems to parallel the physical process described by Raine's
(1990) hypothesis in which immune system cells breach the BBB and attack elements
of the CNS they misidentify as pathogenic agents. Perhaps, the relevant challenges
posed by the irresolution of developmental processes, such as separation and
individuation, for persons who are at a critical stage in their lives when they are “just
formulating their identities”, explains MS's high frequency of onset in young adults.
The fact that serial MRI studies convey a fairly different clinical picture for each
patient's scleroses might reflect each person’s fairly different psychological profile. I
am, therefore, positing that the development of MS may be associated with negative
and unresolved inter- and intrapsychic tensions without making the claim that
emotional disturbances are causal or that it is not a real illness.

Research into the body-mind aspects of people with MS could become a major area
of investigation for counselling psychologists. As a starting point, it would seem
appropriate to qualitatively assess the life experiences of other people with MS, not
just the ones preselected for therapy, in order to discover whether there are prevalent
commonalities with the emotional and intrapsychic aspects identified in this paper.
Another issue that warrants investigation relates to the fact that twice as many women
as men appear to have a diagnosis of MS. It might be that a negative interaction
between unresolved developmental issues and oncoming pressures related to
motherhood acts as a precipitating factor for the illness in women.

If unresolved developmental issues are shown to be common in people with MS, then
this would imply the need for insight oriented psychotherapy to help patients come to
terms with their ongoing persecutory experiences. Unexamined intrapsychic tensions
might, for example, potentially contribute to future exacerbations of the illness. On the
other hand, working through these issues might enable patients to help contain the
disease, especially for those with the RR disease course. It is also possible, however,
that insight oriented psychotherapy could stir up overwhelming feelings and increase
the likelihood of relapse. While studies on group psychotherapy (Crawford &
McIvor, 1985), cognitive behavioural therapy (Larcombe & Wilson, 1985) and stress-
inoculation training (Foley et al., 1987) have all reported improvement in patients’
symptoms and functioning, the potential risks and benefits of individual
psychoanalytic therapy would have to be carefully examined and researched. Perhaps
counselling psychologists could develop an appropriate therapeutic model for this patient group that would combine insight oriented and supportive work.

Finally, few studies have looked at clinical management programmes for people with MS (Greenwood et al. 1997). This is an area that would present an excellent opportunity for counselling psychologists to address with other professionals. An ideal care package for patients with MS would involve the close collaboration of a multidisciplinary team comprised of, for example, a physician, a counselling psychologist, and a community based nurse. From the perspective of practice, this approach would seem beneficial as the very real threat of serious illness is too big a burden for one person to carry alone. Team work would make it possible to carry the burden of the patient together.
REFERENCES


THERAPEUTIC PRACTICE DOSSIER
Introduction to Therapeutic Practice Dossier

This dossier reflects work fulfilled during the three years of my psychotherapeutic training. It contains a description of each of my clinical placements followed by a paper about my integration of practice, theory, and research.

Further details of client studies, process reports, placement logbooks and supervisors' evaluation forms pertaining to this dossier are available to the examiners in a separate appendix. Due to the confidential nature of the material contained within this appendix, it is not available for public access.
Descriptions of Clinical Placements
My first year placement took place at Psychological Services, an adult mental health care service which is part of an NHS Trust. Psychological Services provides assessment and treatment to individuals in the community either on an outpatient basis, or on an inpatient basis at a nearby hospital which is part of the trust. This service caters to a variety of clients, between the ages of 16 and 65 years old. They are generally referred by either general practitioners or psychiatrists for psychological difficulties. These range from post traumatic stress disorder, panic attacks, anxiety, personality disorders, obsessive compulsive disorder, eating disorders, childhood sexual abuse, anger, depression, and bereavement. The service aims to improve the health and social functioning of individuals, who have been referred within the community, to prevent relapse, readmission or at least minimise hospital stays.

Psychological therapy is offered both on a short term and long term basis. Staff include clinical and counselling psychologists, psychotherapists, counsellors and behaviour nurse therapists. They apply a wide range of theoretical frameworks, including psychodynamic, cognitive behavioural, and systemic models.

This placement provided me with the experience to practice both short and long term therapy, as well as co-facilitate an anxiety management group. Individual supervision took place on a weekly basis. The theoretical orientation was humanistic. A person-centered approach prevailed, and I was also able to begin to apply psychodynamic and cognitive behavioural approaches, where appropriate.
Second Year Placement: Psychotherapy Services
September 1998 - August 1999

My second year placement took place at Psychotherapy Services, a specialised outpatient unit based in the Department of Psychiatry at an NHS hospital. Psychotherapy services provides adult mental health care for the local community and caters to a wide spectrum of clients, between the ages of 17 and 70 years old. Its prevailing theoretical orientation is psychoanalytic psychotherapy.

Psychotherapy Services included a consultant psychotherapist, an adult psychotherapist, and a consultant family therapist. Individual therapeutic provisions consist of weekly psychoanalytic therapy sessions. Some of the department members were also involved in the provision of family therapy. The Family Therapy Clinic offers input to families where one or more family members is experiencing psychological difficulties. However, where a child or young person has significant difficulties, the family is referred on to Child and Adolescent Services. Both Psychotherapy Services and The Family Therapy Clinic are interconnected with other mental health divisions of the trust and accept patient referrals from psychiatrists, general practitioners, and social workers.

This placement provided me with experience in long term psychoanalytic psychotherapy. I saw clients on a weekly basis for the duration of my training. Furthermore, I also took part in The Family Therapy Clinic throughout the placement.

Individual supervision was provided by a Kleinian psychoanalytic psychotherapist. It took place on a weekly basis and each session focused on discussing one process report from one session with a client. In addition, I took part in a weekly, closed group supervision session which was facilitated by the consultant psychotherapist. The members of this group included two psychodynamic counsellors and a trainee psychiatrist. This supervision group integrated different psychodynamic perspectives.
Third Year Placement:  A Specialist Amputee Unit
October 1999 - August 2000

My third year placement took place within a specialist amputee facility that is part of an NHS Trust. It is comprised of an outpatient amputee service at the rehabilitation centre and an inpatient amputee service at the rehabilitation unit. Inpatients arrive at this unit following surgery at off site locations. Both services cater to inpatients and outpatients, between the ages of 16 and 65 years, whose amputations have resulted from a variety of causes, including peripheral vascular disorder, diabetes mellitus, infections and, of course, accidents.

The overall aim of this specialist amputee facility is to improve health, facilitate prosthetic rehabilitation, and enable psychological adjustment to limb loss. A multidisciplinary team works with each amputee to facilitate their rehabilitation. The team consists of a surgeon, a consultant in rehabilitation medicine, nursing staff, physiotherapists, occupational therapists, social workers, a clinical psychologist, and a counselling psychology trainee, in this case myself.

My work involved assisting patients who required psychological input pre and/or post amputation make sense of and more effectively manage their adjustment to limb loss. I contributed to team assessment and decision making by assisting non-psychologist professionals obtain a greater understanding of patients’ psychological difficulties. Access to psychological assessment is available to all patients, partners, and their families where appropriate. Common psychological difficulties among the amputee patient group include grief and bereavement reactions, post-traumatic stress disorder, chronic pain, and the experience of a variety of social and psychological threats to their identities. Psychological therapy is offered on a short and long term basis depending on the needs and concerns of each amputee.

I was supervised by a clinical psychologist who was part of the Psychology Department. It has a direct access service which takes adult referrals from local general practitioners. One of my cases was taken from the direct access route. A cognitive orientation prevailed throughout this placement. I was also able to integrate interventions from different theoretical paradigms, where appropriate.
Final Clinical Paper
ON BECOMING AN INTEGRATIVE
SCIENTIST-PRACTITIONER
Overview

This paper endeavours to synthesise the processes which have been crucial to my development as an integrative scientist-practitioner. Its main body is comprised of five interrelated sections. The first one reviews aspects relating to counselling psychology's phenomenological value base and scientist-practitioner model, which I have assumed as the foundations of my training. The next section relates to the development of my theoretical fluency of the humanistic, psychodynamic, and cognitive paradigms. It is followed by a microanalysis of a session from my clinical work which seeks to illustrate my integration of ideas and concepts from the three paradigms. The fourth section discusses some approaches I have adopted to pursue an integrative understanding about the impact of adverse life circumstances upon identity and psychological functioning. Finally, some ethical and practical factors inherent to my therapeutic practice are briefly reviewed before the conclusion.

The foundations of my training

My training as a counselling psychologist is grounded in a phenomenological value base. This framework sets itself apart from the reductionist ethos of the traditional scientific model (Woolgar, 1988), which emphasises universal laws of cause and effect based on logical positivist assumptions that reality consists of objectively discoverable facts. The phenomenological approach maintains that knowledge is always correlated with consciousness and, in turn, phenomena cannot be captured 'in themselves'. Transcendent or external objects are perceived by individuals in adumbrated or partial ways (Giorgi, 1996). The resulting phenomenal object reflects the way in which each person subjectively construes aspects of the world (Merleau-Ponty, 1962). Research literature which indicates an unavoidable bias in individuals' recall processes (see Williams, 1996) is a good example of the phenomenal quality of consciousness. Here, rather than seeking to measure the extent to which a recollection is true in itself, phenomenologists would explore its significance as a referent within the individual's system. Likewise, my training has encouraged me to seek understandings of clients based on the psychological processes in which they perceive and attribute meanings to their experience.
An integral part of the process of "caring to know" clients' inner worlds and subjective experiences (Strawbridge, 1992) involves evaluating the social and contextual factors which may be associated with their respective mental and emotional predicaments (Strawbridge & Woolfe, 1996; Wilkinson et al., 1997). A shared exploration of the client's presenting issues and concerns unfolds between client and therapist within an 'interactive model' (Strawbridge & Woolfe, 1996). This approach represents a shift from a 'one person psychology', with its emphasis on the psychology of the client (Kahn, 1996), to an intersubjective psychology, where the therapist's frame of reference is considered to have an impact on the client's experience of the therapy (Strawbridge, 1992). The capacity to remain aware of the principles that organise my phenomenological experience has, therefore, been a prerequisite for relating to the otherness of the client in the therapeutic encounter.

Developing a self reflective awareness has required me to engage in an ongoing reflexive endeavour about the thoughts, feelings, and intentions that are enmeshed in my own frame of reference. My experience of personal therapy has assisted me to examine how these impact upon my subjective construal processes. Supervision has also enriched my reflective awareness of therapeutic issues. Throughout my placement experiences, it has included countless meticulous examinations of interactions with clients, as well as contemplating the content of sessions from different vantage points. This dialogical process has helped me to become aware of how the principles that organise my phenomenological experience may influence my therapeutic interventions and, in turn, be experienced by individual clients. In these ways, both supervision and personal therapy have nurtured my capacity to self-monitor and enabled me to progressively forge my own 'internal supervisor' for reflecting in action with clients (Casement 1985).

Reflective awareness is the basis of what it means to me to be a scientist-practitioner. The scientist practitioner model operates on a micro and macro level (Karpas, 1999). The micro level refers to issues pertaining to therapeutic practice. These include how I gather information about a client's problem, develop explanatory hypotheses about its origins, and then use this information to formulate predictive hypotheses about the possible outcomes of different therapeutic interventions (Wilkinson, 1997). My understanding of the scientist-practitioner approach sets itself apart from the
pragmatic and value free ethos of technical rationality (Strawbridge, 1992). It involves integrating reflective practice within my psychological knowledge base. Finding a balance between how formal and informal research (including my experience of ‘being with’ individual clients) informs my understanding of their unique situation, needs, and difficulties (Schon, 1983) is a recurring challenge that I am confronted with throughout my practice. The ensuing example intends to illustrate this point.

Research literature on psychological responses to amputation indicates that the predominant experience of the amputee is one of loss (Waites & Zigmond, 1999). Bereavement models (Kubler-Ross, 1970; Murray Parkes, 1996) traditionally have been used to assist clients work through their emotional responses to amputation. However, I have realised that applying this knowledge base prescriptively risks overlooking individuals’ unique feelings and reactions. For instance, I have assessed several inpatients at the rehabilitation unit, whose amputations occurred after a long period of illness and loss of function. By attending to their accounts, I discovered that they did not have any need for grieving following their amputation and, instead, looked to their prosthetic adjustment as a means to recover their long lost functional mobility. This example points to the importance of weighing up formal research against the individual’s phenomenological experience. The reflective application of the scientist practitioner model, therefore, would seem to guard against objectifying subjective conditions into neat categories as well as theraping people’s feelings and reactions when this does not appear necessary.

On the macro level, practising as a scientist-practitioner implies producing formal research about effective intervention strategies. Hopefully, my third year investigation, about the developmental experiences of persons with Multiple Sclerosis (MS), may be taken as an example of such research. Its main aim is to obtain insights and information to assist the advancement of psychotherapeutic treatment and care for this client group. My research interest emerged out of my clinical practice with a client with MS during my second year placement. I compared my reflections on her psychological processes, as well as my experience of being with her, to the existing body of literature about the emotional and interpersonal aspects of people with MS (see Gore, 1999). Through this process, I was able to identify issues that had not been sufficiently explored and seemed potentially very relevant to this client group. I doubt
that this would have been possible, however, without the development of concerns from my own clinical experience and the benefit of supervision, which helped me to clarify my ideas and encouraged me to pursue these with formal research. This experience has shown me, therefore, that reflective practice underlies being a scientist-practitioner and the capacity to integrate practice, theory and research.

The development of my theoretical fluency

A humanistic attitude, based on a deep respect for the ways in which each client perceives and attributes meanings to their respective phenomenological experience, forms the basis of my therapeutic practice. This approach involves being open and receptive to individual clients' accounts of 'what hurts' and 'what problems are crucial', as well as enabling them to guide the direction of the therapeutic process (Rogers, 1959). The use of humanistic techniques, such as reflecting, clarifying and paraphrasing, has helped me to check out with clients whether my explanations and/or interpretations are congruent with their experience. In turn, these techniques have also enabled me to convey to clients that they are being heard and understood. Along with many authors, I believe that the therapeutic relationship, more than any other factor, has indeed determined the effectiveness of my clinical practice (Luborsky et al., 1983; O'Malley & Strupp, 1983; Clarkson, 1996).

The core conditions of my therapeutic approach, empathy, congruence and cooperativeness, derive from the person-centered model. I have replaced the notion of unconditional positive regard with cooperativeness, however, because the reality of experiencing countertransference feelings and reactions seems to betray the utopia of unconditional positive regard. Cooperativeness does not imply that I do not experience clients' 'interpersonal pull' (Safran, 1990). It means that rather than following my countertransference responses to withdraw or retaliate, for instance, I try to use my feelings and reactions to facilitate understanding and clarification in the therapeutic process (Clarkson, 1995). This capacity constitutes a key part of my commitment to being a skilled helper. It has strengthened my working alliance (Bordin, 1979) with clients, especially when they may be 'communicating by impact' (Casement, 1985) to test its credibility and endurance. Generating a safe holding environment is necessary to facilitate clients to tolerate working through unresolved and unwanted thoughts, emotions and memories. When this occurs, I have found that
the therapeutic encounter tends to evolve into a transference-countertransference relationship (Clarkson, 1995).

The phenomena of transference and countertransference convey unconscious aspects of individual client’s object relations. Object relations theory (ORT) puts forward that the mind is comprised of intrapsychic aspects of relations with other persons, known as internal objects, which are derived from early relationships with caregivers (Moore & Fine, 1990). The maturing person’s ego and object become connected by affects which create a dynamic system of parts in relation, called the internal object relation (Scharff & Scharff, 1998). ‘Bad’ object relations are characterised by harsh and persecutory feelings, whereas ‘good’ object relations are introjected from positive experiences with parents and the surrounding environment (Klein, 1957). ORT maintains that people react to and interact with not only actual others but also internal others, which continue to condition their subjective construal processes (Greenberg & Mitchell, 1983). Research supports ORT by indicating that early experiences with caregivers are aggregated into ways of thinking which provide templates for subsequent attitudes, reactions, and perceptions in the maturing person (Bretherton, 1985; Main et al., 1985; Ricks, 1985; Stuart et al., 1990; Fonagy et al., 1996).

My individual and family therapy training during my second year placement, set within a psychodynamic context, enabled me to observe and experience how clients displace internalised patterns of feelings, thoughts, and behaviour on current relationships with others. In individual therapy, for example, clients frequently transfer attitudes such as hate and anger, originally experienced in relation to significant figures during childhood, on the therapist. My client study of Mrs. Susan Smith reveals her initial apprehensions that I would treat her badly. The process of bringing her unconscious anxieties, enmeshed in her internal world, to conscious awareness required me to interpret the latent content of her transference. I suggested that perhaps she feared that I would behave with her like her abusive father and neglectful mother had done. This interpretation relieved Susan’s anxieties and helped her begin to gain insight about how her earlier unresolved trauma unconsciously influenced her ongoing interactions with others.
Many times transference interpretations enable clients to feel contained, which reinforces the reparative quality of the therapeutic environment. Clients can, in turn, begin to idealise therapists as a wish fulfilment of their earlier unmet mirroring needs. An essential part of my training has involved learning to calibrate my ‘role responsiveness’ to clients (Sandler, 1998). This has meant being able to interpret the transference in both negative and positive instances to help clients own their affects, motives and intentions. To me, this skill underlies the capacity to empower clients’ personal growth and development. Potentially or inadvertently colluding with their idealised fantasies, on the other hand, may generate dependency and a repetition of previous disappointing experiences, especially when the therapy comes to an end.

During the transition between my second and third year placements (when I moved to a cognitive oriented service), I was skeptical about whether the theoretical principles of the humanistic and psychodynamic paradigms could be reconciled with those of the cognitive paradigm, let alone integrated. I could not fathom how the cognitive model’s nonaffective conceptualisation of psychological disturbance as a malfunction in the processes of construing experience (Beck, 1976), could possibly accommodate emotional and unconscious aspects. Moreover, I was aware that the focus on psychological defence mechanisms was one of the issues that traditionally divided psychodynamic from cognitive models (see Brewin, 1997). I soon learned that my perceptions were, at least in part, anchored in archaic stereotypes.

There are now substantial theoretical and empirical grounds for regarding psychological defence mechanisms as important contributors for understanding clients’ construal processes, their automatic thoughts and beliefs, as well as the strategies they use to manage external and internal sources of threat (see Westen, 1991). Shedler et al. (1993) have shown that denial is one of the major forms of defensive appraisal for stress and coping. Several retrospective studies suggest evidence of repression. They provide broadly similar findings that a substantial portion of clients in therapy for the effects of child abuse report having had periods in their lives when they could not remember that the abuse had happened (Herman & Schatzow, 1987; Briere & Conte, 1993; Loftus et al., 1994). Similarly, research on paranoid patients has provided evidence of projection, in which self reproach becomes repressed and articulated as a distrust of other people (Kaney & Bentall, 1988; Kaney
& Bentall, 1992; Lyon et al., 1994). Due to such developments, psychologists of different theoretical affiliations are becoming receptive to integrating the notion of unconscious defensive mental operations within their practice (Brewin, 1997; Stein & Young, 1997; Weinberger & Weiss, 1997).

Cognitive conceptions of unconscious processing have been developed from the theory of parallel distributed processing (McClelland & Rumelhart, 1986; Rumelhart & McClelland, 1986), which postulates that the mind is composed of many associative networks operating simultaneously. Implicit processes, which occur outside of awareness, constitute the cognitive unconscious. Mental content is transformed and stored into associative networks called schemas, which provide an organising framework for the processing of new information and the implementation of action. Schemas are strongly assimilative (Piaget, 1970), which implies that the meaning of an experience can be distorted to fit schematic structures. Beck (1967) put forward that schemas contain thoughts, beliefs and assumptions which represent individuals’ understanding of themselves, their world and others. The schema concept has become increasingly adopted by cognitive theorists who stress understanding the developmental origins of clients’ subjective construal processes and characteristic behaviours and communications (Safran & Segal, 1990; Liotti, 1991; McGinn & Young, 1996; J.S. Beck, 1996).

Cognitive theorists’ notion of the interpersonal schema, as a generalised representation of self-other relationships, seems to share the theoretical interface with object relations and internal working models (Bowlby, 1969). These explanatory constructs rest on the premise that human beings have an innate propensity for maintaining relatedness with others. In their own language, each conceptualises interpersonal development as being abstracted from past experience with attachment figures, whose internalised relations can determine the individuals’ affective states and overt behavioural reactions. For instance, maladaptive schemas (Young, 1990), like insecure attachment patterns (Ainsworth et al., 1978; Main & Solomon, 1986) and ‘bad’ objects are considered the result of developmentally deficient experiences with parental figures. These unconscious or implicit internal models contain representations of both desired and feared interpersonal outcomes that have to be “warded off” (Horowitz, 1991).
Thus, like their humanistic and psychoanalytic counterparts, some cognitive therapists have come to regard the therapeutic relationship as a primary experiential forum in which clients can learn to work through and evaluate the meanings they place on interpersonal events (Safran, 1990; Safran & Segal, 1990; Burns & Auerbach, 1996). They have incorporated their use of self as participant-observers in the therapeutic relationship. To me, what cognitive therapists refer to as clients’ 'interpersonal pull' seems a derivation of transference and, similarly, therapists’ ‘action tendencies’ seem a derivation of countertransference. Cognitive therapists metacommunicate about their reactions to clients to enable them to explore their own feelings and automatic thoughts. This form of feedback seems to synthesise the transparency of the humanistic therapeutic skills with a more accessible and user friendly approach to incorporate the subtle, and sometimes mysterious, self-other nuances contained in transference interpretations. The revelation of these apparent convergencies among the humanistic, psychodynamic, and cognitive paradigms bolstered my confidence to integrate their languages within my therapeutic approach. A microanalysis of a session from my clinical practice will seek to demonstrate how their integration has enhanced my understanding of the client’s intra- and interpersonal processes and, in turn, informed the progress of therapy.

A microanalysis of my therapeutic integration

Mr. Michael Davis, an attractive man in his early twenties, sought cognitive behavioural therapy (CBT) to help him cope better with his generalised anxiety features, characterised by persistent negative thinking about his self-image. As a background to his current difficulties, he reported that ever since childhood his parents had put a lot of pressure on him to excel academically. He felt that they conditionally based their affection upon his achievements, which reinforced his determination to exceed. Michael attended a very competitive secondary school, where the other boys bullied him about his appearance. He reported understanding that their behaviour probably stemmed from envy related to his academic excellence. Changes in his body image during adolescence, nonetheless, further reinforced his belief that he was socially undesirable.

The session upon which the process report was based reflected my efforts to explore with Michael the core beliefs and assumptions contained in his 'thought diary' (Beck,
et al., 1979). At the outset of the session, he conveyed his tendency to think dichotomously, by explaining that he believed his thoughts but simultaneously did not. This was due to a "logical voice" within himself which said he "shouldn't" believe his thoughts. In cognitive therapy, 'should' statements reflect tyrannical demands one makes on oneself (Wills & Sanders, 1997). The integration of a psychodynamic understanding suggested that they were symptomatic of Michael's demanding internal object, which seemed to have been introjected from the experience of his parents' unrelenting expectations. Michael appeared to project this superego anxiety (Freud, 1923), expressed through his "logical voice", as a defence against his irrational impulses. The latter appeared to convey vulnerable thoughts and feelings, which were likely to derive from his early, unmet mirroring needs (Kohut, 1984).

Michael discussed that one of the negative automatic thoughts (NATs) he had had during that week was that some young boys on the bus would view him with suspicion. He explained that this thought made him feel nervous and tense and, in turn, it had seemed to unleash his cognitive and affective cycle of distress. Through further exploration, Michael acknowledged that his negative thinking had its roots in his destructive experiences with peers during adolescence. It would appear that he consequently internalised features of a 'social undesirability' schema (Young, 1990), which conditioned the ways he acted and reacted to actual others in the "here and now". For example, Michael conveyed that he tended to feel instantly "paranoid" about what other people "would automatically think about me just from the way I look". Through Socratic questioning, he identified that he was inclined to react badly to others "but kind of as a defensive thing". In turn, Michael consequently revealed his belief that he was "the kind of person they would instinctively dislike".

It would seem that Michael's defensive behaviour reflected his desperate need to "ward off" the activation of his social undesirability schema. He appeared to achieve this through paranoid-schizoid mechanisms of splitting and projecting his persecutory feelings. For instance, these were expressed through his self defeating ways of construing what he imagined others thought of him. Such defensive operations reflected Michael's difficulty to reconcile good and bad object experiences (Winnicott, 1965; Klein, 1957) and, in turn, appeared to prevent him from actualising an integrated pattern of self-related perceptions (Rogers, 1959).
During the course of the session, Michael differentiated his core belief that he was “unattractive” from “nerdy”, which was the way he imagined that other people perceived him. It might be that his use of 'unattractive' referred to his 'true self' and his experience of its lack of intrinsic worth, and that he unconsciously applied 'nerdy' as a derogatory metaphor for his 'false self' (Winnicott, 1965). Throughout his development, Michael appeared to focus upon his academic achievements in order to ensure some degree of nurturing from his parents. It seems likely that this reactive form of living impeded him from unfolding the spontaneous expression of his true self. It is, in turn, plausible that his NATs that others would not be drawn to him because he was unattractive unconsciously maintained the early trauma of his unmet mirroring needs, which was subsequently reinforced through his adolescent experience with peers. Michael’s underlying core beliefs and maladaptive assumptions, therefore, might have enabled him to avoid the repetition of potentially further threatening experiences to his fragile self concept.

Throughout the session, I tended to withdraw in technical CBT interventions rather than being able to empathise and ‘be with’ Michael. My feelings of resistance were reinforced by my sense that any intervention I made was not ‘good enough’. When I listened to our audio taped session, I found that some incidents of my Socratic questioning sounded persecutory. Even though my overwhelming experience of incompetence had prevented me from reflecting in action during the session, I used my reactions to assist my reflections after the session. With insights from the psychodynamic paradigm, I realised that my action tendencies were likely to stem from Michael’s projective identification (Klein, 1957) of his own persecutory feelings of inadequacy. This reflective process enabled me to understand how Michael’s interpersonal pull may have instigated characteristic responses in others which acted as self fulfilling prophecies (Safran, 1990). I resolved to tentatively metacommunicate my reactions to him in further sessions. These assisted him to examine the meanings he attributed to his self-other interactions and evaluate his role in intensifying his negative experiences. The process of sharing my reactions with Michael strengthened our therapeutic relationship and seemingly enabled him to feel more confident about working through his internally threatening thoughts, emotions and memories.
CBT is a frequently applied intervention strategy for treating anxiety disorders. Its rationalist techniques, of identifying and challenging NATs and maladaptive beliefs and assumptions, nonetheless, may have stood in the way of facilitating Michael’s own meaning making process. His complex needs and difficulties suggested that he would benefit from a more integrative and less constrictive approach. Upon reviewing his progress in supervision, I resolved to adopt an approach that integrated the practice of cognitive interpersonal therapy within Winnicott’s concept of the ‘holding environment’. Michael’s apparent lack of a nurturing environment throughout his upbringing suggested that he needed to introject experiential rather than intellectual disconfirmation of his beliefs. The safe holding context of the therapeutic relationship aimed to enable him to work through and repair unresolved emotional issues from the past in order to enable him to unfold the expression of his true self.

Integrating the impact of threats to identity on psychological functioning
So far this paper has focused on the emotional, cognitive and psychic processes which condition individuals subjective construal processes and interactions with others. My third year placement, set within a specialised amputee unit, gave me the privilege to expand my understanding of how individuals respond to adverse life circumstances, such as illness and disability, which tend to threaten the continuity of their previously established identities. Working within this context required me to draw from formal as well as informal research, based on my own practice, to develop flexible and ‘tailor made’ intervention strategies to facilitate individual clients’ adjustment processes.

As mentioned before, research literature on the psychological impact of amputation indicates that the predominant experience of the amputee is one of loss. This tends to be characterised by the obvious loss of the limb and its concomitant losses in function, self-image, career and relationships (Waites & Zigmond, 1996). Body image-related problems are frequently experienced following amputation. These include anxiety, due to ‘the discrepancy between the perceived disturbed physical state and the previously established body image’ (Henker, 1979). Depression follows when the person feels they have lost their previous image of themselves. These changes tend to generate negative self esteem which, in turn, threaten individual’s self concept and well being (Logue, 1998). While the majority of amputees recover from
the experience without any lasting depression (Stephen, 1982; Shukla et al., 1982), a considerable minority show significant levels of psychological morbidity and social isolation in the longer term (Thompson & Haven, 1983).

Breakwell's identity process model (1986) has complemented my formal knowledge base, by providing me with a useful framework to assess the significance of individual client's psychological reactions to amputation. Breakwell considers that the structure of identity is comprised of content and value dimensions. The content dimension refers to aspects such as role, profession, and status, which characterise an individual's experience of continuity and distinctiveness. The value dimension refers to issues related to self esteem and self efficacy which underpin an individual's sense of self worth. The processes of assimilation-accomodation and evaluation, in turn, maintain and monitor identity. Breakwell has conceptualised a threat to identity as one in which identity processes are not able to cooperate with an individual's previously established principles of continuity, distinctiveness, and self esteem.

In my client study of Mrs. Kadee Silvers, a woman in her fifties who had undergone a transfemoral amputation, I used Breakwell's model to elucidate the threats posed to her identity. For example, it appeared that Kadee's amputation shattered her previously established body image. She reported that her amputation was "a big blow" to her identity as a strong, independent, and energetic person. Her loss of function jeopardised her role as "the doer" in her personal relationship and thus aggravated her feelings of low self worth. In these ways, her amputation disrupted her experience of continuity and personal distinctiveness, which both individuates a person from others and assimilates them into groups (Breakwell, 1986). As a result, Kadee reported that she had become reclusive out of fear of being rejected by others due to her disability. According to Breakwell, social isolation is a commonly used 'inaction strategy' to avoid the rejection, pity or aggression associated with stigma.

My own informal research of Kadee's presenting issues seemed congruent with the findings of the formal knowledge base, described above, about commonly shared difficulties among amputees. However, I found that in order to enable individual clients to adjust to their disability, it is important to uncover what their limb loss represents within their own phenomenological experience. This involved exploring
with Kadee the meanings underlying her negative assumption that able-bodied people would reject her due to her disability. I discovered that her maladaptive thoughts seemed rooted in her core belief that her mother resisted from relating to her due to her ‘differentness’ as an adopted member of the family. Throughout this exploratory process, it became increasingly apparent that Kadee’s amputation had reactivated her internalised experience of her mother’s “permanent barrier”. This appeared to personify the stigma which implicitly threatened her relatedness with able bodied people now that she perceived herself as ‘Other’ again.

Developing a shared understanding with Kadee about the background to her current situation enabled me to recognise that merely applying a traditionally adopted bereavement approach to help her adjust to her limb loss did not seem appropriate. Rather, it appeared that she would benefit from a person-centered orientation that combined aspects of bereavement therapy and cognitive interpersonal therapy (CIT). The integration of CIT (Safran, 1990; Safran & Segal, 1990) seemed suitable for assisting Kadee to test her maladaptive self-other representations within the safe holding context of our therapeutic relationship. Kadee began to understand her need to be the ‘doer’ in her interpersonal relationships as a defence against her early unmet mirroring needs. In turn, she was able to reevaluate the meanings she previously attributed to her self efficacy upon which her self esteem apparently hinged. This process enabled her to work through her difficulty to accept the help and support of others and, in turn, made it possible for her to assimilate and accommodate the reality of her present circumstances. Kadee seemed to benefit from the therapeutic process as a developmentally reparative experience. At the end, she explained she had been able to “unblock” her “hurt”, beginning with the loss of her natural family and culminating with her amputation, and experience herself as a “whole person” again.

Kadee’s case exemplifies what happens when adverse life circumstances reinforce unresolved and unwanted emotional and psychological issues. In some cases, however, these events generate enormous social threats which can be contained but not resolved within the context of therapy. This is when professional work can go beyond giving therapy. Such a case involved my work with Mr. Jacob Ross, a man in his forties who had undergone bilateral lower limb amputations. He had been attending therapy to help him cope better with his low mood and overwhelming
feelings of hopelessness and loss. Jacob had remained an inpatient at a nearby hospital for nine months due to failure to find appropriate living accommodation. The housing department offered him a studio flat, in an area where he strongly believed that he would not feel physically safe. Notwithstanding pleas from his advocacy scheme, the housing department continued to offer him the same studio flat, in a refurbished condition, but no other option. These circumstances aggravated his feelings of helplessness and depression. Upon discussion with my supervisor, we resolved to write to the housing officer to give a psychological opinion of the oppressive predicament in which Jacob found himself. Even though we were aware of the possibility that taking this step might collude with his experience of victimisation, we considered that the benefits associated with relieving some of his external pressures outweighed those of bystanding the issue. I thus took political action with the hope of successfully mediating on behalf of my client.

**Ethical and practical factors underlying my therapeutic approach**

This paper has discussed examples from my clinical practice of how my therapeutic approach evolves from an understanding of each particular client’s situation, needs and difficulties. This section briefly reviews some ethical and practical factors which are inherent to my therapeutic practice. These relate to ‘ego strength’, the context of therapy, and the therapeutic frame.

Clients in need sometimes have difficulty recognising the fragility of their affects, motives, and intentions. As a practitioner, I believe that it is my ethical responsibility to assess each individual client’s ‘ego strength’. This expression refers to a client’s ability to tolerate anxiety, frustration and impulse control, as well as use appropriate defences. Evaluating these factors depends on an awareness of the context and background of each particular client’s presenting issues. ‘Denial’, for example, has been considered an adaptive defence for helping people to cope with the initial stages of adverse life circumstances (Waites & Zigmond, 1999) and, thus, should be handled and challenged with caution. Furthermore, evaluating ego strength requires gauging each client’s psychological mindedness. Any approach adopted needs be to first and foremost accessible to the client.
Contexts of therapy, which only fund practice within a given theoretical model, are bound to impinge upon the development of ‘tailor made’ therapeutic approaches for individual clients. The length of therapy is also a contributing factor. If its course is constricted to six sessions, for example, then it might seem more appropriate to begin working with clients at the symptom relief level. This may involve helping clients to discover more effective coping strategies for managing their difficulties. It can often also include enabling clients to clarify their problems or crises and assist them to explore new ideas and possibilities for which to approach these.

The next issue pertaining to frame refers to the frequency of therapy. Many settings do not allow practitioners to meet with their clients more than once a week. Sometimes, because of the overwhelming demands of waiting lists and limitations of therapists’ case load, the frequency is even less. This can affect a client’s capacity to feel contained by the therapeutic process and the depth of psychological work that a therapist may consider safe to pursue with a client. In particular, I believe the provision of a reliable holding environment is necessary to facilitate clients to work through their internalised maladaptive experiences. Compromising this process, on the other hand, risks aggravating their original wounds by potentially depriving them of a more trustworthy relationship to reexperience their earlier difficulties. These are important issues in my therapeutic practice. While remaining cautious about generalising, they reflect some of the concerns that are present in my mind when I try to discern the most appropriate approach for each particular client and their situation.

Conclusion

My training has provided me with an invaluable breadth of clinical experience, theoretical expertise, and psychological knowledge. All the colours, shades, and hues that comprise this palette have broadened my awareness and equipped me with tools to reflect upon and engage with the mysterious and illusive quality of our phenomenal reality. This journey has taught me that there are no hard and fast rules, no simple answers and this is why I believe that my psychological work can only survive by being reflective and continually receptive to learning from the perspectives of others. I am grateful that my training has enabled me to practice with client groups in mental and physical health settings. I would like to continue to pursue research on the interrelations between mental functioning, physical trauma and neurological disability.
This aspiration strongly depends upon my intention to practice with people who are part of this client group. It is through my clinical work that I feel I can really 'come to know' the experience of others and attend to issues, needs and meanings that may not have been formally explored or represented yet. Hopefully, this ongoing endeavour will enable me to develop models and metaphors to elucidate my clients' experience and refine intervention strategies to advance their treatment and care.
REFERENCES


Kahn, E. (1996). The intersubjective perspective and the client-centered approach: are they one at their core? *Psychotherapy, 33*(1), 30-42.


Introduction to Research Dossier

This dossier contains three separate pieces of research. These include a literature review and two pieces of empirical research using qualitative methods of analysis. It should be noted that the most recent investigation stands alone and is, therefore, not related to the two previous projects.
THE DEVELOPMENT OF COUNSELLING PSYCHOLOGY AS A POSTMODERN DISCIPLINE
ABSTRACT

This literature review seeks to explore the topic of counselling psychology as a postmodern discipline. A review of some of the contrasts between modernist and postmodernist notions of science, language and meaning unfolds three dimensions to distinguish postmodernist psychotherapeutic practices. These are (1) local meanings and understandings; (2) relational practice; and (3) a pluralistic orientation. These dimensions are adopted to review the literature about counselling psychology. This exploration reveals that counselling psychology's methods appear to reflect a postmodern mindset. Implications for its practice and development are considered to involve a three fold reflective awareness; namely (1) a self reflective awareness about practitioners' personal and subjective frames of reference; (2) a sensitive reflective awareness about the otherness of other people; and (3) a critical reflective awareness about the prejudices and preconceived practices of cultural meaning systems.
THE DEVELOPMENT OF COUNSELLING PSYCHOLOGY AS A POSTMODERN DISCIPLINE

Introduction

Counselling psychology is a new and developing discipline in Britain. It emerged as a Special Group within the British Psychological Society (BPS) in 1982, was transformed into a Section in 1989, and accorded Divisional Status in 1994. Woolfe has put forward that counselling psychology reflects "an idea whose time has come" (1996: 4). This assertion immediately draws my attention to the historical context of the discipline. In turn, Strawbridge and Woolfe have described counselling psychology as postmodern "in offering a practice-led model of psychology which emphasises the pragmatic and fragmentary nature of knowledge and of the centrality of values in professional decision-making" (1996: 607). Nonetheless, I am still grappling with the meaning of postmodernism, its implications for the development of counselling psychology and, in turn, the practice of its discipline.

Baldick (1990) has put forward that postmodernism generally refers to a cultural condition prevailing in advanced capitalist countries since the 1960s, characterised by a superabundance of images and styles, as manifested in television, advertising, commercial design, and pop video. However, I have found that accounts of postmodernism shy away from offering any clear cut definitions. For instance, Usher and Edwards put forward that postmodernity, postmodernism, and/or the postmodern do not designate "some fixed and systematic 'thing'"(1994:7). In turn, Potter has asserted that "defining postmodernism is not easy -- and it is probably not wise either", given that its very ethos challenges received definitions and distinctions (1997: 88). In addition, Sarup (1993) has explained that any attempt to pin down postmodernism would risk generating some metatheory, which is precisely what its ever changing, fragmented and perspectival reality intends to avoid.

No doubt, the writings of the aforementioned authors have made me aware of the inherent difficulties and challenges of embarking on the present endeavour. Yet, I feel that Richardson (1994) has, at least partly, let me off the hook. He explains that 'knowing' is easier in the postmodern context because postmodernism recognises
the situational limits of the knower, and describes 'a postmodernist position' as one that allows us to know 'something' without claiming to know everything. In turn, this is precisely the position that I have adopted here. This literature review, therefore, does not intend to be a definitive or exhaustive account of postmodernism. Instead, it puts forward a subjective and perspectival account, which is confined to understanding something about the relevance of postmodernism to counselling psychology and vice versa.

The first part of my endeavour to explore the relevance of postmodernism to counselling psychology includes highlighting some of the tensions between modernist and postmodernist notions of science, language, and meaning. I then review how these seem to have reinforced the limitations of traditional applied psychology and, in turn, generated postmodern forms of practice. It is with this background that I proceed to discuss counselling psychology as a postmodern discipline. Finally, in the last part of this paper, I put forward some implications for the development of counselling psychology as a postmodern discipline.

**Tensions between modernism and postmodernism**

The project of modernity was formulated in the eighteenth century by the philosophers of the Enlightenment. It consisted in their efforts to develop an objective science, universal morality and law. In science, this endeavour reached its culmination with logical positivism, the dominant philosophy during the period of high modernism (1920s - 1960s). Its paradigm emphasised universal laws of cause and effect, based on a realist epistemology which assumed that reality consists of objectively observable facts. Human beings were viewed as reactive objects that respond to environmental events through learned or genetically predisposed ways. Logical positivists claimed that legitimate knowledge consisted exclusively of observation sentences and logical connections between them. Statements that were not empirically verifiable, therefore, were considered meaningless nonsense or metaphysics. The positivist view of science as a single unified system expected that higher-level sciences, such as psychology and sociology, were reducible to basic sciences and formalised in the same nomological framework as physics to be considered a 'real' science (Bem & Looren de Jong, 1997).
In this section, I will review several developments which challenged the realist, universal and ahistoric foundations of the project of modernity. These have, in turn, influenced my understanding of postmodern approaches to the social sciences. The tensions between modernism and postmodernism that I will discuss are grouped under the following interrelated headings: skepticism about the unitary theory of knowledge; skepticism about empirical certainty and objectivity; and skepticism about the status quo.

*skepticism about the unitary theory of knowledge*

Critics challenged the ‘received’ (‘positivist’ or ‘modern’) view of science, based on a single unitary theory of knowledge, as controlling the resources to produce ever more results that confirm its unquestioned validity. Wittgenstein (1953) cast doubt on the empirical verification of meaning by presenting the notion that the meaning of a term or a statement is not once and for all given, but forms part of a ‘language game,’ a ‘form of life’. Others, such as Hanson (1958), introduced the notion of ‘theory-ladenness’, which undermined the conventional belief that observations are independent of theoretical presuppositions and can be used to reject or confirm a theory. And still others, like Kuhn (1962), introduced the concept of ‘paradigm’ for determining what is seen, which implied that different paradigms have different standards for evaluating evidence. It suggested that political and social forces underlie communities of scientific collectives and contribute to the discovery of a new theory or the validity of any given theory. In turn, Kuhn’s formulation directed attention to the contextual nature of knowledge claims. Popper (1968) subsequently replaced the notion of theory verification with the notion of theory falsification. Such developments were instrumental for casting doubt on the premise that the traditional scientific method could ultimately converge on the “real” truth.

One of the ways in which *The Postmodern Condition: A Report on Knowledge* (Lyotard, 1984) distinguishes the modern from the postmodern is in the abandonment of a totalising idea of reason. Lyotard argues that there is no reason, only reasons. In turn, postmodern thinkers distrust grand theories. They invite a multiplicity of accounts of reality, which explore local contexts and narratives devoid of any single predominating conception of truth (Gergen, 1997; Kvale, 1997a; Polkinghorne, 1997). Their views have generated a dynamically evolving...
understanding of science as a “multifaceted activity” (Smith, 1996: 189). Many postmodern approaches adopt relativist evaluative repertoires (see Erwin, 1997), which steer clear of realist claims to knowing the “way things are” (Guba & Lincoln, 1994). Critical realist epistemology (Bhaskar, 1989), for example, affirms physical reality, while recognising that all understandings are essentially tentative and that scientific methodologies are not ‘value-free’.

skepticism about empirical certainty and objectivity

The traditional scientific ideal of an apprehendable objective physical reality was undermined by evidence, such as the Bohr complementarity principle. Bohr's recognition that in the world of micro physics the interaction between observer and observed forms an intrinsic feature of the phenomenon (1963, emphasis in the original) cast doubt on the positivist assumption of a sharp separation between subject and object. The notion that findings are created through the interaction between the inquirer and the phenomenon offered a more plausible description of the inquiry process in the social sciences, where the phenomenon is usually people, than the notion that findings are discovered through objective observation (Guba & Lincoln, 1994). Habermas (1971), for example, considered the study of “communicative action” as grounded in social norms which depend on intersubjectivity and mutual understanding. Descriptions of people can be neither certain nor objective, therefore, themselves reflecting interpretations and subjectivities that are entrenched in pragmatic and social life-worlds, harbouring prejudices and preconceived practices (Taylor, 197; Ingelby 1982). Postmodern thinkers, in turn, acknowledge the codetermined, interpretative and phenomenological quality of human enquiry (see Kvale, 1996; Smith, 1995).

skepticism about the status quo

The poststructuralist movement, which is considered an integral part of postmodern thought (see Potter, 1997; Richardson, 1994; Sarup, 1993), was particularly instrumental for dismantling the traditionalist assumption of the correspondence theory of truth that a description is true if it corresponds to the object or event in which it describes (Bem & Looren de Jong, 1997: 66). Derrida (1976, 1978) demonstrated that language does not “reflect” social reality, but produces meaning and creates social reality. His analysis of binary oppositions within texts, for
example, showed that the principles of meaning systems are commonly defined by what they exclude. ‘Deconstruction’ is the name given to the critical operation by which such oppositions can be partly undermined, or by which they can be shown partly to undermine each other in the process of textual meaning. In patriarchal society, for instance, man is the founding principle and woman is the opposite, the ‘Other’ of man but, equally, man is what he is only by virtue of excluding this other (Eagleton, 1983). This example casts light on the ways in which language maintained the inequities of the status quo, by marginalising and objectifying the ‘other’ rather than allowing the pluralism of different viewpoints to coexist.

Foucault (1967, 1979, 1980) explored how social organisation and power are defined and contested. He directed attention to how modern discourses on sexuality, madness, and knowledge operate as ‘apparatuses’ of social control and surveillance. His writings progressively undermined the legitimating assumptions of the modernist period that science was geared to the progressive liberation of humanity, and that philosophical logic would generate universally valid knowledge for humanity. Like the poststructuralists, contemporary social constructionists believe that language functions to “invite, rationalise, or justify” patterns of social relations and conventions (Gergen & Kaye, 1992). McNamee (1996), for example, has described the postmodern project as one which examines how particular interactive contexts privilege one form of discourse while other contexts provide opportunities for vastly different discourses. The next section will include some references to the ways in which the work of social constructionists has generated a critical awareness about the limitations of orthodox applied psychology.

From Orthodox Applied Psychology to Postmodern Practices
In the last section, I reviewed some of the tensions between modernist and postmodernist approaches to the social sciences as: skepticism about the unitary theory of knowledge; skepticism about empirical certainty and objectivity; and skepticism about the status quo. It seems to me that these tensions have been instrumental in drawing attention to the inherent limitations of orthodox applied psychology. In turn, the transitions that I will discuss here from traditional to postmodern psychotherapeutic practices are grouped under the following interrelated headings: from ‘truth’ to ‘local’ meanings and understandings; from the ‘objective’
practitioner to relational practice; and from the status quo to a pluralistic orientation. Here, I will occasionally use direct quotations as a means of conveying glimpses of the intensity and extremity of dissatisfaction with mainstream psychology.

from 'truth' to 'local' meanings and understandings

Postmodern thinkers have associated positivist pretences to scientific 'truth' with the "mythologising of expertise" (Foucault, 1967; Kitzinger, 1987; Ussher, 1992). Kitzinger (1987), for example, examined the common tendency among professional accounts to differentiate between 'scientific' and 'lay' conceptualisations of homosexuality and lesbianism. She found that 'common-sense' or 'folk' notions were stigmatised as based on 'taboo', 'myth', 'stereotype', 'fallacy' or 'ideology' whereas the scientific version was represented as 'truth', 'fact' or 'reality'.

Clegg (1998) argues that, deployed in isolation, the scientific language of the medical model removes the person from their position in time and relation to others. This is illustrated in Ussher's (1992) discussion of the tendency to pathologize women, who are depressed, unhappy, or angry after childbirth, as undergoing postnatal depression. She contends that such objectification implicitly ignores the possibility that their behaviour is a normal reaction to the oppressive conditions in which they may find themselves. In turn, Parker has denigrated the tendency to locate the sources of difficulty within the individual, as opposed to the social and contextual forces potentially associated with their respective predicament, as "a powerful rhetorical device" to remove "any responsibility from society" (1995: 61). For example, Ussher argues that the term 'depression' objectifies the woman into a "neat category", denying her the reality of her feelings and the right to any recourse or positive action which might relieve them (1992: 57). For social constructionists, arbitrary classifications of psychological distress reflect the "hegemonic and subjugating process" (Gergen & Kaye, 1996) of positivist science, which suppresses pluralistic forms of subjectivity through the "systematic government of the psychological domain" (Rose, 1990: 106-10).

On the other hand, postmodern approaches emphasise the importance of remaining open to diverse accounts and, in turn, challenge assumptions that only one version of events can be 'right'. Harper (1996), for example, cites his own and others' research...
in arguing for diverse voices in mental health practice, for placing the accounts of service users alongside biological and psychiatric accounts. Postmodern practitioners consider that obtaining ‘local’ understandings of clients is necessary for helping each client make sense of the meanings they attribute to their respective memories, perceptions, and experiences (see Lax, 1996). In particular, the work of Anderson & Goolishian (1996) encourages assuming a ‘not knowing’ position, in which the therapist positions themselves in a state of ‘being informed’ by each client’s account and distinctive language and metaphors associated with their predicament. This position emphasises remaining attentive to the process of therapy rather than giving primacy to the content (diagnosis) and change (treatment) of pathological structure (Bruner, 1984). As such, it seems to sharply contrast with the positivist tendency of conveying preconceived opinions and expectations about a phenomenon or behaviour from generalised theory (Polkinghorne, 1997).

*from the ‘objective’ practitioner to relational practice*

Postmodern thinking distrusts the notion of the objective practitioner in the human sciences. The idea of neutrality as part of the psychotherapeutic frame is gradually disappearing with the realisation that the client-therapist dyad reflects an intersubjective encounter (see Diamond, 1997; Kahn, 1996; Rubin, 1997). Many practitioners acknowledge that their theories and interpretations are inevitably conditioned by the rich matrix of social and cultural meanings, as well as formative experiences, which underlie their respective frames of reference (Sedgewick, 1987; Bregman Ehrenberg, 1992; Stolorow, 1994; Stolorow & Atwood, 1994). Such accounts direct attention to the dangers of imposing meanings on clients experiences and, in turn, stress the importance of cooperatively reaching these with clients.

Postmodern practitioners emphasise the intersubjective context between individuals in the unfolding of meaning and intention in human behaviour. Thus, a collaborative relationship between client and therapist is considered essential for enabling the client to move beyond their current crisis or continuing difficulties. The therapist’s role and expertise is intended to facilitate the client discover a free space to explore and reevaluate the principles which have governed their experience and creation of meanings (see Anderson & Goolishian, 1996; Gergen & Kaye, 1996; Lax, 1996). Interpreting and understanding is seen as a reflexive dialogue between therapist and
client, rather than the result of predetermined theoretical narratives. In addition, in situations involving adverse life events, such as illness or loss, the work of Charmaz (1991) and Frank (1992) draws attention to the significance of therapists’ role in validating patients’ suffering and enabling them to share meanings about their experience(s). These accounts seem to cast light on the value of ‘being with’ clients rather than focusing on ‘doing’ or ‘fixing’ a ‘pathological structure’.

from the status quo to a pluralistic orientation

Some authors have asserted that, under the guise of objectivity and value neutrality, the traditional paradigm of scientific psychology seeks to predict and control human activity (see Strawbridge, 1992; Ussher, 1992). Moreover, Grover has put forward that there are certain biases built into experimental design and data interpretations which lead the scientist to retain theories without disconfirming evidence (1981: 17). The tendency of the DSM-IV to report consistently higher rates of women than men suffering from psychological distress may be considered one such example. Goldberg and Huxley have contended that men undergo similar experiences of psychological distress as women, but that women "are more willing to acknowledge illness, to make contact with a doctor, to present psychological complaints, and to remember having had psychological symptoms" (1992: 19). This issue, for instance, directs attention to the need to examine the social and linguistic practices which position women (and within which women may position themselves) as those who seek assistance within a psychological framework.

Social constructionist approaches to therapy have sought to generate an expanded range of alternative social and political agency for challenging unhelpful constructions of self, gender knowledge, social relations and cultural exchange. For instance, White and Epston (1990) maintain that disempowered people are more likely to internalise social values about what manner of person they ‘should’ be. Externalising the problem by separating it from any defining feature of ‘self’ is thus considered a potential solution. Nevertheless, this approach is not without its difficulties. In particular, White (1989) warns against the dangers of redefining problems such as violence and abuse and enabling people to disown these.
Finally, postmodern approaches to research consider that each individual and each group is shaped by many forces. The emergence of qualitative research methodology reflects a number of evaluative repertoires to explore the personal and social life worlds of participants. The overall aim of these methods is to open up areas of human experience that may benefit from further research rather than arrive at any conclusive definitions. In this manner, these methods can be regarded as nurturing a pluralistic orientation by seeking to represent the different meanings, experiences, and viewpoints which comprise postmodernity’s perspectival reality. In the next section, I will discuss the ways in which counselling psychology has integrated many of these methods into its practice, theory and research components.

**Counselling psychology as postmodern discipline**

I should state right from the start that counselling psychology does not share the same epistemological framework as the social constructionist approaches to therapy. Their narrative view maintains that it is the process of developing a story about one’s life that becomes the basis of all identity and thus challenges any underlying concept of a unified or stable self (see Lax, 1996). On the other hand, counselling psychology rests on a phenomenological base and humanistic value system (Woolfe, 1996; Clarkson, 1998), which considers human beings free and autonomous individuals. In turn, Woolfe’s (1996:10) conceptualisation of counselling psychology as located “between narrow scientism on the one hand and a failure to take sufficient account of any scientific method on the other” seems more akin to House’s description of what a postmodern practice should be like:

Perhaps postmodernism is a kind of ‘reaction formation’ against the excesses of soulless scientism of modernity; and it seems to me that the fields of counselling and psychotherapy are in a unique position to develop an embodied, humanistic approach to research that transcends the ideology of objectivism and which honours both our need for communicable intersubjective knowledge about the world and core humanistic principles, which elevate the values of holism and human meaning above those of mechanism and quantifiability (1997: 59).
House’s representation conveys a different rendition to the one of the social constructionists. Notwithstanding their differing epistemological perspectives, it seems to me that what most postmodern practices share are the three dimensions that I discussed in the last section to differentiate them from orthodox practices; namely: local meanings and understandings; relational practice; and a pluralistic orientation. Thus, I will now adopt these to review how the literature about counselling psychology and/or by counselling psychologists reflects a postmodern mindset.

**local meanings and understandings**

Counselling psychology’s practice led approach seeks local understandings of people, informed by their subjective accounts of their world and experience (Woolfe, 1996: 7). Rather than the pursuit of an "objectively discoverable 'truth'" (Strawbridge & Woolfe, 1996: 619), its discipline gives primacy to exploring the ways in which individuals perceive and attribute particular meanings to their phenomenological realities (van Deurzen-Smith, 1990). McLeod (1996a), for example, considers that attempts to impose diagnostic labels on clients risk obscuring the inevitable ambiguities that comprise individuals’ unique perspectives. Psychological practice emphasises evaluating emotional and mental health with respect to a person’s position in the life cycle, along with their lifestyle and relationships (Woolfe, 1996: 8). This concern represents the shift from locating the sources of difficulty within the individual to consideration of the social and contextual forces associated with each client’s respective predicament.

While counselling psychology embraces both the quantitative and qualitative research paradigms, this paper will focus on its use of qualitative methods as the clearest example to demonstrate the role of social and contextual factors involved in the formation of psychological realities. These have equipped counselling psychologists with a repertoire of non-experimental approaches for collecting and analysing the accounts that people put forward regarding their experience (McLeod, 1996b). Phenomenological approaches, for instance, strive to capture and understand the character and complexity of meanings which encompass participants' subjective conceptions of the issue(s) under investigation (Smith, 1995). Discourse analysis is considered useful for examining the linguistic resources and social discourses embedded in notions of identity, constructions of self, other and the world, and the
conceptualisation of social action and interaction (Potter & Wetherell, 1995: 81). In turn, counselling psychology’s openness to using these methods seems to reflect its commitment to exploring the different facets of the local experiences that comprise and construct postmodernity's perspectival reality.

Social constructionist approaches to psychotherapy warn against destroying or replacing the client's narrative by the professional account. For example, Gergen and Kaye have contended that the danger with using traditional models of human development to inform practice is that “the client’s account is transformed by the psychoanalyst into a tale of family romance, by the Rogerian into a struggle against conditional positive regard, and so on” (1996: 169). In turn, Clarkson (1995) encourages an approach to psychological practice that goes 'beyond schoolism'. Instead of rejecting these models, however, her work provokes thinking about how we use them. For example, she considers the three paradigms (behavioural, psychoanalytic, humanistic) as “mutually complementary and enriching” (Clarkson, 1996a: 263) and maintains that these can be applied in the postmodern sense as "models and metaphors" (Polkinghorne, 1997; Clarkson, 1998: 10-11) to elucidate an understanding of the person as 'learner' for behaviourism, as 'reactor' for psychoanalysis, and as 'creator' for humanistic existentialism (Clarkson, 1996a: 263).

Rather than leaving theory to police practice (see Richer, 1997), counselling psychologists put forward that clinical work entails the flexible application of different theoretical orientations based on what seems most effective for meeting a client's needs and difficulties at a given time (Clarkson, 1996a; Strawbridge & Woolfe, 1996; Woolfe, 1996). It might be appropriate for treatment to focus on graded exposure techniques with a person presenting with what appears as a simple case of spider phobia. A more complex therapeutic approach, however, may be required for Sandra (pseudonym), who presents with agoraphobic features, triggered by nightmares about either harming significant others or of this harm being inflicted upon her, which seem to relate to her developmental experience of mental and physical abuse by her parents. Treatment for this client may include aspects of the cognitive behavioural model, for developing effective coping mechanisms to combat her agoraphobic features, coupled with aspects of the psychodynamic model, for working through the repressed content of her mental and emotional tension.
Hopefully, this example illustrates that any given therapeutic approach evolves out of a local understanding of the ways in which each client perceives and associates particular meanings to their personal experience of psychological distress.

A key and defining feature of counselling psychology is that practitioners engage in an ongoing process of critically researching and evaluating their work. The purpose of this is to ascertain the effectiveness and relevance of psychological therapies to the evolving needs of clients (Barkham, 1990; Strawbridge & Woolfe, 1996; Woolfe, 1996). The next section will discuss the ways in which counselling psychology rests on a relational practice, between client and therapist, in which local meanings and understandings are not imposed or prescribed, but collaboratively reached.

**relational practice**

The ‘helping relationship’ forms an integral part of counselling psychology’s practice-led discipline (see Woolfe, 1996). Its system of ‘cooperative inquiry’ involves developing a shared understanding between client and therapist to address the purpose that has brought them together, and that concerns the client. This approach represents the move from a ‘one-person psychology’, with its emphasis on the psychology of the client (Kahn, 1996), to an intersubjective psychology, where the frame of reference of the therapist is considered to have an impact on the client’s experience of therapy (Strawbridge, 1992; Wilkinson et al., 1997). The intersubjective context of the therapeutic encounter implies that therapists’ understandings of clients are inevitably relative and perspectival. I believe this highlights the imperative for tentative psychotherapeutic interventions, continually informed by clients’ local accounts of their difficulties. In turn, the use of counselling techniques, such as summarising, paraphrasing and reflecting, seems crucial for enabling therapists to check out with clients the congruence and accuracy of their interpretations.

Even when conducting research, counselling psychologists work as collaborators in seeking to understand the ways in which participants perceive and attribute particular meanings to their experiences. They engage in a variety of methods of human enquiry (the research interview, open-ended questionnaires, and interpersonal recall tasks) which involve a co-determined interaction. While the questions addressed in
semi-structured interviews, for example, are based on the topic under investigation, these projects also seek to gain an understanding of the particular psychological and social world of each participant. (S)he is considered the expert of their subjective reality and should be allowed considerable scope to tell their story, as it relates to the topic at stake, and also introduce issues that the researcher may not have considered (Smith, 1995: 12). Coyle (1998) has pointed out that the use of counselling techniques (paraphrasing, reflecting and summarising), coupled with the defining qualities of a person-centered relationship (empathy, genuineness and unconditional positive regard) are relevant to the research situation. They contribute to the quality of the personal information obtained from participants.

A wealth of studies indicate that the relationship between client and therapist, more than any other factor, determines the effectiveness of psychological therapy (Bergin & Lambert, 1978; Luborsky et al., 1983; O'Malley et al., 1983). A review of a range of research studies, for example, demonstrated that the key themes that emerge from clients' experience of effective therapy are "accept me, understand me, talk with me" (Howe, 1993). As mentioned before, counselling psychology gives primacy to relational practice. In turn, Clarkson (1995) has gone as far as developing a five-relationship framework that is "a fairly abstract theory of therapeutic relationships" (Clarkson, 1996b: 154). The relational modalities are all grounded in a person-centered orientation, while integrating aspects from different psychotherapeutic approaches. They evolve out of a therapist's joint understanding with the client of their circumstances, needs and difficulties at any given time.

As the basis of any therapeutic relationship, the 'working alliance' represents the commitment between client and therapist to work together even when the client experiences averse inclinations. In addition, for example, Sandra, the aforementioned client with the complex case of agoraphobic features (see previous section), may be helped from a 'transference - countertransference relationship'. This would require the therapist to attend to her transference of unconscious wishes and fears on the therapeutic partnership and, in turn, interpret these to help her work through the unresolved and repressed aspects of her developmental experience. Clarkson (1997) considers that the relationship modalities represent subtly overlapping states in psychotherapy. In turn, Sandra may also benefit from a 'reparative relationship'. This
modality describes the process in which the therapist intentionally provides the 'corrective emotional experience' where the original parenting of the client was abusive, deficient, or over-protective.

The primacy of the therapeutic relationship in counselling psychology is congruent with postmodernist practices, which emphasise remaining attentive to the process of therapy. I am learning that healing occurs by ‘being with’ the client rather than ‘doing’ a diagnosis and/or ‘fixing’ what an orthodox practitioner would objectify as ‘the problem’. In this manner, Clarkson’s theory of therapeutic relationships has assisted my therapeutic training by providing me with templates, from which to reflect on my interactions with clients. The relationship modalities have opened up possibilities for me to relate and respond to each client’s subjective world and experience, and begin to use the space between us as a place where local meaning and understanding can be facilitated, clarified, and transformed. The next section will discuss the ways in which counselling psychology’s methods also appear to lend themselves to generating greater social and political awareness and agency.

**pluralistic orientation**

Counselling psychology’s humanistic ethos incorporates the view of the "person-in-process" (McLeod, 1996a: 137). Its belief system resonates with the implication that persons have within themselves vast resources for self-understanding and for constructive changes in ways of being and behaving. Strawbridge and Woolfe consider that "counselling psychology is not just a psychological activity but is also a cultural enterprise" (1996: 606), which involves reflexive questioning about its relevance to society, as well as its role in maintaining and/or challenging the existing social structure. In turn, the discipline’s evaluative repertoire seems committed to clarifying, understanding and potentially transforming the meanings and recurrent patterns that tend to oppress and constrict the identities and behaviours of people.

Counselling psychology’s 'methodological pluralism' (Barkham, 1990) reflects its openness to engaging with different ways of exploring the personal and social dynamics of human activity. Some of these methods are particularly appropriate for uncovering the contextual forces that influence social narratives and the self definitions of people. Recalling Goldberg and Huxley's finding (1992), for example,
discourse analysis may be appropriate for deconstructing the social and linguistic conventions that position women (and within which women may position themselves) as those who seek assistance within a psychological framework. In turn, findings can be used to generate a greater critical awareness about the cultural and sexist forces which maintain the status quo. Rather than using science to predict and control human beings, therefore, a better understanding of the relations and conventions which uphold the social structure can be used to inform practitioners' capacity to develop an expanded range of alternative agency for thought and action.

Strawbridge & Woolfe (1996) contend that restricting psychological therapy to working through emotional distress with clients may not be enough, as this can inadvertently maintain the social structure that, at least in part, potentially created the difficulties. In turn, McLeod (1996a) has emphasised the need to reflexively examine the values upon which choices are based. Woolfe (1983) considers that putting this process into practice can involve generating self help and imparting skills for clients about decision making, communication, personal relationships and group functioning. For example, he has suggested that this may include enabling women to examine the nature of the social relationship between men and women which generates rape, or assisting the unemployed to evaluate the social values and allocation of resources which maintain unemployment (Woolfe, 1983: 172).

In the ways described above, counselling psychology reflects a pluralistic orientation both in terms of its ideals and in terms of its methods and assumptions. Its discipline seems opened to diversity (Gelso et al, 1988) and 'confluence' (Clarkson, 1996a) of theories and techniques to generate understanding, communication and acceptance among the myriad 'local' meanings and interactions of human activity. It would seem that this pluralistic attitude bodes well for its continuing development as a postmodern discipline that empowers "people's ability to decide for themselves" (Shotter, 1975).

**Implications for Counselling Psychology as a Postmodern Discipline**

One of the main challenges that I see for counselling psychology as a postmodern discipline rests precisely with the acknowledgment of its intersubjective bedrock, one of the main features distinguishing this practice-led model from the 'objectifying
tradition' of orthodox applied psychology. Perhaps the former readily committed themselves to 'objectivity' as a means of side-stepping the inherent uncertainty in any system of human relatedness. Technical rationality apparently sheltered their practitioners from entering into the multi-faceted labyrinth of 'reflective practice' (Schon, 1983; Reason, 1988). Having opened 'Pandora's box', we are now left to tackle the messy and complicated endeavour they tried so hard to avoid.

The realisation that the study of human activity is grounded in an “unavoidable hermeneutical component” (Taylor, 1971: 3) throws light on the implications for counselling psychology as a human science. Rather than resting on pillars of neutrality, detachment, and objectivity, its inherent intersubjective orientation brings together the subjective frames of reference of the client and therapist, and also frequently the participant and researcher. Their subjectivities envelope their respective affects, motives, and intentions, as well as the social and contextual forces that entrench them. The notion that objectivity is not possible in the human sciences has crucial moral and ethical implications. I believe that this calls for 'reflective practice' (Schon, 1983; Reason, 1988), which requires practitioners like myself to have the courage and humility to confront our own subjectivities lest we end up blindly objectifying clients with our own unexamined attitudes and ideas.

Below, I describe three overlapping and interrelated types of reflective awareness which may assist us as postmodern practitioners to accept, respect and contain the inevitable ambiguity and uncertainty of our fragmented and perspectival reality. These refer to a self reflective awareness about practitioners own subjective frames of reference; a sensitive reflective awareness about the otherness of other people; and a critical reflective awareness about the prejudices and preconceived practices of cultural meaning systems. This paper will now discuss each of these in turn.

**a self reflective awareness**

Counselling psychologists emphasise that the ways in which the psychologist perceives, construes, and relates to the client and the context are pivotal factors in the process of psychological therapy (Wilkinson et al., 1997). It seems necessary, therefore, for us as practitioners to develop a self reflective awareness about the values, assumptions, and attitudes that comprise our respective frames of reference.
This is, at least in part, mediated through the training requirement to attend personal therapy, which assists us to look into the “prejudices, biases, and personal distress” we may inadvertently bring to our work (Wilkinson et al., 1997: 80).

Sue and Sue (1990) suggest that counselling professionals need to recognise that race, culture, and ethnicity are functions of each and everyone of us and not limited to “just minorities”. For example, Pederson (1988) contends that practitioners, who depend on a predominating value system about what characterises a state of wellbeing for an individual who asks for help, are dangerous. They risk relying on stereotypes to inform their decisions about clients from different cultural groups, without acknowledging the importance of differences. I would say this point also applies to our need to reflexively examine the norms and attitudes we personally attribute to male and female gender identities, as well as those we associate with the life styles and relationships of heterosexuals, lesbians, and gay men.

In clinical practice, a self reflective awareness seems crucial for us to evaluate which therapeutic approach seems appropriate to the situation of a particular client and, in turn, use it effectively. For me, this has involved learning to recognise when I might be projecting my own local meanings on a client’s needs and difficulties instead of remaining informed by their personal experience of distress. In turn, the ‘transference and countertransference’ relationship demonstrates a clear example of our need to consider and be able to differentiate between the affects, motives, and intentions that we bring to the therapeutic encounter (proactive countertransference) and those potentially arising as reactions to a client (reactive countertransference).

Important ethical implications are associated with a self reflective awareness. Clarkson’s (1996c) exposition of the bystander effect, for example, discusses twelve different excuses we give ourselves for failing to take action. Hopefully, however, the process of reflexively examining our feelings and reactions to situations will facilitate us to handle the inevitable uncertainty and ambiguity that comes with taking responsibility for action. In turn, this may also contribute to our capacity to enter into dialogue with other professionals to mediate and resolve potential conflicts.
A sensitive reflective awareness seems necessary for practitioners' capacity to relate to the emotional and psychological aspects of the client in therapeutic relationship, and the participant in human enquiry systems. The defining qualities of a person-centered relationship (congruence, empathy, and unconditional positive regard) are not inherent givens. Several studies have shown that the congruence of the client and therapist is significantly related to outcome (Hill et al., 1981; Satir, 1987), with positive correlations between congruous feelings and the most "helpful events" of a therapeutic session, and incongruous feelings and the most "hindering events" (Grafanaki & McLeod, 1995).

McLeod (1996a) urges practitioners "to trust" their feelings about respective clients, particularly with respect to whether there will be any personal barriers which may inhibit the development of a congruent therapeutic relationship. I believe this requires our openness and receptivity to contemplate the ways in which our own presence may be subjectively experienced by different clients. Casement (1985) has put forward that this involves remaining alert to direct and indirect communications, such as how a client may mishear what we mean or wish to say. In addition, Lago and Thompson (1997) have suggested that words and phrases can be loaded with connotative and ideological meanings. This observation seems to reinforce our need to remain sensitive to the client's culture and use of language within that culture as part of the process of facilitating exploration by "caring to know" (Strawbridge, 1992) the meaning and content of their local experience and communications.

A sensitive reflective awareness seems a precondition for having what Jacoby (1984) refers to as "one foot in and one foot out" of the therapeutic relationship. 'One foot in' involves the ability to empathise and immerse ourselves into the experience of the client. 'One foot out', on the other hand, entails the capacity to look at the client from a distance and, in turn, monitor our empathy by relating it to the overall context of the experience and developmental phase of the client. I believe that a client's beneficial experience of the 'reparative relationship', for example, partly rests on my ability to distinguish between assisting them to replenish a "real need" and "what would be otherwise overindulgent smothering" (Clarkson, 1995). In my view, the latter risks aggravating a client's distress by potentially maintaining their dependent longings.
rather than facilitating them to reexperience their actual parental deficit, so that their old wounds may have the chance to heal over.

Finally, it seems important to maintain a sensitive reflective awareness about the understanding we derive from our experience of ‘being with’ clients. For example, Shotter (1993) has added knowing from within to the familiar distinctions between knowing how and knowing that. My therapeutic work with Jennifer (pseudonym), a very depressed woman who had been hospitalised for attempting suicide, I think may convey an example of what Shotter means. After our initial session, Jennifer was granted permission by the hospital staff to go home for the weekend. Nonetheless, I sensed that she felt uneasy about this decision and resolved to explore this with her during our second session. In turn, it emerged that she did indeed feel very anxious and she explained that her only motivation to go home was to prove a point to others that she could take care of herself. When I suggested that she may want to postpone this endeavour, she felt relieved. We agreed that I would inform the other professionals, involved in her care, about her change of plans. It felt as though I had made it all right for her to acknowledge her need for the containing context of the hospital environment. I subsequently began to integrate aspects of my experiential knowledge of Jennifer within my discussions with other professionals involved in her treatment, which I discovered, generated a greater understanding about ways of handling her needs and difficulties. This experience, at the beginning of my training, helped me to realise that finding appropriate ways to share our insights with other professionals, involved in our clients’ care, can make a useful contribution to enhancing their treatment.

A critical reflective awareness
A self reflective awareness and a critical reflective awareness strongly overlap. However, the former emphasises our ability to examine and evaluate the biases and preconceived assumptions that comprise our personal frames of reference, whereas the latter emphasises our ability to examine and evaluate the social and political factors that are more generally associated with the culture we inhabit. For example, DeVos, Marsella and Hsu (1985) stress that the Western striving towards the development of a solid well-functioning ego is only one of a number of ways to conceptualise the person in society. In turn, Alladin (1992) has highlighted the
contrast between Western society's emphasis on Individualism and Eastern society's emphasis on Communalism. This value clash implies that we need to think carefully and cautiously about how we use humanistic values with people whose culture may resent the concept of the autonomous self (Laungani, 1999).

A critical reflective awareness may, at least in part, provide us with a greater understanding of how persons from other cultures can present problems in different ways. For example, this has been observed when looking at clients from China (Kleinman, 1977), Saudi Arabia (Racy, 1980) and India (Teja et al., 1971). Hollingshead and Redlich (1958) suggested that psychological problems may be couched in terms of somatic symptoms and the extent of somatization may vary between groups within a culture. In turn, Fitzpatrick (1983) found that in cultures where emotional problems are highly stigmatised, physical complaints are considered as "legitimate metaphors whereby personal problems may be expressed". A critical reflective awareness about the latent content contained in clients' communications can, therefore, guard against the possibility of dismissing their physical complaints as not appropriate for psychological therapy. In addition, this may also potentially facilitate us to help clients feel comfortable about unveiling the emotional aspects of their distress.

So far I have discussed the relevance of critical reflective awareness with respect to our practice with people from different cultures. However, I believe that this is also an indispensable skill for our work with people within our own culture. It implies our capacity to reflexively examine and evaluate the social and political factors which influence our own discourse, conventions, and self definitions. As such, it seems like an essential precondition for our ability to assist clients to uncover new possibilities to approach their problems or crises. In turn, this seems particularly important for helping clients who are in oppressive social relationships explore potentially liberating alternatives for thought and action.

Finally, it seems to me that the onset of postmodernism has opened up many different ways of 'knowing'. While this feels refreshing and invigorating, I am also aware of the responsibility that I am taking on by engaging in this process. Not only does this require me to continually and reflexively examine my process of
conducting practice, theory and research, but also bears implications for the way I deliver what I think I know at any given point in time. In order to preserve the integrity of postmodernism's local meanings, its interactive context, and its pluralistic orientation, there seems to be a strong need for us to clarify our position as the 'knower' with respect to the 'known'. Failing to so, I believe, would risk claiming 'truth', in an era where no truth is self evident.

Conclusion
In this paper, I have sought to elucidate some developments which have challenged traditional notions of science, language, and meaning and paved the ground for postmodern practices. Rather than relying on a single, common standard of measurement and arbitration, it seems to me that counselling psychology is dedicated to engaging with the many different facets of postmodernity's fragmented and perspectival reality. As reviewed here, its discipline involves exploring and discerning the subjective meanings attributed to the mental and social life-worlds of individuals, coupled with a dynamically evolving investigation into the contextual patterns that maintain the structure of social and political relations.

Albeit this paper has reviewed much of the literature about counselling psychology, it still puts forward a subjective and perspectival account. This reflects my attempt, as a first year trainee, to contextualise counselling psychology's recent arrival in the present social and cultural condition. However, there is no basis to assume that other counselling psychologists, who are involved in every day practice, would anchor counselling psychology in the same framework and consider similar implications for their practice. The present literature review, therefore, suggests investigating whether a common and specific identity for counselling psychology has developed among its practitioners. One way to carry out this study would involve researching counselling psychologists' social representations of counselling psychology. Hopefully, this investigation will provide a greater understanding about the ways in which counselling psychologists are putting their discipline across and the kind of client groups they are seeking to help. This is bound to have some impact on the ways we are perceived by clients as well as other practitioners and, in turn, influence the ways in which institutions like the National Health Service value our practice.
REFERENCES


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COUNSELLING PSYCHOLOGISTS’ SOCIAL REPRESENTATIONS OF COUNSELLING PSYCHOLOGY:
MAKING SENSE OF WHO WE ARE FROM WHAT WE DO
ABSTRACT

This study seeks to explore the ways in which counselling psychologists who are involved in every day practice generate social representations of counselling psychology which serve their practices' purposes and vice versa. A total of 22 participants each participated in an in depth qualitative interview. The data were subjected to Interpretative Phenomenological Analysis and generated five main themes. These include: (1) participants' current representations of counselling psychology based on the time before it obtained its Divisional status; (2) participants' motivations for obtaining membership with the Division when it was formed; (3) participants' endeavours to differentiate counselling psychology from related professions; (4) participants' commonly shared representations of their practice; and (5) participants' perspectives about the future of counselling psychology. The present study addresses the question of whether a common and specific identity for counselling psychology is developing among its practitioners. Implications for practice and research are ultimately considered.
COUNSELLING PSYCHOLOGISTS’
SOCIAL REPRESENTATIONS OF COUNSELLING PSYCHOLOGY:
MAKING SENSE OF WHO WE ARE FROM WHAT WE DO

INTRODUCTION

Counselling psychology is a new and developing discipline in Britain. It emerged as a Special Group within the British Psychological Society (BPS) in 1982, was transformed into a Section in 1989, and accorded Divisional status in 1994. In contrast to BPS Sections, which are concerned with specific branches or aspects of psychology, BPS Divisions are concerned with particular professional and practical domains of psychology and focus upon standards of professional education, knowledge and conduct among their members (BPS, 1994). When counselling psychology achieved Divisional status, psychologists with the BPS Diploma in Counselling Psychology (or a statement of equivalence which certified that previous qualifications were equivalent to the diploma) were entitled to call themselves Chartered Counselling Psychologists. This route to chartered status closed in 1996, heralding the formal professionalisation of the discipline.

The current BPS (1999) statistics indicate that there are 360 chartered counselling psychologists out of which 338 have obtained their accreditation through the ‘equivalence’ route. Due to the plethora of counselling and psychotherapeutic practices recognised and enveloped under this scheme, some counselling psychologists have queried the sense of generating yet another ‘name’ (Strawbridge, 1996: 26). This points to the current challenge of identifying “what is counselling psychology?” (Woolfe, 1996a: 7). The relevant literature about the discipline will be included in subsequent sections, as to engage in it now might confound the purpose of the present study. However, it seems necessary to review Pugh’s (1997) recent study in order to elaborate on the intentions of the present one.

In a recent study, Pugh (1997) examined the changing construction of counselling psychology through a discourse analysis comparing articles in *Counselling Psychology Review* from 1990 and 1996 respectively. The findings indicate that, in
the 1990 papers, the construction and legitimation of an identity for the discipline was predominantly achieved through representations of similarity and difference from related professions at a general level. For example, counselling psychology's status was reinforced by likening it to the accreditation routes of the other 'well-established' psychological divisions. Nonetheless, a separate space of inquiry for counselling psychology was concurrently constructed in areas where clinical psychology was seen as having failed, thus differentiating the two disciplines. In the 1996 papers, on the other hand, the findings indicate attempts to minimise differences and highlight common ground with other related therapeutic professions. At the same time, there was evidence of subtle constructions of difference with the other applied psychologies. This was predominantly reflected in the emphasis on the phenomenological base and value system of counselling psychology as opposed to positivist principles governing the traditional scientific paradigm.

With regards to the present investigation, Social Representations Theory (SRT) has been considered a suitable theoretical framework for exploring the beliefs, perceptions, and practices which constitute counselling psychologists 'talk' about their discipline. According to Moscovici, social representations (SRs) are "concepts, statements, and explanations originating in daily life in the course of inter-individual communications" (1981: 81). Their character is essentially collective in that they serve to orient people in the world and provide a code of social exchange, for naming and unambiguous classification. Jodelet (1993) has written about the importance of shared practices for generating commonly held SRs. The meaning-making role of SRs involves contextualising new elements of knowledge into a preexisting frame of reference. SRs are forms of social thinking that are used to 'master' and 'make sense' of the social, material, and intellectual environment (Hewstone et al., 1996).

Moscovici (1981) believes that 'anchoring' and 'objectification' are two basic ways of conventionalising ideas and generating social representations. Anchoring is the process of categorising and naming phenomena. It involves generating stable and coherent aspects that organise the unfamiliar phenomena and lend themselves to its elaboration. Billig (1993) considers that anchoring is a universal feature of thought but that objectification, if understood in terms of the materialisation of abstract concepts, is not a universal property of social thinking. It entails the transformation of
ideas and processes into common sense knowledge. As such, objectification involves selecting certain key aspects of the unfamiliar idea which ultimately serve to personify its autonomous existence as a SR (Elejabarrieta, 1996). Moscovici (1976), for example, demonstrated how psychoanalytic concepts, such as 'ego' and 'neurosis', entered everyday discourse and are associated with a concrete reality.

Moscovici and Hewstone (1983) have stated that SR's contribute to group-identity formation, in the sense that sharing a representation itself leads to distinctions from other categories and generates a common 'world view'. However, Doise (1993) and Breakwell (1993) contend that researchers have over emphasised aspects of SRT, related to describing the content of existing representations or examining how anchoring and objectification operate, at the expense of investigating how social groups develop representations which serve group purposes. Breakwell has suggested that integrating social identity theory (SIT) with SRT can help elucidate the processes which may be both shaping the form and determining the functions of a representation, "beyond simply making the new familiar" (Breakwell, 1993: 182).

SIT (Tajfel, 1972, 1982; Tajfel & Turner, 1979; Turner, 1975; Abrams, 1992; Hogg & Abrams, 1998) is a non-reductionist theory which considers that categorisation and social comparison are central to group behaviour. Self-categorisation accentuates similarities between self and other ingroupers and, in turn, accentuates differences between self and outgroupers. Social comparison was originally developed by Festinger (1954), who maintained that people resort to social comparisons only when they cannot directly refer to reality to confirm the veracity of their beliefs. However, SIT upholds that no truth is self-evident and that all knowledge is derived through social comparisons (see Hogg & Abrams, 1998). It considers that intergroup social comparisons promote selective accentuation of intergroup differences on dimensions on which the ingroup considers itself to fall at the evaluatively positive pole. This process is geared to acquiring a relatively positive social identity which tends to endow the ingrouper with a sense of enhanced self worth (Abrams, 1992). In turn, social identity is largely composed of self descriptions, with some emotional and value significance, to the individual of the social group(s) to which he or she belongs (Tajfel, 1972).
The present study aims to explore the ways in which counselling psychologists who are involved in everyday practice develop representations of counselling psychology which serve their practices' purposes and vice versa. A focus will be on the ways in which SRs are generated and used to build a common identity for counselling psychology. The integration of some aspects of SIT with SRT is intended to obtain a greater understanding of the evaluative, motivational, and cognitive components which may be both shaping the form and determining the functions of participants’ representations, including their processes of anchoring and objectification. In turn, this research endeavours to cast light on commonalities and tensions among the beliefs, perceptions and practices which constitute participants’ representations. The findings will be compared to the public construction of the discipline (Pugh, 1997). This study will ultimately address whether a shared understanding of the discipline has evolved and consider some implications for its future development.

METHOD

Participants
113 chartered counselling psychologists in the London and Surrey areas were identified in the 1998/1999 BPS Register of Chartered Psychologists. These areas were selected due to their accessibility to the researcher, whose aim was to conduct face to face interviews. In order to maximise the number of respondents and obtain a diverse group of participants, they were all contacted by post and invited to take part in the study. Each of them received a letter which informed them about the aims of the research investigation (Appendix 1), a questionnaire about their demographic, training and practice details (Appendix 2) and a participation form (Appendix 3). A total of 34 responded but 7 were not eligible for the investigation's purposes, having indicated that they were not practising counselling psychologists, and 5 were not available for the interview. The remaining 22 participated.

Data Collection Procedure
There is concern that the adoption of quantitative techniques runs the risk of objectifying a social representation as merely defined by its “consensual nature or clustering structure” (Augoustinos & Walker, 1995: 183). In particular, SRT places
communication and, more particularly talk, at centre stage (Potter & Wetherell, 1998: 141). An interview based approach, therefore, seemed appropriate for attending to the dynamic quality of SRs contained in participant’s discourse. Furthermore, this approach has an increased potential to elucidate aspects of commonality and diversity among the experiences of those being studied that are not usually presented when employing such instruments as postal questionnaires (Elliott et al., 1999).

The majority of participants were interviewed at their home, although 3 found it more convenient to be interviewed at their private consultancy. The participants signed a consent form which outlined confidentiality procedures (Appendix 4). Any identifying details have been deleted in the following analysis, or replaced by a pseudonym. A semi-structured interview guide was administered (Appendix 5).

The questions on the interview guide were informed by previously identified literature (see Gore, 1998). The guide was designed with the aim of exploring the ways in which counselling psychologists who are involved in everyday practice develop representations of counselling psychology which serve their practice’s purposes and vice versa. It was tested and refined by conducting a small pilot study on two therapeutic practitioners, who are members of the counselling psychology course team at the University of Surrey. Their feedback was used to enhance the clarity of the research propositions and the interviewing process.

The main content areas of the interview guide elicited questions about current conceptualisations and meanings of counselling psychology; beliefs and descriptions of therapeutic practice; and views and ideas about the discipline’s future development. The semi-structured format allowed participants considerable scope to introduce issues that may not have been directly probed by the researcher, as well as address the areas that the interview was aiming to cover. Interviews lasted between 40 and 90 minutes, were audio-taped and later transcribed.

Analytic Procedure

The central aim of adopting a SR framework is to investigate how people make sense of their worlds. Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 1997, 1999) was considered an appropriate method as it is concerned with
analysing participants' subjective views and beliefs about a particular topic by, as far as possible, adopting an 'insider's' perspective. IPA is strongly influenced by symbolic interactionism (Denzin, 1995) which maintains that the meanings individuals ascribe to events are of central concern to the researcher, and that such meanings can only be arrived at through a process of interpretation. While seeking to elucidate individual perceptions of meaning, therefore, IPA recognises that the interpretative aspect of research requires the researcher to be actively involved in accessing and making sense of participants' personal worlds. As such, the research product represents a 'co-determined interaction' (Smith, 1996) between the participants' accounts and the researcher's interpretative framework.

IPA assumes that there is some, though not a transparent, relationship between what a person says in verbal reports (e.g. interview transcripts) and beliefs and thoughts they can be said to hold (Smith, 1995). Nevertheless, the analytic process is undertaken with the hope that meaningful reports can be made about that thinking (Smith et al., 1997, 1999). SRT does not privilege a particular method of research (Farr, 1993) and, thus a variety of epistemological positions have been adopted ranging from a realist through to a social constructionist perspective (McKinlay et al., 1993). The epistemological position adopted in this investigation, which seems compatible with IPA, is that of critical realism (Bhaskar, 1989). It affirms physical reality while recognising that all understandings are essentially tentative and not value-free.

Stages of Analysis
The first stage of the analysis involved reading and re-reading the individual transcripts. Notes were made for each transcript as attempts at summarising, making associations with other aspects of the transcript, or initial interpretations. The notes were then condensed and key words were used to represent the emerging themes. Although the research sought to uncover shared themes among the transcripts, it was hoped that by paying particular attention to participants' separate accounts, the complex nature of the phenomenon under investigation would become clearer. Individual variation was, therefore, an important element.
The primary catalogue of themes led to the development of a consolidated list of general themes. An index of extracts pertaining to each theme heading was then produced. Themes that would function as ‘superordinate concepts’ integrating ‘lower level’ thematic clusters together in meaningful ways were identified (Smith, 1995). In order to provide credibility checks (Elliott et al., 1999), these interpretations of the data were subjected to interrogation by the researcher’s supervisor, a social psychologist, who was likely to have a different interpretative framework from a counselling psychology trainee.

The final stage of the analysis involved going back to the transcripts to make sure that other pertinent extracts had not been overlooked. This cyclical process of moving backwards and forwards between the themes and the data continued until the researcher was satisfied that all relevant connections between different themes were drawn, and that issues of similarity and variability were attended. Finally, this cyclical process aimed to ensure that each interpretation was based on primary source material.

**Evaluating the analysis**

Due to the subjective nature of the analytic process, the criteria traditionally used to evaluate research (i.e. validity and reliability) are inappropriate as they assume a disengagement between the researcher and the topic under investigation (Henwood & Pidgeon, 1992). More pertinent criteria need to be considered, such as transparency, persuasiveness and internal coherence (Elliott et al., 1999).

In evaluating the analytic process, the researcher should own their perspective in the resultant interpretations (Elliott et al. 1999). In the present case, it is important to recognise the influence of the researcher’s position as a counselling psychology trainee, who supports the development of her discipline. A tendency could occur to attend more closely to particular themes which appear to reflect the researcher’s concerns. Another investigator may identify different features of the data set. However, situating the sample, making explicit the data collection methods and analytic procedures adopted, as well as presenting a representative sample of raw data (through quotations) should enable the reader to challenge the transparency of the interpretations, assess the persuasiveness of the analysis, and evaluate the coherence of the study (Elliott et al. 1999).
Participants have been given pseudonyms throughout the analysis to facilitate the reader to distinguish between different accounts. In the extracts included in the analysis, the information shown within brackets has been added for the purpose of clarification. Empty brackets demonstrate the omission of material and ellipsis points (...) reveal a pause in the participants’ speech. In addition, the figure(s) in the brackets at the end of each extract respectively refer to the transcript number of each interview.

ANALYSIS

Demographic Information
There were 9 (41%) male and 13 (59%) female participants, with a mean age of 50.1 (range 35 - 73; SD = 9.4 ). 20 (91%) identified their ethnic group as White-Caucasian; 1 (4.5%) as Middle-Eastern; and 1 (4.5%) as East-African. Several participants were also members of other Divisions (Table 1) and Sections (Table 2) of the BPS. Many were affiliated with other professional registration bodies (Table 3). Taken together, participants located their therapeutic practice in a variety of theoretical orientations (Table 4). Participants worked on a part-time and/ or full-time basis in a wide range of professional contexts (Table 5). 20 (91%) achieved their counselling psychology accreditation through the ‘equivalence’ route [13 (59%) through the ‘grand parenting clause’ and 7 (32%) through the ‘statement of equivalence’, for qualifications earned in this country], 1 (4.5%) through the BPS diploma and 1 (4.5%) through a BPS accredited course. The mean duration of their practice as counselling psychologists was 9.9 years (range 2 - 25; SD = 6.6).
Table 1: participants’ memberships of other BPS Division(s)

<table>
<thead>
<tr>
<th>Membership of other BPS Divisions *</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology Division</td>
<td>3</td>
</tr>
<tr>
<td>Occupational Psychology Division</td>
<td>2</td>
</tr>
<tr>
<td>Forensic Psychology Division</td>
<td>1</td>
</tr>
</tbody>
</table>

* Some participants were members of more than one Division.

Table 2: participants’ memberships of other BPS Section(s)

<table>
<thead>
<tr>
<th>Membership of other BPS Sections *</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy</td>
<td>3</td>
</tr>
<tr>
<td>Counselling</td>
<td>1</td>
</tr>
<tr>
<td>Transpersonal</td>
<td>1</td>
</tr>
</tbody>
</table>

* Some participants were members of more than one Section.
Table 3: participants’ membership of other professional affiliation(s)

<table>
<thead>
<tr>
<th>Membership of other professional affiliations *</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of Family Therapists (AFT)</td>
<td>1</td>
</tr>
<tr>
<td>Association of Humanistic Psychology Practitioners (AHPP)</td>
<td>1</td>
</tr>
<tr>
<td>British Association of Psychoanalysts (BAP)</td>
<td>1</td>
</tr>
<tr>
<td>British Association of Counsellors (BAC)</td>
<td>12</td>
</tr>
<tr>
<td>British Confederation of Psychoanalysts (BCP)</td>
<td>3</td>
</tr>
<tr>
<td>Cognitive Analytic Therapy - Guy’s (CAT)</td>
<td>1</td>
</tr>
<tr>
<td>European Association for Transactional Analysis (EATA)</td>
<td>1</td>
</tr>
<tr>
<td>Forum of Independent Psychotherapists (FIP)</td>
<td>1</td>
</tr>
<tr>
<td>Institute of Transactional Analysis (ITA)</td>
<td>2</td>
</tr>
<tr>
<td>International Transactional Analysis Association (ITAA)</td>
<td>1</td>
</tr>
<tr>
<td>Institute of Personnel Development</td>
<td>1</td>
</tr>
<tr>
<td>Nafiyar (Psychotherapy for Ethnic Minorities)</td>
<td>1</td>
</tr>
<tr>
<td>Metanoia</td>
<td>1</td>
</tr>
<tr>
<td>Society for Psychotherapy Research (SPR)</td>
<td>1</td>
</tr>
<tr>
<td>Tavistock Society of Psychotherapists</td>
<td>1</td>
</tr>
<tr>
<td>United Kingdom Council of Psychotherapists (UKCP)</td>
<td>10</td>
</tr>
<tr>
<td>United Kingdom Registered Councillors (UKRC)</td>
<td>1</td>
</tr>
<tr>
<td>University Psychotherapy Association (UPA)</td>
<td>1</td>
</tr>
</tbody>
</table>

*Some participants had more than one professional affiliation.
Table 4: participants’ specified theoretical framework(s)

<table>
<thead>
<tr>
<th>Theoretical orientation of therapeutic framework*</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Analytic Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive Behavioural</td>
<td>4</td>
</tr>
<tr>
<td>Integrative/ Eclectic</td>
<td>9</td>
</tr>
<tr>
<td>Existential - Phenomenological</td>
<td>2</td>
</tr>
<tr>
<td>Humanistic</td>
<td>8</td>
</tr>
<tr>
<td>Psychodynamic/ Psychoanalytic</td>
<td>4</td>
</tr>
<tr>
<td>Systemic</td>
<td>1</td>
</tr>
<tr>
<td>Transactional Analysis</td>
<td>2</td>
</tr>
<tr>
<td>Transpersonal</td>
<td>1</td>
</tr>
</tbody>
</table>

* Some participants had more than one theoretical orientation.

Table 5: participants’ professional context(s) of practice

<table>
<thead>
<tr>
<th>Professional Context</th>
<th>No. of participants</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Time</td>
<td>Part Time</td>
</tr>
<tr>
<td>Private Practice</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Research Trust</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>GP Surgery</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Student Counselling</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>NHS</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

* Some participants worked in a combination of these.
Key Findings

SRs contained in participants’ current accounts elicited five interrelated themes, which encompassed three different temporal contexts: past, present, and future. The analysis begins with the wilderness years. As the vast majority of participants obtained their chartered status through the ‘equivalence’ route, this theme relates to their practices before counselling psychology came into existence. It is followed by membership motivations which conveys their reasons for joining the division when it was formed. The next theme, differentiation, elucidates participants’ attempts to accentuate differences between the practice of counselling psychology and those of related professions. It is followed by individuation which conveys commonly shared descriptions among participants’ representations of their practice. Finally, future perspectives reveals participants’ long-term views for counselling psychology.

The wilderness years

This theme recurred throughout the majority of transcripts. It relates to participants’ experience of practising in the wilderness before counselling psychology came into existence as a Division. For example, Marsha related:

I got my qualification because I was one of the ones who was working out there before qualifications were put in place (9).

Marsha seems to identify herself with a category of practitioners who lacked Divisional accreditation for their qualifications. Not only was this category referred to by participants who previously did not have Divisional membership, it was also described by those who did. For example, Joseph, who was already a member of the forensic and occupational psychology Divisions, explained:

That is where counselling psychology began to emerge, really out of need, because there were lots of psychologists working in this area who did not really have a home (17).
Joseph's reference to "working in this area" seems analogous to Marsha's reference of "working out there" due to its associations of being without Divisional membership. These extracts suggest that, prior to achieving its Divisional status, counselling psychology had already been anchored at some level within a familiar category (e.g. the possession of certain qualifications without recognition) and, in doing so, seems to have been endowed with a particularised 'reality' (e.g. that of professional homelessness). This may explain why many participants indicated (on the demographic questionnaire) that they practised as counselling psychologists for many more years than the age of the Division.

Having had different career paths before obtaining their Divisional accreditation, several participants did not consider themselves "typical" counselling psychologists:

I think that I should state right from the start that I am not a typical (counselling psychologist) ( ) I suppose I have not had the normal route that I believe a lot of counselling psychologists have had (Peter, 4).

Peter seems to anchor being a "typical" counselling psychologist in the stereotypical perception of having undergone a prototypical training scheme. This also appeared to be the case for Henry:

My training was not what you are doing, so should I even be a counselling psychologist by title or what else should I be? (1).

The experience of having had a different training to the implicitly 'normal' or 'typical' one of the researcher has made Henry query the validity of his counselling psychology status. It would appear that the experience of the wilderness years, without a formalised training programme, has tinged Peter and Henry's respective identifications with counselling psychology with feelings of doubt and uncertainty.

Other participants were more inclined to stress personalised explanations of the discipline. Angus responded to 'what is counselling psychology for you' in the following manner:

140
Just like that! I don’t know. I trained as a psychologist. I trained as a counsellor and as a psychotherapist (5).

It would seem that Angus overcomes his ambivalence about counselling psychology by associating it with a series of qualifications he achieved prior to acquiring his Divisional accreditation. Likewise, Miranda stated:

Well, counselling psychology to me was that I had the Graduate Basis and I practice and train sometimes at the BAP -- psychoanalytic psychotherapy -- and I had the qualifications to become a chartered counselling psychologist (16).

It would appear that both Angus and Miranda’s representations of the discipline are contextualised in fragments of their local experiences rather than fixed and rigid notions of the discipline. In particular, Miranda’s account of what counselling psychology means to her appears to convey a perfect example of rendering the unfamiliar more familiar by anchoring it within a preexisting frame of reference. The issue about chartered status ushers the ensuing theme about what drew this amorphous group of individuals to join the Division when it was formed.

Membership Motivations
A striking feature throughout the analysis of the data and one that appeared pervasive in all the transcripts was related to a network of thematic clusters associated with participants’ motivations for joining the Counselling Psychology Division when it was formed. Nancy revealed:

It was sort of by default. I became a counselling psychologist because of the work I had already done and because I wanted to achieve chartered status (12).

This type of explanation was put forward by several participants. The extract is representative of their views by implicitly conveying how chartered status provided them with the professional recognition to frame and represent work they had already achieved, which had not been validated as such, before the arrival of the Division.
Others stressed the sense of belonging that consolidated their professional recognition. For example, Sophia revealed:

So for me it was a huge relief to actually finally have a professional home, the body I belong to, because I didn’t see myself as belonging to the BAC as an accredited member and I didn’t see the UKCP as my true home (13).

The factor that seems to distinguish the BPS from the other organisations cited is its psychological knowledge base. Just as with Nancy, therefore, Sophia’s motivation to obtain membership with the Division seems, at least in part, anchored in the achievement of chartered psychological status. Sophia’s experience of belonging, nonetheless, endows her accreditation with the particularised ‘reality’ of having a ‘professional home’. It would, in turn, appear that Counselling Psychology’s arrival as a Division represented a shelter for her qualifications.

Participants accorded exclusive meanings and implications to their chartered psychological status. For example, Miranda stated:

Anyone can call themselves a psychotherapist, but at least psychologists have got something together, they’ve got a register. They had to have a reasonable training to be on that register ( ) (16).

It would seem that Miranda makes reference to the register as a way of making a social comparison that secures a positive evaluation for her chartered psychologist status. She represents its accreditation as an exclusive membership which resonates with norms of rigorous training, and professional unity and credibility. In turn, her extract would seem to support the view that a key motivator in obtaining professional recognition with the division was the desire to exclude others by defining tight boundaries around one’s practices (Woolfe, 1996b: 51). The values attributed to Divisional membership appear to generate representations which give power and interests meaning (Moscovici, 1998: 214). For instance, Joanna revealed:
Right now I have a supervisee, who has an undergraduate degree in psychology, but she is doing a psychotherapy training. I am encouraging her, and mention it quite regularly, whether she has registered along the independent route to become chartered (as a counselling psychologist). What I keep pointing out to her is that that is where the jobs are, that is where the recognition is (14).

As with Miranda, Joanna conveys the belief that chartered counselling psychology status bears a more valuable professional recognition than registration as a psychotherapist. She has, in turn, objectified her representation of counselling psychology with the expectation of greater employment opportunities.

Participants’ membership motivations included considerations about the benefits associated with the discipline’s social identity. For example, Helen explained:

When the Division was finally formed the idea that counselling and psychology had been combined really appealed to me because it then seemed to me that: a) people could become chartered; b) the public had a source of complementary knowledge and information; and c) counselling psychologists could ensure themselves against litigation ( ) (20).

Helen implies that counselling psychology accreditation bears at least three desired functions for her: firstly, it provides her with chartered status to validate her qualifications; secondly, it raises public awareness about her practice; and thirdly, it offers her legal protection. These attributes reflect “beliefs about life in common, about what it should be, about what should be done” (Moscovici, 1998: 214) which would appear to represent some of the building blocks of counselling psychology’s social identity. In turn, Helen’s emphasis on the discipline’s ethical and legal aspects suggests that she perceives Divisional membership as maximising her professional credibility (Markova, 1987). These values seemed to influence participants’ ways of representing their Divisional membership. For example:
I use it (counselling psychology title) because I think chartered status is very important. I think professional recognition is an essential part of good work practice and ethics and educating the public to make the right choice (Henry, 1).

Again, chartered counselling psychology status is contextualised as a more valuable social identification than that of other related professions. This appears to impact on Henry’s way of objectifying his membership with the Division as ‘the right choice’. His extract, in turn, would appear to champion the belief that a counselling psychologist should be “most likely to provide an effective and non-abusive therapeutic experience for clients” (Bellamy, 196:49). It would seem that the representations of counselling psychology, conveyed in this theme, would be geared to uniting its members through anticipatory and rationalising beliefs and values which ensure their existence in common (Jodelet, 1993).

Differentiation

Examples of differentiation are inherent throughout this analysis. However, this theme has been called such because it illustrates participants’ active and concerted attempts to maximise the positive distinctiveness of their practice compared to that of other related professions. Social comparisons with counselling and/or psychotherapy recurred in most of the transcripts. For example:

It (being a counselling psychologist) is not a question of being a counsellor or therapist, operating in a vacuum, but that continual feedback process moving to and from theory and research to the clinical setting (Sophia, 13).

Sophia seems to use the expression ‘operating in a vacuum’ as an ‘objectification device’ (Wagner at al., 1995) to downgrade other therapeutic professions. It is interesting that Woolfe (1996c: 9) has also referred to “this vacuum” as a way to describe the failure of counsellors to evaluate their practice. The repeated use of this metaphor hints at the possibility that, used in this context, it may have come to personify the lack of counselling’s scientific basis. In turn, it seems to enable Sophia to secure a more favourable evaluation for counselling psychology on a positively
valued dimension. Many participants, appeared to selectively accentuate the discipline’s scientific basis as a means of contextualising counselling psychology as a higher level practice. For example, Paula stated:

I think there is a lot of potential because I think that maybe counselling psychology is getting to be a little more of a science than counselling (3).

In comparison to counselling, counselling psychology is represented as closer to a science. Paula’s account implies that this harbours more prestigious and far-reaching prospects for its practitioners.

Even though participants made social comparisons with other therapeutic practices which, in turn, promoted the positive distinctiveness of their discipline, some felt ambivalent about categorising themselves with with either counsellors or psychologists. For example, Alexa explained:

I think if I had to choose between counsellor or psychologist, I would be a counsellor because I couldn’t abandon this deep respect for my client and the empathy and unconditional positive regard, which I do not always believe that psychologists, I mean pure psychologists, will maybe feel because they are probably expert oriented (15).

It would appear that counselling is anchored in the core conditions (respect, empathy, unconditional positive regard) of the humanistic framework which seem to stand in sharp contrast to Alexa’s perception of ‘pure psychologists’. In accordance with her, most, if not all, participants expressed their allegiance to humanistic values rather than principles of detached objectivity. Many regularly made comparisons with clinical psychology to accentuate the anti-expert attitude of their discipline. For example:

My feeling is that they (clinical psychologists) drop in and they are experts, whereas counselling psychologists are more on an equal with the client or person they are working with; it is more like a team -- let’s work on this together (Joanna, 14).
The comparison with clinical psychology's expert oriented approach appears to be used as a concept to highlight the more equal and accessible characteristics of counselling psychology's humanistic orientation. Most, if not all, participants emphasised the overriding importance of the therapeutic relationship to their practice. For example, Marsha conveyed:

There are different disciplines and different models, but still the therapeutic part of that in terms of the relationship being the most important part of what is going on in the room, which I don’t see in clinical psychologists a lot of the time (9).

It would appear that Marsha refers to the therapeutic relationship as a way of representing and personifying the positive distinctiveness of counselling psychology’s practice. This would seem to support literature about counselling psychology which states that its practice rests on a ‘helping relationship’ between client and therapist (see Clarkson, 1996; Strawbridge & Woolfe, 1996; Woolfe, 1996c).

Another dimension which many participants appeared to selectively accentuate in the process of making social comparisons with clinical psychology relates to counselling psychology’s training requirement of personal therapy. For example, Peter revealed:

I disagree very much that they (clinical psychologists) don’t have to have any personal therapy (4).

The statement “disagree very much” conveys a negative value judgment which enables Peter to positively distinguish his training. In turn, Miranda remarked:

How can you attempt really to understand others, if you don’t have a little bit of inner knowledge of yourself, if you haven’t been through or had a bit of psychotherapy for yourself ? (16).
It would seem that Miranda is casting doubt upon the capacity of practitioners who have not had their own personal therapy to empathise with what it is like to be in the client’s shoes. Her extract would appear to reflect Williams’s (1997) findings. These revealed that a significant majority of counselling psychologists considered the personal therapy training requirement as integral to their profession, particularly for understanding the experience of therapy from the client’s perspective. In turn, Miranda’s extract suggests that the insight and self-awareness derived from personal therapy is a precondition for practitioners to use their own psychic apparatus to ‘come to know’ others. In particular, her use of the word ‘really’ appears to emphasise an understanding of others anchored in a phenomenological experience of human relatedness which begins with an understanding of one’s own subjectivity (Strawbridge, 1992, 1996; Van Deurzen Smith, 1990).

Several participants made comparisons between the philosophical underpinnings of counselling psychology and clinical psychology. For example, Tom, who previously trained as a clinical psychologist, put forward:

> I would like to think that counselling psychology is a move in the right direction to humanise psychology, a bit. You know, people are fed up with this kind of -- ‘if it moves, measure it’ -- sort of attitude, rather than if it moves let’s try and think about it. You know, this contempt for subjective emotion as if it is somehow mindless, stupid and self indulgent, but that is the way human beings relate to one another (21).

Tom’s representation of counselling psychology as “a move in the right direction” accentuates his disappointment with the other applied psychologies’. It is possible that his experience with the positivist principles of reductionist objectivity is rooted in his previous training as a clinical psychologist. This extract would, in turn, seem to support van Deurzen-Smith’s view that (1990) counselling psychology developed in areas where clinical psychology was seen as having failed. The information conveyed in Tom’s extract anchors counselling psychology in a framework of human relatedness, disposed to subjectively reflecting upon rather than objectifying human behaviour (Strawbridge, 1992). Moreover, Helen explained:
I think that a counselling psychologist is much more inclined to want to achieve the outcome that was appropriate for the client and to have a range of methods and techniques and tools available. Whereas a clinician might be more inclined to adopt an approach that had measurable outcomes (20).

This extract seems to concretise the difference between the practice of counselling and clinical psychologists in terms of a client led as opposed to an outcome driven approach. It would appear that participants revealed representations relating to more personal and qualitative issues about “exploring the person” (Pugh, 1997) to generate a positive distinctiveness for counselling psychology. It seems that social comparison processes enabled participants to accentuate what counselling psychology’s practice is not and, in turn, begin to unfold what it is for them (Oyserman & Markus, 1998), which ushers the following theme.

Individuation
The social comparison processes illustrated in the last theme enabled participants to positively evaluate counselling psychology on a variety of dimensions. This theme elaborates upon recurring practice based representations throughout the transcripts which appear to individuate a commonly shared and distinctive social identity for counselling psychology.

In the last theme, the therapeutic relationship emerged as a representative feature of counselling psychology’s positive distinctiveness. Many participants sought to qualify their role in its endeavour. For example, Emma conveyed:

By the quality of the relationship I mean that people see me as a resource and trust me to be able to work with what their inner pain is (10).

Emma’s use of the metaphor ‘resource’ seems to objectify the dynamics of her role in the healing process. Based on her account, this is one in which the therapist represents the medium through which the client is facilitated to confront their distress. The use of the word ‘trust’ to describe the client’s hoped for disposition in the
therapeutic relationship resonates with implications of their feeling safe, heard and understood. In turn, Henry explained:

The therapist has to provide the container into which they (clients) can pour their worst fears, their darkest secrets, their self disgust, their hate, their loathing, all the dark feelings and know that they are going to be safe (1).

This extract represents the therapist’s task as one of nurturing a supportive environment, which enables the client to unveil their unspoken, hidden, and repressed thoughts and feelings. Henry’s use of the metaphor ‘container’, in particular, seems to objectify the dynamics of his role as providing a safe-holding outlet for the client.

The vast majority of participants, regardless of the theoretical orientation in which they located their therapeutic practice, related that they used theory as a background to help them understand and appreciate the client’s life experience. Miranda, who practices as a psychoanalyst, stated:

The important thing to me is the client, the patient, their story. I don’t take a theory and fit it into their lives ( ) I would wait and see what the client says and sometimes it is amazing, the clients can be like a textbook of Freudian stuff and other times it seems perfectly irrelevant to those particular people (16).

This extract elucidates a client led rather than a theory driven therapeutic approach. Miranda anchors her understanding of the client in the client’s phenomenological experience. In turn, her account reflects the use of theoretical constructs as ‘models and metaphors’ (Clarkson, 1998) for the purpose of facilitating and clarifying understanding between therapist and client rather than destroying or replacing the client’s narrative by the “professional account” (see Gergen & Kaye, 1996). Moreover, Emma, an integrative practitioner, explained:
Theory is used when we need to reframe the client’s story ( ) So I will try to help the client to understand their story, but I will never let the theory get between the client and myself (11).

Here, the application of theory seems to be used as a clarification tool that comes second to the therapeutic relationship. Her practice seems to be congruent with the psychological approach of ‘beyond schoolism’ (Clarkson, 1997), which considers ‘schools’, ‘orientations’ and ‘approaches’ less important than the experience of a positive therapeutic relationship for generating change. Participants who located their therapeutic practice in a specialised theoretical framework, on the other hand, accepted the strengths and limitations of their practice. For example:

So my practice seems to be CBT (cognitive behavioural therapy) because that is where I am most effective, but if having done an analysis of the person, it seems that it is not the most appropriate way to work with them I will refer them on (17).

In the same vein as the others, the emphasis is on using the most appropriate method to meet the client’s needs and difficulties. Giving primacy to the client, therefore, seems to represent the underlying ethos of participants’ practice.

Participants’ understanding of their role as counselling psychologists included considerations about the objectives of their practice. Angus explained his goal was:

For a client to recognise that they can in fact change themselves, to recognise that they are doing the changes, not me and to enable them to be able, if you like, to understand the processes (5).

The therapeutic encounter seems geared towards assisting the client to recognise, examine, and assess the principles that organise their experience and creation of meanings. Angus’s description would seem to represent his functions as a “skilled helper”(Egan, 1994). Participants generally anchored their practice in facilitating well-being rather than enforcing cure. For example, Paula conveyed:
My aim is to help people grow and be able to live a more satisfactory life. I don’t feel that I can cure things. I can’t change things for people, but perhaps you can help them change the way they live in their lives (3).

Paula seems to contextualise her role as one geared towards helping the client self-actualise their resources for personal development. This seems to imply that improvement is anchored in the client’s free will and autonomy, thus reflecting the beliefs expressed in the literature about counselling psychology (McLeod, 1996; Woolfe, 1996c; Strawbridge & Woolfe, 1996b).

**Future perspectives**

Having discussed participants’ conceptualisations of the discipline at the present time, this final theme relates to long-term views about counselling psychology. Some participants conveyed a sense of uncertainty about its future. Henry revealed:

> I am curious about what counselling psychology becomes because it seems to me that it is a bit out on a limb (1).

The expression ‘out on a limb’ seems used to objectify Henry’s sense of the discipline’s fragmented and unfinished metamorphosis. Other participants, however, revealed more definitive visions, which will be described below. The hodgepodge of each of their projects and intentions reflects SRT’s view that the organisation of action in social systems is multi-level and that the lowest level is generally comprised of individual processes (Cranach, 1998).

A prevalent issue among participants’ representations about the future of the discipline relates to the prospects of counselling and clinical psychologists practising alongside one another. For example, Marsha revealed:

> I think that they (clinical psychologists) are going to have to be thinking about working with us as two different types of psychologists working beside each other (9).
It seems that having differentiated counselling psychology from clinical psychology, participants are considering the possibility of complementing one another’s practices. Many participants revealed that collaboration would be based on an acknowledgement of their different skills and areas of expertise. A distinctive and impending growth area for counselling psychology, that recurred throughout a significant number of the transcripts, was anchored in facilitating mental health. For example, Angus revealed:

In mental health centres where I worked they said, we can’t deal with the worried well, because we have got to deal with psychotics as though these were two separate groups. If you tracked back on many of those who were supposedly labelled psychotic, you ended up with worried well (5).

Here, working with ‘the worried well’ is not represented as a ‘lesser’ or ‘softer’ option than the more chronic psychopathology disorders, but as an earlier stage on the mental health continuum. The focus seems to be on safeguarding psychological wellness rather than attending to people when they are finally ‘labelled’ sick (Woolfe, 1996c). Several participants, in turn, targeted the need for counselling psychologists in “front line” practice. For instance, Sophia explained:

I think that primary care is really important in helping to pick them (patients) up and support them and help prevent them from going into more serious mental health services (13).

The information conveyed in these extracts represents counselling psychology as a kind of ‘catch net’ in the mental health service. The arrival of the discipline might, in turn, serve to debunk traditionally dichotomised stereotypes of mental health and mental illness by attending to the different gradients between the two points.

Some participants emphasised the potential of developing counselling psychology’s diversified enabling capacities. Joanna related:
The skills we have are so useful in so many contexts, in the organisational context, for instance ( ) you are training them in counselling skills, but it is not counselling skills, it is facilitation, that sort of thing (14).

In her extract, the expressions “counselling skills” and “facilitation” seem to objectify the possession of interpersonal communicative competences. Several participants expressed the “social responsibility” associated with these skills (19). For example, Theresa stated:

My vision is that counselling psychologists would become much more involved in policy making and decision making particularly, for example, I think about the problems that go on in Northern Ireland. I am not hearing that there are psychologists to help people mediate ( ) but I would like counselling psychologists being more involved and it being part and parcel of the help that is available for people (11).

Rather than operating at the level of clinical practice, “help” in this context appears to represent the function of facilitating understanding among dissenting parties. The key aspects of the counselling psychologists’ endeavour would, therefore, still rest in their collaborative and relational approach. This supports SRT’s view that knowledge and action are interconnected and jointly determine development (Cranach, 1998).

DISCUSSION

It is important to bear in mind that 20 of the 22 participants involved in this investigation obtained their chartered counselling psychology status through the ‘equivalence’ route. This is not necessarily a representative sample, even though the 91% of 22 participants closely reflects the current BPS (1999) statistics that approximately 94% of the total 360 chartered counselling psychologists obtained their Divisional membership through the ‘equivalence’ route. The five interrelated analytical findings are, therefore, particularly relevant to this sample. A study on the same subject based on a sample of counselling psychologists who had obtained their
Divisional membership via a BPS accredited course, for example, may not have uncovered the wilderness years as one of their themes.

Integrating aspects of SIT with SRT has been useful for examining participants’ current accounts of the past, present and future development of counselling psychology. This time span has enveloped a diversity of contexts in which representations of the Division have unfolded. For example, ‘working out there’ conveys images of some participants’ experience of being dispersed in the wilderness prior to the arrival of counselling psychology. As such, it seems to support Moscovici’s belief that the formation of a group identity involves selecting (as a representation) “whatever has a figurative capacity in keeping with the group’s past beliefs and stocks of images” (1981:199). In membership motivations, on the other hand, representations, such as ‘professional home’, embody the sense of continuity and belonging which appears to underpin some participants’ identification with the Division. In turn, those which convey counselling psychology as ‘the right choice’ personify feelings of value and distinctiveness associated with participants’ Divisional membership. These examples reflect Breakwell’s (1993: 193) belief that “individuals customise their SRs to suit personal goals”. In turn, this study has also found that SRs assist in the elaboration of a common and specific social identity.

The present study’s findings about the ways in which participants generated SRs to legitimate counselling psychology’s identity tend to diverge from Pugh’s (1997). In particular, the public construction of the discipline legitimated an identity for counselling psychology by comparing its accreditation routes to that of the other well-established psychological professions. In this investigation, however, membership motivations generally legitimated counselling psychology’s identity with representations of higher status and greater professional recognition than other therapeutic professions. This may imply participants’ sense of moving forward from the areas of practice which they were lodging in during the wilderness years.

Differentiation includes social comparisons with other therapeutic professions, in which participants considered their practice to fall at the evaluatively positive pole. However, findings also reflect a general sense of ambivalence among participants about defining themselves in opposition to related therapeutic professions. Given that
the ‘equivalence’ route enveloped and recognised a diversity of counselling and psychotherapeutic practices, it seems understandable that participants did not, as a whole, seem to manoeuvre themselves against the very elements that have become fused into their discipline. On the other hand, clinical psychology seems to function as a ‘generalised other’ (Mead, 1934) in the formation of common and specific representations of counselling psychology. Participants’ tended to promote counselling psychology’s positive distinctiveness by accentuating what it *is not* in comparison to clinical psychology, which consequently unfolded aspects of what *it is*. In turn, this dynamic bears parallels with Pugh’s (1997) findings that a separate space of inquiry for counselling psychology was constructed in areas where clinical psychology was seen as having failed.

This investigation affirms Jodelet’s (1993) view of the importance of practice for generating shared representations that address a group’s ‘existence themes’ (Shweder, 1982). Differentiation for counselling psychology is predominantly achieved through practice related comparisons which unfold participants’ common and specific ideas, beliefs, and values. The next theme conveys how these are *individuated* into metaphors, such as therapist as a “resource” or “container”. Whether or not participants directly used these personifications, it would appear that these images concretise the ways in which many of them described their role in the therapeutic relationship. Breakwell has stated that “sharing the representation can become the badge of membership and the precursor for understanding the reason for sharing common goals” (1993:186). Thus, uncovering participants’ representations of their practice has been useful for obtaining a greater understanding of how these guide action by influencing perspectives about counselling psychology’s future development. In particular, participants’ emphasis on facilitating emotional, as well as social and political wellbeing seems interconnected with their perceptions of their therapeutic role as a “resource” and/or “container”.

The findings of this investigation suggest that counselling psychology has developed a common and specific identity. Participants’ accounts represent the Division as providing a new practice based method on the professional psychological scene, which integrates counselling and psychotherapeutic skills with a psychological knowledge base. Participants’ emphasis on a client led approach that is maintained
and monitored by the therapeutic relationship reflects the search for local meanings and understandings within the context of relational practice, which are dimensions which seem to underlie many postmodern practices (see Gore, 1998). Furthermore, future perspectives appear to convey aspects of a pluralistic orientation, manifested by some participants' intentions to facilitate greater understanding and acceptance among dissenting parties. These findings reflect the view that representations are specific to the historical and socio-cultural contexts in which they emerge (Wagner et al., 1995) and, as such, condition habitual culture-specific patterns of thinking, feeling and acting (Farr and Moscovici, 1984). This may, at least in part, account for the perceived differences in concepts and values between counselling psychology, whose development coincides with the arrival of the postmodern age (Clarkson, 1998; Strawbridge & Woolfe, 1996; Woolfe 1996a) and clinical psychology, whose maturity concurred with the logical positivist era (see Ussher, 1992).

Finally, it seems that participants' representations convey multi-level possibilities for the future of counselling psychology. Taken together, they indicate that their skills are applicable to a number of different settings, ranging from mental health to the organisational and political contexts. Such perspectives may come to have significant implications for the future training of counselling psychologists. In addition to clinical settings, for example, trainees may be given the option to apply and further develop their skills in other contexts. This would contribute to the diversified potential of counselling psychology and, in turn, remain congruent with its aims of facilitating wellbeing and providing an anti-oppressive practice (Clarkson, 1998; Hooper, 1996; Strawbridge, 1994; Strawbridge & Woolfe, 1996; Woolfe, 1983; Woolfe, 1996c). One way to investigate the prospects of collaborating with other fields of expertise would be to research what social representations professionals in organisational and political settings put forward about counselling psychologists. Hopefully, their anchoring and objectification processes will convey insights about their needs and biases and assist to address whether they would welcome the practice of counselling psychologists alongside their colleagues and coworkers.
REFERENCES


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PUGH, D (1997). The construction of counselling psychology in Britain: a discourse analysis of counselling psychology texts. University of Surrey, School of Human Sciences, Department of Psychology.


WILLIAMS, F. (1997). How counselling psychologists view their personal therapy. University of Surrey, School of Human Sciences, Department of Psychology.


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Dear

As part of my PsychD in counselling psychology at the University of Surrey, I am conducting research on counselling psychologists' ideas, perceptions and practices of their discipline. I found your name and address in the 1998/99 BPS Register of Chartered Psychologists and would like to appeal to you to take part in the study.

Participation would first entail completing the enclosed participation form and questionnaire. The next stage would involve taking part in an interview held at your convenience. The interview would be audiotaped and later transcribed. In order to ensure confidentiality, your name would not appear on the transcript and the audiotapes would be destroyed before any coding of the analysis begins. Even though some of your responses may be reproduced in the final report, at no time would your name be identifiable. If you would like a synopsis of the completed research, please indicate this on the enclosed form. I hope to publish the results.

If you are interested in participating, I would be very grateful if you would kindly complete the enclosed form and questionnaire and return it to me in the stamped addressed envelope by Monday, 15th March, 1999. In the event that you wish to discuss the research further, please do not hesitate to contact me by telephoning 0171 589 4996. I realise that you are very busy and would like to thank you in advance for your time and attention.

Yours sincerely,

Maria Caltagirone
APPENDIX 2

QUESTIONNAIRE FOR COUNSELLING PSYCHOLOGISTS

PART I:  INDIVIDUAL DETAILS

1. Age: ________________ YEARS (please state)

2. Sex: MALE or FEMALE? (please circle)

3. Which of the ethnic groups listed below would you say you belong to?
   (please tick the appropriate answer)
   - White
   - Black - Caribbean
   - Black - African
   - Indian
   - Pakistani
   - Bangladeshi
   - Chinese
   - Other (please specify: _________________________________)

PART II:  TRAINING DETAILS

1. Year of chartering as a counselling psychologist? __________________ (please state)

2. How did you obtain chartered status as a counselling psychologist?
   (please tick the appropriate answer)
   - A BPS Accredited Course
     If so, which one? __________________ (please specify)
   - The BPS Diploma in Counselling Psychology
     (The Independent Route)
   - Via the 'Grandparenting Clause'
     (for holders who applied for membership of the Division within the
     'transitional period': 1994 - 1997)
   - Statement of Equivalence
     (for holders who obtained membership for training and qualifications
     gained abroad)
   - Lateral Transfer
     (for holders who obtained membership from another Division of the BPS)
   - Other (please specify: _________________________________)

3. Are you a member of any other BPS Section or Division? YES / NO (please circle)
   (a) If so, which one(s)? _________________________________ (please name)

4. Are you affiliated with any other professional registration body? YES / NO (please circle)
   (e.g. BAC, UKCP, etc...)
   (a) If so, which one(s)? _________________________________ (please name)
PART III: PRACTICE DETAILS

1. Are you currently employed in therapeutic practice? YES / NO  
   (please circle)

2. Are you practicing as a counselling psychologist? YES / NO  
   (please circle)
   (a) If so, how many years have you been practicing as a counselling psychologist?  
   _____________________________________________  
   (please state)

3. What is your employment setting? (e.g. NHS Trust, GP Surgery, etc...)
   ___________________________  
   (please state)
   (a) Please state your job title: ___________________________________________________
   (b) Are you employed on a PART-TIME or FULL-TIME basis?  
       (please circle)

4. Do you work in independent / private practice? YES / NO  
   (please circle)
   (a) If so, please specify how many client contact hours, on average, per week:  
   ______________

5. Please specify the theoretical framework in which you locate your therapeutic practice:  
   (e.g. psychodynamic, Rogerian, etc....)
APPENDIX 3

PARTICIPATION FORM

Maria Caltagirone
Department of Psychology
University of Surrey
Guildford GU2 5XH

Name: ________________________________

Address: __________________________________

___________________________________________________________________________

Telephone No. ____________________________

If you prefer to telephone me and/or have any queries, you may contact me at the University of Surrey:

(0171) 589 4996

If I am unavailable at the time of your call, please leave a message for me and I will return your call as soon as possible.
APPENDIX 4

RESEARCH CONSENT FORM

The aim of this research is to explore how different counselling psychologists talk about their discipline. A particular focus of the interview study is to explore how your views and beliefs as counselling psychologists relate to your therapeutic practice.

You have been asked to take part in an informal interview about your views and feelings on the above subject. The interview will be recorded on audio tape to enable the author to directly quote your responses when writing the research paper. In order to ensure confidentiality, your name and practice will not appear on the transcript and the audio-tapes will be destroyed before any coding of the analysis begins. Some of your responses may be reproduced in the final report but at no time will your name be identifiable. I will also delete the names of other people or places that may arise in the interview.

Please read the following paragraph, and if you are in agreement, kindly sign where indicated.

I agree that the purposes of this research and what my participation in it would entail have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my perceptions and practices of counselling psychology. I also consent to an audio tape of this discussion and its subsequent transcription for the purposes of this research.

Signed................................................................. Date .....................

On behalf of all those involved in this research, I undertake that confidentiality will be ensured in respect of the audio tapes and any transcription of same made with the above participant. I also undertake that any use of the audio tapes or transcribed material will be for the purposes of research only. The anonymity of the above participant will be protected throughout.

Signed................................................................. Date .....................

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APPENDIX 5

INTERVIEW GUIDE

Introduction to the participants:
Counselling psychology is a developing applied psychology within the BPS, having acquired its divisional status in 1994. The current research is concerned with investigating how different counselling psychologists talk about their discipline. A focus of this interview is to explore how your views and beliefs as counselling psychologists influence your therapeutic practice.

PART I: DEFINITIONS
Firstly, I would like to explore your ideas about CP. What is CP for you? (meanings, definitions, conceptualisations)

Potential issues to probe:
(The questions will not all be used, it will depend on their previous answers)

*How do you think CP fits into the framework of other applied psychologies?

FOR EXAMPLE:
-In your opinion, are there any differences with other applied psychologies?
If so, what aspects do you view as different?
What makes you say that?/Can you tell me a little bit more?/Give me an example
-In your opinion, are there any similarities with other applied psychologies?
If so, what aspects do you view as similar?
What makes you say that?/Can you tell me a little bit more?/Give me an example

PART II: PRACTICE
How would you characterise your therapeutic practice as a CP?

Potential issues to probe:
(The questions will not all be used, it will depend on their previous answers)

* Bearing in mind that counselling psychology has been seen as an outgrowth of counselling, psychotherapy and aspects of other Divisions and Sections within the BPS, how do you position yourself in terms of counselling, psychotherapeutic and psychological practice?

* Were there any aspects of your training which stand out as being influential in your current conceptualisation of therapeutic practice?
Can you tell me more about that?/What effect has this had on you?
* CP accommodates a diversity of theoretical models, which are the most significant to your practice?
Can you tell me more about that? / Can you give me some examples?

* Based on what you are telling me, how would you describe your experience of the therapeutic relationship?

* How does this inform your understanding of the client, his or her difficulties and concerns? Can you give me an example of that?

PART III: VISIONS
How do you envision CP as making a contribution to psychological research and practice in the future?
(How do you see CP as evolving in the future?)
Do you agree or disagree with this?

Potential issues to probe:
(The questions will not all be used, it will depend on their previous answers)

* How do you see the role of CP and counselling psychologists within society?
Can you tell me more about that? / Can you give me an example of that?

* Are there any settings that you think would most benefit from counselling psychologists? What makes you say that?

* Do you think certain client groups over others would benefit from its practice? If so, why? / If not, why not?

PART IV: CONCLUSION
I don’t have any further questions, is there anything you would like to add?
Thank you.

Probes and Prompts to be used with the questions and statements
--Can you tell me more about that?
--Why do you say that?
--What makes you say that?
--Can you give me an example of that?
--What effect has this had on you?
APPENDIX 6

SAMPLE INTERVIEW

Counselling Psychology is a developing applied psychology within the BPS, having acquired its divisional status in 1994. The current research is concerned with investigating how different counselling psychologists talk about their discipline. A focus of this interview is to explore how your views and beliefs as a counselling psychologist influence your therapeutic practice.

To begin with, I would like to explore your ideas about counselling psychology. What is counselling psychology for you?

For me, I had been counselling for some years before I became a counselling psychologist, so I don't suppose I changed all that much in the way that I viewed how I was counselling anyway. Except for myself, I don't think in practice it is very different, but in myself perhaps I feel more structured and I am more aware of what orientation I am using at a specific time, whereas perhaps... I might just be more instinctual.

Can you tell me a little bit about how that change occurred?

I think it occurred with knowledge more than anything else and more understanding of the different therapies that I would use. I think I was always not only person centred, but using a bit of this and a bit of that, whereas maybe I still do that, but at least I realise what I am doing and I am aware of when I am doing it. I am also aware of when I can use different types and different orientations.

Right. What made you aware, was it training or what happened?

Well I suppose it ... years because I had been counselling for about ten years before I did a psychology degree and so I don't know training in anything other than counselling skills; a very theoretical training. Then with the Psychology Degree it gave me more of an insight, more understanding of the theorists. I did some placements, clinical placements, which also gave me more background if you like. I suppose when doing my Masters and having to do a transcript of counselling sessions, where I actually had to actually pinpoint what I was doing all the way through; what each intervention was. It really came from there. Now I do quite a lot of training people in counselling skills which has made me even more aware of what I am doing.

What kinds of training do you do?

Counselling skills training to people who are working in jobs that involve them using counselling skills, like teachers and health visitors. They are using counselling skills in their work, or they want to, but they really don't know how they should.

So it is not necessarily for counsellors, but also for-

No, we are not turning out more people to be counsellors, because there seem to be enough counsellors, but it is for people who want to use it within their profession.

OK. Can you tell me a little bit about those skills?
Well I suppose we initially teach them to be person-centred because how they ... is that people need to make a relationship with the client. The relationship is the most important tool and that within that relationship comes other skills, types of theories, orientations or approaches and that is the basic.

So basically we say, person-centred, that is the starting point. Within that, OK there is the psychodynamic which perhaps delves more into the past than into the present, but to have an understanding of why you want to do that and ....

Then I think what we would be doing for a lot of the time, what I certainly do an awful lot, would be to use some of the cognitive therapy which I wasn't aware that that was what I was doing, but I think I am... Well, how would you like it to be, where do you see yourself going, what would happen if you didn't do that, there are other ways of doing it.

I suppose it is basically knowing what you are doing, rather than just doing it.

So you have mentioned how you have training people in organisations outside of counselling how to build relationships, how to challenge existing ideas and beliefs. I am wondering how those relate to your therapeutic practice as a counselling psychologist?

How do you mean; do I use them?

Yes.

Yes I do, but I suppose the difference is with the training and using yourself is that the training is much more basic, it is just giving the basic idea of what there is. I mean teachers at school don't go into a transference- Well, we can teach them to understand what happens in the transference, but they wouldn't use it in the way I might with a client.

Can you tell me a little bit about your therapeutic practice?

What sort of things do you want to know?

Anything that comes to mind, anything which is important to you.

Well, as I said, I think the most important thing is to make a relationship.

What is that relationship?

It is a trusting relationship and that they feel comfortable and not judged, that they can say whatever they want to say. It is not a friendship, but it is something which enables people to grow, to be safe; not always comfortable, but they need to feel able to say whatever it is that they want to say.

So you consider that the most important aspect?

Well, I would consider that a starting point because I think it is what happens from there.

My aim is to help people grow and to be able to live a more satisfactory life. I don't feel that I can cure things, I can't change things for people, but perhaps you can help them change the way that they live in it or view their lives.

Can you give me an example of that?

Well I suppose one of the things is if you have a client from a couple, whose partner perhaps has left and they will come in a state of distress because they have been left, you cannot help them in as much as bring back that person. You can help them understand what went wrong in the relationship and maybe, if it is something that they keep on repeating themselves, help them understand that and change that, if they want to. I mean you cannot
make anybody change and you cannot turn the clock back and change what has happened either.

So when you have got a question-?

*Well, I was listening to you and you said that the therapeutic relationship is a starting point and I was interested to hear a little bit about how you work in your therapeutic practice?*

So did that answer that, or-?

*Well, is there anything else that-*

What, other examples or where we would go from there?

*Yes.*

Well, I suppose if I was working with somebody who messed up all their relationships, I think the time comes, once you have made a relationship, that they may be doing to you what they have done to other people. This would be in the unconscious obviously and that is when transference comes in by using psychodynamic theory comes in, to be aware of what is happening and to be able to show them what they do. Because I don't believe quite honestly that you can tell people; I think you have to experience it, you know, where did it come from.

*So it is.....*

Yes, yes.

*You know counselling psychology encompasses a diversity of theoretical models and I am wondering which one, if any, are prevalent in your practice?*

I recently had to apply for reaccreditation to the BAC and my supervisor has to write a report and I was discussing it with him. He is very analytical, he is a psychoanalyst. O said I don't think that I - because he's always described me as being psychodynamic - I said I really don't think that I am psychodynamic, I am more integrative and he insisted that he still feels that I am psychodynamic. So I suppose that would be my mainstream field.

*Is that what you believe?*

Well I do believe in the fact that, yes, one can experience people put on unconsciously onto the other what is going on.

*Sure.*

So I suppose, yes, basically I should imagine it would be, though I do feel that there is a very strong place for cognitive work as well.

I think that depends, I mean psychodynamic is much more long-term and if somebody hasn't got a lot of time or doesn't want to spend a lot of time, one can work in a more cognitive way, more focussed.

*But you seem like you could go along with him and be-*

My supervisor?

*Yes*
Yes, I suppose I could. I have got great respect for him and he knows my work so I suppose in a way I do and that probably is what I am most comfortable with.

So what would you say informs your understanding of the client's issues?

...the hypothesis which I make; try out some sort of way, It is what the client tells me.

So when you say you make hypothesis, what is that like?

Well, as they are talking I may think of, you know, I wonder if and perhaps in some way we will come around to testing out if that is so or it isn't; sometimes it might be and sometimes it might not.

What happens when it is not?

Nothing, that is OK, I mean I was wrong. I mean I've sort of got a hunch that may be, I could be right, I could be wrong. Sometimes I might be right, but they don't realise it. I am what I want to admit to.

So, are you saying that the client's experience provides the basis of the therapeutic process?

I am client led.

OK. If being client led, how do you manage to incorporate your theory?

I am not sure I understand your question.

Client led resonates a more humanistic-

Yes, that is person centred.

So do you use theory within the process or how does it figure within the relationship?

I don't know how to answer that. When you say, how does it figure in the relationship-?

How does it come into the relationship?

Into the process?

Yes.

I suppose if we are talking about something that happens today, I might want to know has that ever happened to them before, if so, when did that happen, what was going on for them at the time when it did? If it is something from childhood or whatever, we are going to be able to look at that in the present.

So you are saying that you hear the client’s story and then based on what they are telling you, you find an appropriate theoretical aspect to help them understand what is going on?

...No, it is applying theory.

I mean they give a story where... it, getting some sort of feeling of what is going on. I think it is something which changes ever so quickly. It is not it is not that you think, well, OK, that is psychodynamic. If I was perhaps transcribing it later, I might think, yes, that is what I was doing then, but in the actual here and now, I don't think I do, I think I just sort of let it go on, but I somehow know what I am doing.

Right.
I don't say, Oh yes, that needs that.

You know if somebody comes along with a particular problem saying; this is what I want to do; I don't want to talk about my childhood, that is not important, that doesn't come into it. I suppose I would immediately think that there is something that they don't really want to talk about, but OK, I will respect that; we don't have to talk about it. So we would deal with the problem, which I would see as being much more focused and solution based.

If then, after some time, we get to a point where I really want to go on because I do think that something has come up or something may come in about their childhood which I may then feel, yes, this does need taking a bit further. ... this is something which you didn't want to talk about, but I feel that it is something which is important to you now. This would really be bringing a bit of psychodynamic into it and using that, but that would still be their choice.

So there is a very strong respect for the client and their choice and basically what you agree on?

Yes.

So practice is negotiated between client and-

Yes. I think it is all the time.

That is interesting. I am wondering whether - you said that it is like that all the time and do you think perhaps that is particular of you in that you are a counselling psychologist or have you ever thought about how perhaps counselling psychology might be different from?

I am sure that everybody works in different ways. A psychoanalyst works in a different way from me.

How's that?

Well, they would use a couch, they wouldn't give anything of themselves.

What do you mean by giving anything of themselves?

Well they work more - they are sitting behind, they are just using the transference and interpretations whereas that is not how I work.

I might give them an interpretation which can be accepted or rejected, but I am not only working in that way. So I would never say that I work in an analytical way.

So when you say, giving of yourself, are you implying that you put yourself in the therapeutic...?

No, what I would say is that if somebody were to say, "the holiday is coming up" for example. They would maybe say, yes, and where are you going, I would answer them and tell them where I was going, rather than say that it doesn't really come into our relationship or whatever.

So it is making less of a mystique?

Yes and not being totally a blank screen.

Yes. Can you tell me a little bit more about that.
Well I have some photos in the room that I am working in. I go to my supervisor's room where he works and there are books on Freud, there is a filing cabinet, there is a bed and two chairs and a picture which is of a flower, that is about it. It really doesn't give anything away about the sort of person he is.

Whereas you are acknowledging your subjectivity?

Yes.

You mentioned before that you started off as a counsellor and you did the ... and you went back and did Psychology and then did a Masters and 'became' a counsellor psychologist. I am wondering what drew you to counselling psychology?

Counselling psychology as such or-?

To become a counselling psychologist as opposed-

Well only as a sort of ongoing professional development. One I did my psychology degree, I felt that I wanted to go on and become chartered, which is why I went on and did my Masters.

What did it mean to you?

It meant that I was a professional, that a belonged to an organisation that was professional.

Did you belong to the BAC before?

I belonged to the BAC and I belonged to the BPS ever since I was a student, but then I was a graduate member. Then I decided that I wanted to be chartered...status as a professional.

Yes. Have you ever thought about where you would position yourself in terms of counselling, psychotherapy and other applied psychologies?

Do you mean....?

Well, having worked as a counsellor and now having a psychotherapist as a supervisor and being a counselling psychologist, I am wondering which of those you feel the most affinity with?

I think I feel the most affinity with counselling psychology because, having done psychology, having a much broader theoretical knowledge than I did as a counsellor, as I think most counsellors don't have, I suppose I put myself in a counselling psychology slot for that reason.

How would you say that counselling psychologists are different to psychotherapists?

I don't think that psychotherapists necessarily have all the different sort of theoretical faces, or the broader view that you do when you do psychology. They also, I don't think, do the research element, not as far as I know they do. It is not so scientifically based.

OK. So you see that as one of the things that-

Yes. I see psychology as a science.

OK. How would you describe science in terms of counselling psychology?

It is difficult again because I suppose what I see myself as working, I see myself in the counselling mode and the psychology bit doesn't come into that.
I see it more in respect of myself and a colleague are going to be starting training ... prisons and we want to evaluate it and write it up and I suppose I see that as being more on the scientific side. You know, is this going to work, are we going to see some ...different behaviours that we see and will they re-offend if they gain self-esteem? Which I think if I was just looking at it purely as a counsellor, it wouldn't really matter. It might matter, but I don't think I would see the way that I would ... any more and approve it.

So whether you are saying whether increased self-esteem leads to less offence, how are you thinking about measuring that?

Well, we are using Rosenberg measurements of self-esteem at the beginning and at the end and the Beck hopelessness scale...so there is a feeling that they can get somewhere afterwards, give them some hope. Then we are going to be able to follow it up in re-offenders. There aren't very many other ways, that is at the beginning of the course and then again at the end.

That sounds very interesting. At the beginning you said that your work involves assisting people change and I am wondering whether this project fits into-?

Well it does really.

Can you tell me a little bit about your notion of change and how the different ways in which therapeutic work can assist change?

Well I see change mostly as growth really, strengthening the ego; that people who are insecure will be able to be a bit more secure in themselves, but mostly it is growth, you know if you achieve aspects-

Because when you just mentioned your research in the prison with offenders it seemed like you were also touching on social and contextual issues.

It does, but that is not the reason that we are doing it.

Right. Can you tell me a little bit more about the reason?

Well the reason was that we were approached to do it, I mean that was the beginning. It feels like a challenge, ...particularly altruistic ...

How is it a challenge?

I think it is a challenge because it hasn't been done before so it is a challenge to see whether it can make a difference, we don't know. If anything new can perhaps stop re-offending, give somebody some sort of feeling of worth in their life, it is a challenge.

So there must have been something which drew you to it?

If there is, I don't know, maybe it is just wanting to do something different all the time.

I am wondering how you think counselling psychologists can make a contribution to psychological research?

You mean as opposed to counsellors?

As counselling psychologists?

Well I suppose, as I said before, one has the counselling skills a counsellor doesn't. We also have some idea of how to put them to use in a more scientific way. To be able to demonstrate if you like to other people outside -
I mean there has been such little research really on counselling and whether counselling really does work. Nobody ever really studied different therapies and then came up with the same answer, that it was the relationship that was the most important. But then who is ever really sitting there with the counsellor seeing what happens, nobody really does, you know nobody is sitting in on counselling sessions so there is no way of being scientific about what counselling does.

Perhaps the only way you can be scientific is to do something -- to test what happens before and what happens after and look at it that way. I don't know, I've probably been talking a load of rubbish.

Well no, it is interesting, you have made a comparison with counselling and I am wondering how you think counselling psychology fits into the framework of the other applied psychologies?

You mean as opposed to clinical?

Yes, or occupational, forensic, educational.

I don't think that it is really all that different to clinical, except that I would say as counsellors we don't see so many psychotic people. As a counsellor I feel that I work with neuroses, rather than psychoses. If I was going to say what is the difference between those, I would really say it was about the only difference, as far as I am concerned because I don't work in a hospital setting. There may be counsellors who are dealing with psychoses, I don't know.

Do you think that counselling psychology would be more beneficial in certain settings over others?

Not necessarily no.

What about client groups?

That is interesting. I find I get the same client groups that apply to me through the BAC which is a counsellors directory and the ones who apply through the BPS register; I don't find there is any difference.

How would you describe them?

What sort of clients do I have?

Yes.

Couples with marital problems, relationship problems, you know relationships; individuals who cannot make relationships; a client who is always feeling ill and wants to know why or stop feeling ill; mothers who come about their daughters worrying about them; people with a partner who may be ill or somebody they work with who has got psychiatric problems and puts a great pressure on to her.

You know they are very varied, but they are not really psychotic. They don't seem to come in saying, I need to see a psychologist, rather than a counsellor.

OK. I am thinking about how you would see the future of counselling psychology?

I think it is going to grow, I really do. I think there is a lot of potential because I think that maybe counselling psychology is getting to be a little bit more a science than counselling. There may be a difference through having this division that there are counselling psychologists.
I think it is also perhaps somehow professionalised counselling as such. Counsellors... sometimes or being laughed at and it has sort of raised the self-esteem of counsellors.

*When you say the science of counselling, can you tell me a little bit more about that?*

Well, as I said earlier, I don't think there has been very much that has been seen as being scientific in counselling or anything really being done with any of the therapies. I think that having this profession of counselling psychology, something will evolve from that, people will try and investigate much more. Because it means that people will have a psychology background for a start which is very strongly based on scientific methods and I think that that will sort of change the idea of counselling and look at it in a more scientific way.

*Right and -*

I say everyone would, but certainly maybe amongst all the counselling psychologists some people will want to.

*Yes. Do you think that other counselling psychologists agree with your idea?*

No idea.

*You've never thought about it?*

Not really, no.

*What role do you see counselling psychology or counselling psychologists having in society?*

I think it would be the role of people who want to have counselling, want to know that they are getting it from someone who is a professional and who don't feel that they want to be seen as psychiatric cases... sometimes go to hospital and the wards and see clinical psychologists.

*So are you saying that it is destigmatising mental health?*

Yes with counselling.

*OK I think you have pretty much covered all my questions and I am wondering whether there is anything you would like to add?*

No, I think you have asked so many that have made me think.
NOTES FOR CONTRIBUTORS

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DEVELOPMENTAL EXPERIENCES OF PERSONS WITH MULTIPLE SCLEROSIS:
THE LACK OF A HOLDING ENVIRONMENT
This study seeks to obtain a greater understanding of the developmental experiences of persons with Multiple Sclerosis (MS), based on their present memories. It explores common patterns among participants’ psychological processes, and also considers possible associations between these and their development of MS. A total of 12 respondents each participated in an in depth qualitative interview. The data were subjected to qualitative content analysis and yielded four thematic categories. It was found that most participants: (1) experienced unsupportive developmental environments; (2) experienced parental figure(s) as hindering their maturational processes from childhood to adulthood; (3) experienced the long term psychological repercussions of their developmental experiences; and (4) experienced the first symptoms of MS and/or its exacerbations during periods of emotional stress. This paper discusses possible implications for future theory, research and practice to enhance the wellbeing of persons with MS.
DEVELOPMENTAL EXPERIENCES OF PERSONS WITH MULTIPLE SCLEROSIS: THE LACK OF A HOLDING ENVIRONMENT

INTRODUCTION

Multiple Sclerosis (MS) is the most common disease of the central nervous system (CNS) among young adults (Allen & Goreczny 1995; Miller, 1997; Taggart, 1998). Its neurological symptoms result from an autoimmune attack on the insulating myelin of the nerves, which cause a disruption of nerve impulses in the brain and spinal cord. The two prevalent forms that typify its disease course are relapse-remitting (RR) and chronic-progressive (CP). Both contain a plethora of very disabling motor, sensory, perceptual, sexual, and cognitive dysfunctions (see Sibley, 1990). The etiology of MS, however, remains unknown (Allen & Goreczny, 1995). Raine (1990) has posited that an immunological breakdown occurs when immune system cells breach the blood-brain barrier (BBB) and attack elements of the CNS they misidentify as pathogenic agents. Others have hypothesised that MS is caused by an immunological response to a slowly progressive childhood viral infection (Sullivan et al., 1984; Sibley, 1990).

The diagnosis of MS, based on evidence of brain lesions disseminated in time and space and the exclusion of other conditions which may produce the same clinical picture, can be very difficult to ascertain (Baum & Rothschild, 1981; Scheinberg et al., 1984; Fieschi et al., 1997). Many individuals, ultimately diagnosed with MS, initially seek treatment for psychiatric disturbances (Schiffer & Babigian, 1984; Minden et al., 1987). Clinicians have, on several occasions, overlooked the MS diagnosis and misdiagnosed patients as suffering from psychiatric disorders (Skegg et al., 1888). Studies have shown that MS patients have more depressive disturbances compared to patients with various medical (Minden et al., 1987) and disabling disorders (Rabins et al., 1986). However, controversy persists as to whether affective disturbances are the consequences of damage done to the CNS; precipitants of MS and future exacerbations of the disorder; normal reactions to the disease; or some combination of these factors (Rabins, 1990; Schiffer, 1990; Warren et al., 1991).
The convergence of neurologic and affective symptoms has inspired research on the psychological aspects of persons with MS. Drawing from his experience as a neurologist, Paulley (1977; 1985) discovered the prevalence of emotional dependence, passivity, and problems in separation from primary caregivers among this patient group. He contends that emotional stress is a major determinant in the causation of MS. In a series of qualitative interviews with MS patients in Italy, Diana (1980) found the recurring use of early and rigid defence mechanisms. In a subsequent investigation Diana et al. (1985) discovered that, in comparison with healthy subjects, MS patients reported having had many more unhappy childhood experiences; appeared to manifest more feelings of autoaggressiveness and depression; and indicated greater difficulty in resolving their inner conflicts. Diana et al. considered that these personality features potentially enhance the development of MS and, in turn, also possibly become aggravated by the illness. Fischetti and Borgia’s (1990) case study reflects the aforementioned findings and posits that MS may have its underpinnings in intensifying primitive and unresolved intrapsychic tensions. Albeit the difficulty in determining whether early experiences generate personality problems and pathogenic mechanisms which act as risk factors for the illness, these and other investigations (Caviglia et al., 1990; Caviglia et al., 1985) suggest an intensity of emotional and intrapsychic tensions in persons with MS.

The present researcher found striking parallels with the psychological profile of Fischetti & Borgia’s case study in her psychotherapeutic practice with an MS patient (see Gore, 1999). This discovery provoked her interest and concern in pursuing research on the developmental experiences of persons with MS, and exploring their potential associations with the development of the disease. She noticed that the aforementioned investigations convey information about specific inter- and intrapsychic tensions and/or isolated aspects of the life histories of persons with MS without conveying much about the psychological processes that potentially link their developmental experiences together. Moreover, most of these investigations (except Diana, 1980) either reveal quantitative findings (Caviglia et al., 1985; Caviglia et al., 1990; Diana et al., 1985), or are written as case studies from the perspective of the researcher(s) (Fischetti & Borgia, 1990; Paulley, 1977; 1985) instead of elucidating their meanings and experiences from the perspectives of those being studied. Furthermore, many of these studies were conducted in Italy; thus their findings may
be culturally specific (Caviglia et al., 1985; Diana, 1980; Diana et al., 1985; Caviglia et al., 1990; Fischetti & Borgia, 1990).

The present researcher has considered Winnicott's object relations theory a suitable theoretical framework for obtaining a greater understanding of the developmental experiences of persons with MS. It rests on the premise that healthy intra- and interpersonal development stems from an accumulation of positive experiences with primary caregivers (Winnicott, 1986). Parental availability and reliability form the basis of the 'holding environment', which Winnicott considers necessary to support and facilitate an infant's maturational processes. The 'good enough mother' provides a setting of ongoing basic empathy and containment, in which she survives the infant's love and hate without retaliation. The father is the 'protecting agent' of the family unit, who enables the mother to abandon herself without anxiety to the needs of the infant. The stabilising influence of both parents enables the maturing child to test their 'good' and 'bad' feelings and, in turn, experience a gratifying human context to unfold a subjective sense of their own being, expression, and creativity.

Favourable developmental circumstances nurture the internalisation of a safe inner world which enables the child to manage anxiety and tolerate frustration, aggression, and loss. This development facilitates the child's psychological organisation of the 'true self', which has a 'me' and a 'not-me' clearly established (Winnicott, 1958a). The lack of parental ego support, however, confronts the child "with a handicap in his own self-integrating task" (Winnicott, 1958b). This tends to result in the predominance of a 'false self', primarily concerned with defending itself against its feelings of overwhelming anxiety stemming from the failure of holding (Winnicott, 1965a). A 'fear of breakdown' forestalls the achievement of psychological wellbeing and maturity (Winnicott, 1963a).

A significant feature of Winnicott's notion of a child's growth towards maturity is the gradual movement towards body-mind unity (1970). The inter-relationship between the psyche and the soma is achieved from personal experiences and environmental experiences, such as the 'holding' and 'handling' provisions of the 'good enough mother'. Winnicott's non Cartesian-Dualist position lends itself to integrating recent scientific discoveries. For example, Schore (1994, 1996) has drawn together findings
from developmental psychology, psychoanalysis, neuroanatomy, and neuropsychology, which indicate that the infant brain is sensitive to and dependent upon the affective interaction with the caregiver mother for its development. Her regulatory functioning not only modulates the infant’s internal state but permanently shapes the emerging self’s capacity for self-regulation. His contributions have been especially valuable in pointing out that the formation of an attachment bond between infant and caregiver generates experiences which shape “the maturation of structural connections within the cortical and subcortical limbic areas that come to mediate socioaffective functions” of the nervous system (Schore, 1996:60).

Winnicott and Schore’s work emphasise the importance of the environment for healthy emotional and neurological development. The present study, therefore, aims to explore the developmental experiences of persons with MS, based on their present memories. As a retrospective investigation, it does not set out to establish the objective truthfulness of those memories. Instead, it seeks to obtain a greater understanding of potential patterns among participants’ subjective psychological processes contained in their recollections. In turn, this will make it possible to compare participants’ phenomenological accounts with those of the aforementioned investigations (Caviglia et al., 1985; Caviglia et al., 1990; Diana et al., 1985; Fischetti & Borgia, 1990; Paulley, 1977; 1985). Bearing in mind that the theoretical framework adopted here considers the mind and body to be interrelated, this study also seeks to explore possible associations between the psychological processes of persons with MS and the development of their disease. Few studies have looked at clinical management programmes for people with MS (Greenwood et al., 1997). This is an area which would present an excellent opportunity for counselling psychologists to begin to address with other professionals.
METHOD

Participants
Cognitive deterioration, which occurs between 54 and 65 per cent of persons with MS (Peyser et al., 1990), was considered a potential exclusion criteria for participation. However, this was not established on the basis of a priori information, as research shows that cognitive dysfunction in MS follows a unique pattern and time course for each individual which cannot be predicted from any other aspect of the disease (Langdon, 1997; Beatty et al., 1990; Rao at al., 1987; Rao, et al., 1985; Ivnik, 1978). Furthermore, the present researcher considered it unlikely that MS sufferers with significant signs of cognitive impairment would comprehend the research purposes and want to participate in the interviewing process.

Ethical approval was sought and obtained from the Kingston and Richmond NHS Trust for recruiting MS outpatients (APPENDIX 1). This trust was chosen due to its accessibility to the researcher, who aimed to conduct face to face interviews. A total of 25 invitational letters were distributed among practitioners within the trust, who have ongoing contact with MS outpatients, to forward to prospective participants. This recruitment procedure was intended to preserve patients’ confidentiality and anonymity. The information offered to each potential participant included an invitational letter, which outlined the aim and design of the study (APPENDIX 2), and a stamped addressed envelope to return the participation form (APPENDIX 3).

Data Collection Procedure
An interview based approach was used because it provides an opportunity to document rich and detailed information. It has an increased potential to elucidate the experiences of those being studied that are not usually presented when employing such instruments as postal questionnaires (Elliott et al., 1999).

All of the participants were interviewed at their homes. An information sheet was provided, including details of support groups and counselling services to contact in the event that the interview restimulated painful memories and feelings (APPENDIX 4). The researcher also summarised the contents of the information sheet to ensure each participant’s understanding. For example, participants were informed that they could
Avoid answering any question and/or also choose to end the interview at any point at their sole discretion. All of the participants signed a consent form, outlining confidentiality procedures (APPENDIX 5). Any identifying details have been deleted in the following analysis or replaced by a pseudonym. Participants completed a demographic questionnaire form (APPENDIX 6). A semi-structured interview guide (APPENDIX 7) was then administered.

The questions on the interview guide were informed from the relevant literature (see Gore, 1999). The guide was designed to explore participants’ memories of their developmental experiences and any potential links between these and their development of MS. Its main content areas elicited questions about their early environments; their ongoing relationships; their circumstances at disease onset and progression; and their experience of counselling and/or psychotherapy.

The semi-structured interview format allowed participants considerable scope to cover potentially personal and sensitive issues relating to the research questions that might not have been directly probed by the researcher. The research interview was located within a counselling framework to give primacy to the development of a supportive interaction between the interviewer and respondent (Coyle & Wright, 1996). Each participant was offered an opportunity to debrief with the researcher, for their own benefit, immediately following the interview (Breakwell, 1985). Interviews lasted between an hour and an hour and a half and were audio-taped and later transcribed.

**Analytic Procedure**

Mostyn’s (1985) approach to qualitative content analysis (QCA) was considered an appropriate analytic method for uncovering potential patterns, regularities, and new relationships among participants’ accounts. This approach advocates knowledge of theories of human behaviour to interpret the symbolic meanings of communications. QCA involves exploring the manifest and latent meanings by, as far as possible, seeking to understand the content of the data from the perspective of each participant’s phenomenological experience (Mostyn, 1985: 18). This analytic method also takes into account the context in which the data was obtained, especially with regards to researcher’s influence on what participants say or do.
QCA's commitment to uncovering patterns, regularities and new relationships among subjective accounts seems compatible with a transcendental realist epistemological position. This position was developed by Miles and Huberman (1994) for conducting qualitative research. It puts forward that social phenomena exist not only in the mind, but also in the objective world: “things that are believed become real and can be inquired into” (Miles & Huberman, 1994: 4). Miles and Huberman affirm the importance of the subjective, the phenomenological, and the meaning-making at the center of human life. Their epistemological position aims to register the regularities and sequences among individual experiences and transcend these by highlighting the phenomena which link them together.

Stages of Analysis

An essential aim of Mostyn's (1985) approach to QCA involves generating thematic categories from the data. These must reflect the purpose of the research, be exhaustive, and mutually exclusive. In addition, categories must have an internal aspect, in that they must be meaningful in relation to the data, and an external aspect, in that they must be meaningful in relation to other categories (Day, 1993).

The first step of the analytic process involved reading and re-reading the transcripts. Ideas were annotated, their significance was assessed and relevance evaluated. Aspects of the data that were considered key concepts were coded. These codes were condensed and labels were used to represent emerging categories (Miles & Huberman, 1994). An index of extracts, pertaining to each prospective category heading, was then produced. This included clusters of similarities and differences among participants' accounts, as well as patterns of processes involving connections in time and space within a context.

In order to provide credibility checks (Elliott et al. 1999), another researcher read all the transcripts and evaluated the present researcher’s accuracy of the allocation of material to prospective categories. This stage resulted in the creation of mutually agreed upon categories, which was then subjected to the interrogation of the researcher’s supervisor. This entire process contributed significantly to generating new categories, and refining the inclusion and exclusion criteria of the original ones.
The final stage of the analysis involved going back to the transcripts to make sure that other pertinent extracts had not been overlooked (Day, 1993). This cyclical process of moving backwards and forwards between the categories and the data continued until the researcher was satisfied that all relevant distinctions between observations were drawn, and that observations could be compared effectively in terms of the established category system. Finally, this cyclical process sought to ensure that each interpretation was grounded in primary source material.

**Evaluating the Analysis**

Due to the subjective nature of the analytic process, the criteria traditionally used to evaluate research (i.e. validity and reliability) are inappropriate as they assume a disengagement between the researcher and the topic under investigation (Henwood & Pidgeon, 1992). More pertinent criteria need to be considered, such as transparency, persuasiveness and internal coherence (Elliott et al., 1999).

In evaluating the analytic process, the researcher should own their perspective in the resultant interpretations (Elliott et al. 1999). In the present case, it is important to recognise the influence of the researcher's position as a counselling psychology trainee, whose practice has made her particularly sensitive to discerning psychotherapeutic issues. A tendency could occur to attend more closely to particular themes which appear to reflect the researcher's concerns. Another investigator may identify different features of the data set. However, situating the sample, making explicit the data collection methods and analytic procedures adopted, as well as presenting a representative sample of raw data (through quotations) should enable the reader to challenge the transparency of the interpretations, assess the persuasiveness of the analysis, and evaluate the coherence of the study (Elliott et al. 1999).

Participants have been given pseudonyms throughout the analysis to facilitate the reader to distinguish between different accounts. The information that appears within brackets in the quotations has been added for clarification purposes. Empty brackets indicate the omission of material and ellipsis points (...) indicate a pause in participants' speech. In addition, the figures in the brackets at the end of each extract respectively refer to the transcript and page numbers of each interview.
ANALYSIS

Demographic Information
Out of the 12 participants, 9 (75%) were female and 3 (25%) were male. The mean age of participants was 44.2 years (range 29 - 64; SD = 10.9). All identified as white. 8 (66%) participants identified themselves as married; 2 (16.5%) as separated/divorced; and 2 (16.5%) as single. The mean length of time since their MS diagnosis was 9.7 years (range 8 months - 22 years). 4 (33%) participants reported having the RR form of MS; 3 (25%) reported having the CP form; and 5 (42%) reported not knowing which form they had. 10 (83%) participants were recruited via community physiotherapists; 1 (8.5%) via a psychologist; and 1 (8.5%) via another participant.

Key Findings
The analysis yielded four sequential and mutually exclusive thematic categories, which refer to separate stages of participants’ present memories of their developmental experiences. Lack of a holding environment elucidates recurring social and affective aspects among their recollections of their early environments. Hindrances to maturational processes illustrates commonly experienced parental impingements to their developmental transitions from childhood to adulthood. Enduring repercussions conveys participants’ psychological predicaments in adulthood. Emotional stress surrounding MS reveals many of their affective circumstances at disease onset and progression.

Lack of a holding environment
The lack of a holding environment elucidates commonly experienced social and affective aspects among participants’ memories of their developmental environments. This overarching category is comprised of four thematic clusters, namely: parental neglect; loss in the family; violence in the family; and sibling relationships. Each will be discussed in turn with extracts from participants’ accounts.
Parental neglect was a recurring issue throughout most, if not all, the transcripts. At the most basic level, it was manifested by a prevailing sense of maternal and/or paternal unavailability. For example:

My dad was always working and he was that strange man because we really didn’t see him much. He wasn’t working away, but we would almost be in bed by the time he got home or whatever (Rebecca, 8:14).

Rebecca’s recollection conveys that she experienced her father as primarily attending to his work commitments rather than actively providing care within the family. In addition, her reference to him as “that strange man” seems to emphasise her lack of safety and relatedness with him as a primary caregiver.

Participant’s experience of parental neglect frequently implied feeling deprived of adequate nurturing. In the following extract, for example, Nancy recalls her mother’s failure to put her children before her foster children:

All three of her actual children, we all say this now that we are grown up, that she (mother) always put them (foster children) before us. Again, because she made money doing that and she didn’t get paid for having her own children (6:2).

Nancy’s portrayal suggests that her mother used children as vehicles for profit rather than nurturing them as beings with intrinsic worth. Her experience of her mother’s tendency to undermine what her children needed from her seems antithetical to Winnicott’s notion of a facilitating environment, in which the ‘good enough’ mother is devoted to enabling her children’s personal growth and wellbeing.

Some participants’ experience of neglect included feeling unwanted by their parents. This is exemplified in Gertrude’s representation:

My dad was always at work and my mum I always felt favoured my sister. I used to stay with Nan a lot of the time (5: 5).
Gertrude conveys feeling of secondary importance to her mother in relation to her sister. Her experience of her mother’s indifference appears to have been compounded by her father’s unavailability. In turn, Gertrude’s recollection suggests that she felt her family environment was not ‘good enough’ to handle her needs and desires and appears to have sought the necessary ego support elsewhere.

**Loss in the family**

Three participants reported that their developmental environments were fraught with issues relating to loss. Below, Dorothy describes the destabilising circumstances, which her mother has told her, accompanied her father’s loss via abandonment:

My mum lived in a lovely flat in Woking. She had brand new furniture all the way through she was pregnant with me. They were going to get married and then one day he came home drunk and he said we are not going to have this for much longer and walked out () She (mother) had to go back to her mum’s and then she had me and she had a nervous breakdown which lasted for about two years. She thought she had cancer. She was always at the doctors and the hospital saying I’ve got this cancer or that cancer (2:8).

According to Dorothy’s portrayal, the traumatic events which surrounded her birth suggest that she may have been deprived of what Winnicott calls ‘primary maternal preoccupation’ (1960). This condition unfolds from the mother’s emotional and physical involvement with her baby in the first weeks before and after its birth. It involves the mother’s ability to discern and satisfy the infant’s needs, as well as her willingness to be used as an object for the infant to express its anxieties and desires. Yet, Dorothy’s representation insinuates that her mother was primarily preoccupied with combating her own paranoid and obsessive anxieties. It would appear, therefore, that her mother’s fragile psychological state prevented her from offering Dorothy the necessary stability and containment to facilitate her early development.

The other two participants experienced the realities of illness and death at an early age. For example, Jane conveyed:
I had a little sister. She was seventeen months younger than me and she
died of Hodgkin’s disease when I was eight ( ) I just remember that I
didn’t see my mum and dad for a long time because my mum was
visiting at the hospital ( ) My mum used to organise people to get me
after school (10:11).

Jane resisted from elaborating upon this experience. Bearing in mind Bowlby’s work
on separation and loss (Bowlby, 1973), however, it is possible that these acted as a
significant source of disturbance for Jane during her childhood. It may be that she
lacked a caregiver to help contain her potentially painful feelings during her
separations from her parents throughout her sister’s illness. Her detached reference to
‘people’, who collected her from school, suggests she experienced them as fulfilling a
task rather than providing a substitute for the absence of parental care and support.

**Violence in the family**

Four participants described violence in their families. For all of them, it appears to
have been inflicted by their fathers and reinforced by their mothers lack of protection.
This is exemplified in John’s representation of his parents’ relationship dynamics:

She was the warm loving mother that didn’t really -- she didn’t speak
for herself at all. She was the little woman in the background, sort of
role. She sort of bore the brunt of this, and then when my father hit me,
my brother, or even her, she was the cuddle (1:4)

In John’s recollection, his father epitomises the aggressor, who readily used his
children as targets of his uncontained impulses. In turn, his experience of his
mothers’ passivity, possibly reflecting a fearful-avoidant response to her husband’s
oppressive disposition, appears to have deprived him of what Winnicott considers the
‘environment-mother’. This is “the person who wards off the unpredictable” in order
to contain and minimise her children’s potential exposure to traumatic impingements
(1965a). In particular, John’s account suggests that his mother offered consolation for
the lack of safety and stability rather than active care and security.
A manifestation of how violence was experienced as a very real threat to the continuity of the family is provided in Sonia’s recollection:

Their relationship, mum and dad’s relationship, was extreme I realise that because they were totally distant or involved in this fighting. I was aware of sexuality as I witnessed my father rape my mother. The first time I learned to use a phone was my mother screaming directions for me to ring the police because my father had beaten her up (7: 3).

Sonia’s representation conveys the absence of any family structure so that the external authority of the police had to be summoned to contain the risk of annihilation. There appears to be an obvious role reversal between mother and daughter as Sonia is called upon to ward off her mother’s traumatic circumstances. In turn, her portrayal intimates that she felt forced to grow up fast as a means to survive, in the absence of a ‘good enough’ environment to nurture her growth towards maturity.

Sibling relationships
A minority of participants reported sharing supportive relationships with their siblings. In most instances, these seemed to provide a safe holding outlet against a hostile developmental environment. Here are two examples:

I get on extremely well with my half-sister, my adoptive sister, I mean. Probably because she used to be bullied (by mother) and I used to stick up for her (Nancy; 6:4).

She (sister) is possibly my only life line emotionally. We have a very close relationship, my sister and I because of our upbringing, because of the problems we had. My mum and dad were basically very involved in their own relationship (Sonia; 7:1).

Nancy and Sonia’s respective representations suggest that their relationships with their sisters compensated for the social and affective deficiencies of their developmental environments. In particular, Sonia’s reference to her sister as her “life line” intimates that she was her source of emotional ego support.
For at least six participants, vehement animosity characterised their memories of their relationships with siblings. Here are two examples:

As children (the relationship between her and her sister), terrible. We argued, we used to fight. She wasn’t allowed to touch anything of mine. I wasn’t allowed to touch anything of hers. This was my bedroom and that was her bedroom, sort of –. We couldn’t walk past each other without saying something nasty (Gertrude, 5:7).

My brother was very responsible for me, because when I went to school he had to take care of me, and bullied me like mad (Helen, 4:1).

These portrayals convey an absence of containment in sibling relationships. For example, Gertrude’s recollection of her and her sister’s desperate attempts to control their respective space and belongings may have reflected a reaction formation to their lack of an internalised sense of security. For Helen, on the other hand, who reported violence in her family, it is possible that her brother was reenacting her father’s abusive propensities on their relationship. It might also be that the lack of a reliable holding environment may have deprived them of using their parents as objects to express and contain their good and bad feelings, hence the need to act these out on each other. These ideas reflect tentative explanations of the dynamics potentially underlying participants’ relationships with siblings. The next theme provides concrete illustrations of participants’ psychological processes during their transitions from childhood to adulthood.

**Hindrances to maturational processes**

During the transition from childhood to adulthood, participants’ experience of an unsupportive developmental environment appears to have continued. Most participants either directly or indirectly recalled their parents’ failure to allow them to engage with critical maturational processes surrounding their adolescence. The following account conveys the difficulties Dorothy experienced in negotiating her independence from her mother:
My mum is a bit possessive. I wasn’t allowed out on my 18th birthday and on my 21rst birthday, we had a Chinese at home ( ). She didn’t want to let go of me ( ). She used to say ‘don’t go out tonight, don’t go out with your friends’ or ‘I don’t like that friend’. I used to listen to her and I used to think well, I’ll stay in. I didn’t have very happy teenage years. I didn’t have my cider days, where you experiment with cider and get drunk (2: 3).

Dorothy’s recollection reveals that her mother’s controlling disposition prevented her from establishing social and affective relationships with others. The development of these interpersonal experiences is essential for the achievement of separation and individuation, in which the maturing individual begins to revise their representations of their parents and become capable of making selective identifications (Esman, 1975). However, Dorothy’s portrayal suggests that she increasingly complied with her mother’s demands at the expense of fulfilling her own needs and desires. According to Winnicott, the tendency to be overresponsive to the exigencies of others reflects the prevalence of the false self (Winnicott, 1965b).

The transition from childhood to adulthood usually requires the accommodation of physical changes accompanying puberty. These have consequences on how the young person feels about themselves (Belsky et al., 1991). The following example illustrates the effects of Helen’s unmet mirroring needs upon her sense of self during the transformative stage of her adolescence:

I remember when I was about 12 saying -- ‘look at this, I’ve got a great figure’ -- and she (mother) said -- ‘that’s disgusting, I never want to hear you say that again’. I like went ‘ugh’ and just ate myself into a blob because it made me disappear. I didn’t have a figure anymore, I didn’t have breasts, I didn’t have -- because she couldn’t cope with it -- I totally couldn’t cope with it (4:5).

Rather than facilitating her to accommodate her maturational changes, Helen’s recollection reveals that her mother crushed her feelings of self worth. Helen does not appear to have differentiated between ‘me’ and ‘not me’ but, instead, seemed to give
in to her mother’s hostile projections. Her memory intimates that she literally swallowed her hurt and turned it against herself by attempting to annihilate her own body. Helen’s behaviour may, in turn, have reflected a physical manifestation of her shattered intrapsychic attempt to unfold a unified self image.

Some participants felt subjugated by their parent’s attempts to impose their expectations on what he or she wanted to become. For example, Mathew conveyed:

As I said, it was against my desire. I didn’t want to be a doctor. I disliked anything to do with blood. I felt I was there under false pretences. Therefore, why couldn’t I be a sailor, which is what I wanted to be. Father’s influence was very important, whatever he said went and you couldn’t really argue (3: 5).

This extract reflects the dilemma of what Winnicott considers adopting ‘false solutions’ to the struggle of establishing personal identity (Winnicott, 1961). His father’s authoritarian disposition seems to have had a paralysing effect on Mathew’s process of unfolding his needs and aspirations. In particular, his recollection suggests that he was likely to take in his own feelings of revulsion, about ‘anything to do with blood’, in order to comply with the role his father had assigned to him.

For some participants, such as Nancy, the failure to comply with her mother’s expectations meant excommunication from the family environment:

Unfortunately, my mother didn’t like my husband, so she beat me up and threw me out. I lived in lodgings for 2 years (6: 3).

Many participants, who felt faced with similar oppressive circumstances, assumed self defensive attitudes towards their parents. For example, Gertude asserted:

I was only 14 when I met my husband and my mum and dad weren’t very happy with that because he is 12 years older than me. I suppose that was a little bit explosive. I wasn’t going to do what they wanted me to do. I think that I am a very strong willed person. I do what I want to
do, not what somebody else wants me to do (5: 6).

This extract conveys Gertrude’s determination to safeguard what she values and desires. It is possible that her uncompromising disposition results from an accumulation of experiences in which her parents imposed their needs and desires on her development, rather than reflecting back what she needed from them (Winnicott, 1965c). This reactive form of living was often associated with participants’ tendency to suppress their need for their parents’ help and support. For example:

I left school and went straight into working so that I could slap my wages down in front of my father and say ‘there you go, you don’t own me’ (Sonia, 7: 9).

It seems that Sonia’s willful attempt to break away from the repressive quality of her developmental environment, in which she felt ‘owned’ rather than nurtured, involved the formation of a ‘caretaker self’ (Winnicott, 1965c). For Winnicott, this defensive organisation of the self occurs when there is a prevalence of failure in experiences of care, to enable the projection of personal needs and the introjection of care details, which underlie the development of confidence in the environment.

Taken together, these recollections convey that participants generally felt hindered rather than facilitated by their parents to engage with crucial maturational processes, such as separation and individuation, the development of a unified self image, and the establishment of a personal identity. All cited seem to have experienced the option of either complying with their parents’ expectations or violently breaking away, two dispositions which reflect the overresponsive and reactive aspects of the false self (Moore & Fine, 1990). These defensive organisations seem to have impinged them from nurturing their own developmental needs, anxieties, and desires. Several extracts, for instance, convey participants’ difficulty to differentiate ‘me’ from ‘not me’, which Winnicott (1958a) considered a key capacity for the achievement of psychological integration and emotional maturity. While this theme sought to elucidate recurring patterns among participants’ transitions from childhood to adulthood, the next theme focuses on their long term psychological predicaments.
Enduring Repercussions

Most, if not all, participants continued to experience the psychological repercussions of their developmental experiences in adulthood. For example, John revealed:

I always stayed in the background in situations because I was afraid of upsetting my father or whatever it was. For example, I eventually moved into management consultancy ( ) I was OK with the desk based work and the research and all this sort of thing, but in terms of communicating with people and relating, I found that very difficult. I am convinced that this goes all the way back to my childhood days to the influence my father had on me (1:1).

This extract suggests that John’s internalised experience of his father continued to influence his affective states and behavioural reactions during his adulthood. His portrayal intimates that he continued to displace unresolved fears, about upsetting his father, on his interactions with others and, in turn, felt inclined to withdraw from social contact. It is possible that his ongoing persecutory anxieties manifest the lack of a safe inner world that can be relied on in human interactions (Winnicott, 1965c).

Some participants appeared to reenact the seemingly negative aspects of their developmental environment on their ongoing relationships. For example:

Basically, it was that I was deliberately seeking dysfunctional relationships to avoid committing myself because I was rejected as a child and I was scared of putting myself in the vulnerable position, of putting myself -- properly loving somebody and believing that they loved me back would make me totally vulnerable again (Sonia, 7:13).

Sonia’s tendency to project fears of rejection on the prospects of forming fulfilling intimate relationships seems to represent what Winnicott considers “an organisation towards invulnerability” (1967). This defensive behaviour appears to enable her to avoid reexperiencing the original agony that she underwent when her primitive needs and longings were not nurtured but, instead, rejected. Her tendency to seek dysfunctional relationships may, nonetheless, repeat aspects of the environmental
failure which characterised her early trauma.

Participants generally tended to cope with emotional pain by suppressing its expression. For instance, Nancy revealed:

I don’t shout and let it all out. If people want to argue with me now, I will sit there and keep quiet. I take it all in rather than shouting back, which is probably not a good thing, but that is how I am. Thinking back about it, I am conditioned from when I was little for that because you weren’t allowed to shout back or voice your opinion, you got smacked (6: 14).

Nancy’s difficulty to express bad feelings seems to stem from her oppressive developmental environment. In turn, she appears resistant to ‘fighting back’, which would imply releasing her hurt and drawing a boundary between ‘me’ and ‘not me’. Even though she realises this may bear negative effects, she seems to continue to internalise her distress and swallow the hostile projections of others.

Some participants appeared to cope with emotional pain by turning seemingly hurtful feelings against themselves. This is illustrated in Paul’s representation of his father:

My father is a typically withdrawn, Freudian gay man’s father. He found it difficult to express or be with his son. We never played football together. I think it is important to share interests, but I am quite convinced that the Andrew Sullivan argument is right. It (withdrawal of affection) is the effect rather than the cause, in that on some sort of unconscious level, parents probably recognise homosexuality in their child and will react in the fashion and father will withdraw affection, so that the withdrawal of affection is the effect, rather than the cause of homosexuality (11:4).

Sullivan’s argument may be valid. Nonetheless, it would appear that Paul is intellectualising his unmet longing for his father’s attention, support, and acceptance rather than expressing his potentially conflicting feelings and projecting these outwards.
The tendency to hold back emotional distress bore its limitations for some participants:

I don’t think I have ever been good at expressing when I am cross and things like that. I would again, probably a bit like my dad, get myself wound up and tend to keep it all inside until it overfilled and I burst into tears (Rebecca, 8:15).

Rebecca’s identification with her father suggests the lack of an internalised sense of containment to enable her to process her emotions. She keeps her hurt inside until it becomes unbearable and then tends to experience an extreme outburst. This paradoxical coping mechanism would appear to disrupt her ‘continuity of being’, which Winnicott considers essential to healthy development (Winnicott, 1960).

Taken together, these extracts indicate a shared difficulty in tolerating emotional pain among participants. Internalised negative representations of their early childhood relationships seem to continue to backfire on their achievement of personal wellbeing. Their overriding psychological tendencies to ward off anxiety and distress by avoidance, projection and/or suppression indicate the use of early and rigid defence mechanisms. As such, these mental operations may reflect a ‘fear of breakdown’, related to the fear of reexperiencing the original agony which caused the defence organisation to emerge (Winnicott, 1970).

**Emotional Stress and MS**

Whereas the previous theme discussed the enduring psychological repercussions of participants’ developmental experiences, this theme focuses on participants’ affective circumstances surrounding the symptoms of MS. Some participants attributed their MS exacerbations to emotional stress. Here is one example:

It was definitely stress that was causing it, because thinking back over the years, the different times that I have had stress -- my father dying, my friend Sarah dying through cancer -- stress. They have been all the times that I have had MS attacks; the doctors put it down to MS attack or spasms. Stress is, I think, a big problem (Nancy, 6:12).
Nancy links her relapses with emotional stress deriving from the loss of significant others. Her account seems congruent with findings which have shown that MS patients in exacerbation score higher on emotional disturbance and intensity of stressful life events than patients in remission (Warren et al., 1991; Kroencke & Denney, 1999). Several participants also experienced the first symptoms of MS during periods of emotional stress. For example, Emma related:

I started developing the symptoms of MS just before the exams, I suppose two months before my exams. At that time, my sister got married. It was shortly after my grandmother died and I was a very stressed person at that stage (9:12).

Here again, loss features among stressful life events. Its experience seemed to be a recurring issue among participants’ association of the events surrounding their illness. For example, two participants reported that their first symptoms occurred after the loss of hope in their childbearing attempts. Here is one example:

Why I am telling you that is because it was before I started with the MS. During that time ( ) I mean that (the sequence of miscarriages) was stressful because I got very depressed and that put a lot of pressure. I guess that was when I was 41 and I didn’t get my MS until I was 42, post the supposed recovery, the decision that it (another child) was not going to happen (Helen, 4: 12).

Interestingly, for Helen, as well as Rebecca, the other participant who experienced a similar situation, the onset of MS seems to have surged within two years after they let go of their childbearing fantasies. It is possible that the combination of the pressure and frustration preceding their resignation compounded by their consequent grief reactions may be a contributing factor for triggering their MS.

The majority of participants were letdown that counselling and/ or psychotherapeutic help not had been available to help them come to terms with their illness:
There is no doubt that this whole experience (with MS) has been made so much more difficult because there is just no access to counselling. I have had to work all this out myself, which is what counselling is about, but it would have been nice to have someone point me in the right direction (Paul, 11:16).

Paul seems to point to the absence of a support system to guide and contain his adaptation to his illness. It appears that he was forced to tolerate his uncertainties on his own and that this may have aggravated his predicament. Some participants were unaware that help could be available and, in turn, appeared to have suffered the consequences. For example, Dorothy related:

No, I didn’t ask for help (counselling/ psychotherapy at diagnosis). I didn’t know if these things were available. So I had this nervous breakdown (2:5).

Dorothy seems to imply that absence of emotional and psychological containment posed a very real threat to her continuity of being. It may be important to note that, having had the nervous breakdown, she is offered psychiatric input but not counselling or psychotherapy.

Finally, the benefits of professional support were described in the following manner:

It is nice to have professional support because to me it doesn’t feel so patronising. You are not putting people in that position where they have to be caring in a false way. You want to be independent, you don’t want to have them feel that they have to be on good behaviour all the time, taking care of you. You just want to be treated as normal. Therefore, when you have professional care you can go to, you can release all that on them; you can get it out of your system without putting it on to the people who you just want to treat you normally (Helen, 4: 20).

It would seem that Helen seeks a genuine therapeutic encounter to provide her with a personal space to express and contain her good and bad feelings. She seems to imply
that its supportive outlet acts as a buffer against the possibility of making others in her life feel obliged to her needs and, in turn, pathologising her predicament. Needless to say, her extract resonates with the ongoing longing for a holding environment to provide her with the necessary containment, protection, and security to handle the challenges of her condition.

DISCUSSION

The present findings seem congruent with the results of earlier investigations on the psychological aspects of persons with MS. Namely: Diana et al.’s (1985) finding of recurring unhappy childhood experiences; Paulley’s (1985) observation of recurring problems in separation from primary caregivers; Diana’s (1980) finding of the recurring use of early and rigid defence mechanisms; and, finally, Fischetti & Borgia’s (1990) observation of the tendency to internalise emotional conflict and distress. The present findings also appear to support the claims of the aforementioned investigations that emotional stress may be associated with the onset and progression of MS. These results establish a triangulation among quantitative, qualitative, and case study investigations.

The fact that 12 participants consented to participate in the present study, out of the 25 invitational letters distributed among practitioners, suggests the topic of this investigation may be very relevant to this client group. However, it may be that the practitioners encouraged their patients to participate and thus generated the high response rate. Furthermore, it needs to be acknowledged that the present findings are not generalisable due to several likely shortcomings. Firstly, practitioners may have inadvertently preselected prospective participants, and thus potentially biased findings. Secondly, the small sample size, drawn from a single NHS trust, is not likely to be representative of its population. Thirdly, another perhaps inevitable, limitation in an interview based study is the researcher’s influence on how much and/or how little participants say or do. Nonetheless, the present study has explored some potentially meaningful patterns among the psychological processes contained in participants’ recollections which seem worth clarifying and reviewing.
Whether or not participants’ memories are objectively true, taken together they convey an intensity and extremity of negative developmental experiences. Participants’ generally portrayed parents as primarily attending to their own needs, and/or overwhelmed by their own negative experiences, rather than thinking about what was needed from them. An accumulation of participants’ portrayals either directly or indirectly imply their parents’ failure to hold and handle their needs, contain their good and bad feelings, as well as facilitate their progressive adaptation to the external world. During the transition from childhood to adulthood, participants’ recollection of experiencing a lack of holding environment appears to continue. At this stage, it is represented by their parents’ failure to enable them to engage with the crucial processes of separation and individuation and, in turn, foster their capacity to address, manage and tolerate their own needs and anxieties.

If participants’ recollections of their developmental experiences hold some validity, it would seem that most participants developed defensive emotional and psychological processes to cope with their unsupportive developmental environments. These primarily appeared to take the form of either compliance or reactiveness which, in Winnicott’s theory, hinder the achievement of personal wellbeing. One may hypothesise that participants’ long term tendencies of managing emotional distress, either by avoidance, suppression, and/or acting out incorporate elements of their previously adopted compliant or reactive processes. These ongoing defensive features seem to reflect their failure to develop a safe inner world to help them contain and process their anxieties and emotional pain. In turn, participants’ overriding tendency to internalise hostile interpersonal experiences seems to continue to scar their experience of self by reenacting elements that generated their original wounds.

It is also very interesting that most participants recalled experiencing the first symptoms of MS and the progression of its disease course during periods of emotional stress. This suggests the possibility of an interaction between the emotional and psychological tensions of their internal worlds and the additional pressures imposed by stressful life events in their external worlds. In turn, this interaction may act as a precipitant of MS and future exacerbations of the disorder. In metaphorical terms, it seems as if participants reach a kind of saturation level of just how much negative tension and anxiety they are able to suppress and then it is as if their bad
feelings spill over into their immune system. This would seem compatible with Raine’s (1990) hypothesis of an immunological breakdown (see Introduction). The tendency to internalise hostile experiences may have hindered many participants’ intrapsychic capacity to defend ‘me’ from ‘not me’ and may also, in some way, be associated with the body’s difficulty to distinguish ‘self’ from ‘not self’.

The hypothesis that MS is caused by an immunological response to a slowly progressive childhood viral infection (Sullivan et al. 1984; Sibley, 1990) does not exclude a potential interaction with Schore’s findings that affective deficiencies in the developmental environment hinder the organisation and regulation of the CNS. As such, it is possible that the lack of an early holding environment is a predisposing factor for developing MS. It could be that this predisposition becomes reinforced through the reenactment of hostile and unresolved intrapersonal experiences which may not allow the original neurological deficits to find compensatory measures. In turn, there may be a link between the repetition of emotional scars upon the self and the formation of multiple scars or lesions in the brain, after which MS bears its name. These are hypothetical associations which require further research.

One way for counselling psychologists to pursue research about the potential associations between the developmental experiences of persons with MS and their development of the disease is to develop a standardised postal questionnaire from the material comprised in this study’s thematic categories. It would be distributed among a large sample of persons with MS, along with a control group of subjects from the general population and another control group of subjects with a comparable chronic illness. This would make it possible to: (1) assess the validity of the present findings; (2) assess the extent to which the findings are correlated with the two different control groups which would, in turn, address whether or not the dynamics described in this study are particular to MS; and finally (3) assess the possibility of significant differences within the MS sample, in terms of whether certain types of developmental experiences correlate more significantly with one form of MS rather than another. These future directions are ways in which counselling psychologists could begin to open up a dialogue with neuroscientists and potentially use their psychological knowledge to inform and assist further research and understanding about MS.
Finally, whether or not the findings of this investigation are representative of persons with MS, most of the participants seem to be crying out for some form of psychotherapeutic input as part of their care package. It would seem imperative that their experience of a lack of an early holding environment is not repeated during their process of confronting the dependent implications of their illness. Studies on group psychotherapy (Crawford & McIvor, 1985), cognitive behavioural therapy (Larcombe & Wilson, 1985) and stress-inoculation training (Foley et al., 1987) have all reported improvement in patients' functioning. However, the findings of this investigation suggest that persons with MS may benefit from a longer term reparative therapeutic experience that incorporates insight oriented work.

As integrative practitioners, counselling psychologists seem ideally placed to develop a ‘tailor made’ therapeutic approach for persons with MS. Based on the findings of the current study, the present researcher suggests that this should be grounded in two interrelated stages: (1) a steady period of empathic “holding” (Winnicott, 1971) in which clients can begin to develop trust in their therapist to allow them to (2) work through and reexperience emotional situations they were not able to handle thus far. It is hoped that this reparative approach will facilitate persons with MS to heal over their traumatic emotional scars from the past. McFarland Solomon (2000) has suggested that appropriate interactive attunements in the therapeutic relationship may provide optimal conditions for neurochemical and neurobiological correction. More work and time will tell whether a containing therapeutic experience may also help contain the disease course of persons with MS and, in turn, assist in the advancement of their medical and psychological treatment and care.
REFERENCES


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Ms Maria Caltagirone
9 Lincoln Street
London
SW3 3TS

6 March 2000

Dear Ms Caltagirone

The object relations of persons with multiple sclerosis (MS)

Thank you for your letter dated 3 March 2000, with copies of the amended recruitment poster, information sheet, and letter to potential participants.

I am now happy to take Chairman’s action in approving the study.

Yours sincerely

[Signature]

Dr G K Knowles
Chairman
Local Research Ethics Committee

☎ 0181 339 8013 (Direct Line)
APPENDIX 2

INVITATIONAL / EXPLANATORY LETTER TO POTENTIAL PARTICIPANTS

Maria Caltagirone
Department of Psychology
University of Surrey
Guildford GU2 5XH

Dear service user,

I have asked NAME to forward this letter to you in the strictest confidence. I am hoping that you will consider participating in my research study about the relationship experiences of persons with MS. I am conducting the investigation as part of my doctoral training in counselling and psychotherapeutic psychology at the University of Surrey. My research interest in persons with MS emerged out of my psychotherapeutic practice with a client with this illness.

Participation would entail volunteering in a face to face interview with me, of maximum one hour in duration, at a time and place of your convenience. The interview process will seek to learn about your thoughts and feelings about your relationship experiences, from childhood to the present day, and their impact on your present emotional wellbeing. Your participation in the research would provide valuable insights and information to assist the advancement of an appropriate emotional and psychological care service for people with MS. This would be geared towards alleviating some of the additional personal stress and pressures that people with MS encounter in their daily lives and relationships.

The interview will be audiotaped and later transcribed but identifying details such as your name and address will not be recorded in any form. In addition, any potentially identifying data, such as names of places and friends or relatives, will be altered to protect your anonymity. Each participant will be entitled to a copy of the research for their use once it is completed. I hope I have answered all your questions, but if you have any queries please do not hesitate to contact me by telephoning 01483 87 69 31.

If you are interested in participating, I would be very grateful if you would kindly complete the enclosed participation form and return it to me in the stamped addressed envelope by DATE. I will then contact you to arrange a mutually convenient time for the interview. I would like to thank you in advance for your time and consideration and look forward to the possibility of hearing from you.

Yours sincerely,

Maria Caltagirone
APPENDIX 3

PARTICIPATION FORM

Maria Caltagirone
Department of Psychology
University of Surrey
Guildford GU2 5XH

Name: ____________________________________________________________

Address: __________________________________________________________

____________________________________________________________________

Telephone No. ________________________________________________________

If you prefer to telephone me and / or have any queries, you may contact me at the
University of Surrey:

01483 87 69 31

If I am unavailable at the time of your call, please leave a message for me and I will
return your call as soon as possible.
APPENDIX 4

INFORMATION SHEET

This interview will be audiotaped and later transcribed but identifying details, such as your name and address, will not be recorded in any form. In addition, any other potentially identifying data, such as names of places and people, will be altered to protect your confidentiality and anonymity.

If you have any questions or doubts please feel free to raise them with me at any time. Although none of the interview questions is believed to be difficult or intrusive, you may avoid answering any question at your sole discretion. You may also choose to end the interview at any point at your sole discretion.

Please feel free to call me (01483 87 69 31) or one of the support groups, whose details are provided below, after the interview, if any doubt or issues arise at a later stage.

Details of support services

MS Helpline............................................................telephone no. 0808 800 8000
500
8000

MS Telephone Counselling Service..............................telephone no. 0171 222 3123

SPOD
(Association to aid the sexual and personal relationships of people with a disability)

address: 286 Camden Road
London N7 0BJ

telephone no.: 0171 607 8851

UKCP
(United Kingdom Council for Psychotherapy)

address: 167-169 Great Portland Street
London W1N 5FB

telephone no.: 0171 436 3002

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APPENDIX 5

RESEARCH CONSENT FORM

Title of project: Developmental experiences of persons with MS
Organisation: University of Surrey
Investigator: Maria Caltagirone
Telephone contact number: 01483 87 69 31
Supervisor: Ricardo Draghi-Lorenz

Outline Explanation
This research seeks to investigate the relationship experiences of persons with multiple sclerosis. A particular focus of the interview study is to explore the association between your early relational experiences and your present emotional and interpersonal wellbeing.

You will be asked to take part in an informal interview about your thoughts and feelings on the above subject. The interview will be recorded on audio tape to enable the author to directly quote your responses when writing the research paper. In order to ensure confidentiality, your name will not appear on the transcript and the audio-tapes will be destroyed before any coding of the analysis begins. Some of your responses may be reproduced in the final report but at no time will your name be identifiable. I will also delete the names of other people or places that may arise in the interview.

You may withdraw from the investigation at any stage without giving a reason for doing so and this will in no way affect the care you receive as a patient.

Please read the following paragraph, and if you are in agreement, kindly sign where indicated.

I agree that the purposes of this research and what my participation in it would entail have been clearly explained to me in a manner that I understand. Any questions I wished to ask have been answered to my satisfaction. I therefore consent to be interviewed about my relational experiences. I also consent to an audio-tape of this discussion and its subsequent transcription for the purposes of this research.

Signed.................................................. Date.......................
(participant’s signature)

Please print name..............................................................

On behalf of all those involved in this research, I undertake that confidentiality will be ensured in respect of the audio tapes and any transcription of same made with the above participant. I also undertake that any use of the audio tapes or transcribed material will be for the purposes of research only. The anonymity of the above participant will be protected throughout.

Signed.................................................. Date....................... 
(researcher’s signature)

Signed.................................................. Date....................... 
(witness’s signature) 

Please print name..............................................................

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APPENDIX 6

DEMOGRAPHIC QUESTIONNAIRE FORM

1. Age: ________________ YEARS (please state)

2. Sex: MALE or FEMALE (please circle)

3. Marital status: MARRIED or SINGLE (please circle)
   OTHER___________________________ (please specify)

4. Which of the ethnic groups listed below would you say you belong to?
   (please tick the appropriate answer)

   White __
   Black - Caribbean __
   Black - African __
   Indian __
   Pakistani __
   Bangladeshi __
   Chinese __

   Other: ____________________________ (please specify)

5) What type of MS do you have?

__________________________________________ (please specify)

6) How long has it been since you were diagnosed with MS? ______ YEARS
   (please state)

7) How long have you felt like you have had symptoms of MS? ______ YEARS
   (please state)
APPENDIX 7

INTERVIEW GUIDE

Explanations to interviewee

Remarks for the interviewer

Main questions

Continuation questions

Probes and prompts to be used with the questions:
  - What makes you say that?
  - Can you tell me more about that?
  - Could you give me an example(s) of that?
  - What effect has this had on you?

This interview guide outlines a semi-structured format. It is intended that all main questions (bold type) will be asked and that continuation ones (underlined) and probes will be asked only when replies to main questions would laconic. It is possible that participant’s material may make some questions redundant. In such case, the questions will be either eschewed or reformulated in an attempt to elicit more information.

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

I. INTRODUCTION

I would like to begin by thanking you for your participation.

Have you done anything like this before?

If so, what?

If so, what was it like for you?

How do you feel about being here with me?
II. CHILDHOOD EMOTIONAL ENVIRONMENT

As this research is about your relationship experiences, from childhood to the present day, and their impact on your present wellbeing, I’d like to begin by getting a sense of your early relationship experiences.

Can you tell me something about your early childhood?

How did you get along with your mother?
How would you describe her?
Are there any aspects about her that stand out?
What did you like most about her during your childhood?
What did you find most difficult about her during your childhood?
How did you get along with your father?
How would you describe him?
Are there any aspects about him that stand out?
What did you like most about him during your childhood?
What did you find most difficult about him during your childhood?
Who do you consider yourself most similar to, your mother or father?

If appropriate What are your relations like with your parents today?

III. EARLY EXPERIENCE OF SELF AND OTHERS OR ABSENCE THEREOF

Were you an only child?
If so, what was that like for you?
If not, what was your experience with your siblings like?

If only one other, How would you compare yourself to him/her?

If more than one other, Was there one you got along with better than others?
Why do you think that was so?
How would you compare yourself to him/her?

If appropriate How would you compare yourself to the others?

If appropriate What are your relations like with your siblings today?

IV. ONGOING RELATIONAL EXPERIENCE
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What are the aspects that you most value in your others?

What makes you happy?

What are the aspects that you find most difficult to cope with in others?

What makes you sad?

What do you do when you feel sad?

What makes you angry?

What do you do when you feel angry?

If appropriate, what would you say are the aspects that you most value in your partner/spouse?

If appropriate, what would you say are the aspects that are most difficult for you to cope with in your partner/spouse?

IV. CIRCUMSTANCES RELATED TO ILLNESS

Maybe we could start by you giving me an idea about what was going on in your life when you experienced the first symptoms of MS. At what point in your life did you feel things were not quite right?

Do you recall the events/circumstances that were taking place?

Can you tell me a little bit about what the first symptoms were like?

How did you react to the diagnosis?

How easy do you find it to ask others for help when in difficulty?

Has the MS made it harder for you to ask for help? (when you're really ill, do you feel like you're asking for too much of others?)

Do you receive any specialist help?

If so, is it easier for you to accept help from strangers than people you know?

Have your relationships with friends and family changed since the onset of your illness?

If so, how have they changed?

If so, how has this made you feel?

How have you reacted?

VI. EXPERIENCE WITH THERAPY

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VI. EXPERIENCE WITH THERAPY

As you know this research is part of my doctoral course in psychotherapeutic and counselling psychology. By therapy, I refer to any form of psychological help, counselling, or talking with someone who is a professional or volunteer rather than a personal acquaintance.

Have you had any therapy?

If so, What kind?

If so, How useful did you find it?

In what ways do you think you most benefited by it?

If not, Did you ever consider going for therapy?

Why didn’t you?

VII. ENDING

You’ve covered all my questions and I am wondering whether there is anything else you would like to talk about or that you think I should be aware of?

Thank you for your participation. I hope you have enjoyed the interview.
APPENDIX 8

SAMPLE INTERVIEW

I am wondering whether you have done something like this before?
With an MS dimension or have I participated in research projects?
Have you participated in an interview based research project?
Yes.
What was it like for you?
It was interesting and I have also conducted research projects myself so I have been on both sides of the fence so to speak. I found both delivery and being on the receiving end valuable; it is a valuable sort of learning experience from both sides. My particular interest in talking to you today is because you are obviously conducting research into a condition which is very important to me. It gets my mind thinking again and it gets me thinking about issues and things I wouldn't necessarily explore on my own.
Do you have any idea of what those issues might be?
Yes I do. One I hinted at a moment ago is that I am interested in exploring alternative remedies to this condition; a) curing it or at least minimising the effects of it, that is part of it. I also have an interest in research in those areas. I think that those are the main issues I am looking for.
How do you feel about being here with me?
No problem at all. In fact I welcome your participation.
As you know from the letter, the research is about the relationship experiences of people with MS from childhood to the present day and their impact on their present wellbeing. I think to start out with, I would like to get a sense of what your childhood was like?
It was not the most pleasant I would say. I had a very violent father, who died twenty odd years ago, a loving mother, but a very aggressive, violent father. I think that sort of made me - I wasn't forward myself; I didn't present myself as well. I always stayed in the background in situations because I was afraid of upsetting my father or whatever it was. For example, I eventually moved into management consultancy, therefore I was having to be in the situation whereby I was taking charge of situations and having to speak up for myself and this, that and the other. I found that initially very very difficult. I was OK with the desk based work and the research and all this sort of thing, but in terms of communicating with people and relating, I found that very difficult. I am convinced that this goes all the way back to my childhood days to the influence my father had on me. I don't credit him with being very positively influential in my upbringing.
Was he always violent or were there particular things that made him violent?
I think that a lot of it was alcohol induced. I also think that he was like a square peg in a round hole. He was a very intelligent man, but was doing jobs that didn't sort of match - he was doing very sort of low level type jobs and I think he was intellectually capable of better. He was working behind bars and all sorts of things and doing door to door salesman stuff. I don't think that was really - he was capable of a lot better. I think that there was a lot of
I don't think that was really - he was capable of a lot better. I think that there was a lot of frustration in his life which was met through alcohol, violence, whatever, socialising.

**What was your parents' relationship like?**

Well again, my mother I think bore the brunt of a lot of my father's violence, not on a daily basis, but as and when every couple of weeks or whatever.

**What would happen when he would become violent?**

Well often he would take it out on my mother over some sort of petty thing. Like, it is hard to remember now - silly, petty things. If he had been out drinking then that really exacerbated the situation and you could sort of smell trouble in the air. If myself or my younger brother we had actually done something out of the ordinary or something he didn't agree with, then we would feel the brunt of his violence.

**What do you mean by feeling the brunt? Does it mean that you would feel guilty or that he would hit on you?**

He would hit, yes. I can count on the fingers of one hand moments of softness or gentleness or love from my father. I remember one instance particularly when I did see the other side of him then and I thought he was quite bright actually. Myself and my brother were playing out in the garden and I had a ......something I picked up outside and I threw it at my brother and it caught him in the eye and it bled profusely. He had to be taken to hospital; he didn't lose his eye thank God, but I felt really cut up against it. I don't know whether it was guilt or what I had done to my brother or afraid of what my father would say when he got back home from work that day. When he came back that night he actually sat down next to me and put his arm round me and said "don't worry, it is an accident". That is the only time - the only incident I remember of him saying something warm or generally to see how cut up I was about it. They were few and far between moments like that.

**How did you feel in that moment when he was kind to you?**

First of all I felt surprised because I wasn't expecting that. I was expecting a slap around the head or you're not going out for a month, that sort of thing. I was overwhelmingly surprised by what he did. It is only now in the benefit of hindsight that I can think, hang on why did he do that; why wasn't he violent; why was he warm, perhaps there was something else going on in his mind. I think that at the time my feelings were of surprised and certainly when I subsequently analysed it and thought out about why he behaved as he did, that I have tried to make sense of it.

**What do you think now?**

In the same way, I think going back to what I said initially, I think there was a very sort of intelligent man trapped in doing a job in a life which didn't really suit him.

**Going back to that incident, when he said "it's alright". Were you then able to distinguish whether you were cut up about it because you felt guilty for what you did to your brother or because you were afraid of what your father would do?**

I think initially my main focus was on, what is my father going to say, but I think that had my brother lost his eye I would be cut up about that to this day.

**So it all resolved itself so that you were able to forget about it?**

In fact when I see my brother now, I do still talk about that.

**So it was a fundamental incident?**
Well, I say we talk about it, I mean lightheartedly.

Before we go on to talking about your brother, I am wondering - let's stay with your father. So this is what it was like when you were a child and then growing up, what happened, did the relationship change or did it always stay the same?

It has always stayed the same. I mean for my benefit I suppose, my father died when I was 17 years old. He disapproved in a number of areas because I was going out with girls and that sort of thing. If I was going out with a girl I had to report who she was, what her parents were. I had to be home at 10.00 pm at the latest so it was a cruel regime he was running up to that time. My life didn't in effect take off until my father died.

What if you said, "I don't want to answer those questions, I'll come home when I want"?

I don't think that I would have risked that because I knew my place which was to be subservient to my father. My brother felt exactly the same and it is interesting because both myself - on the day my father died I was doing his apprenticeship in XXX and I was called in the office, saying that your father; you're mother's on the phone, this, that and the other. I spoke to my mother and she told me that my father had died that day and for the first time they said they would organise a taxi to take me home. I was sitting in the back of the taxi thinking, yes, ah, release. My brother felt exactly the same. He was exactly the same and was told the same thing. He suddenly felt a great weight lifted off his shoulders.

Before we go on to what happened from there on, I would still like to stay with the past because it is very easy for me to say OK. So your father was this kind of violent, possessive, constricting person. What was your mother's role in all of this?

She was the warm loving mother that didn't really - she didn't speak for herself at all. She was the little woman in the background sort of role. She sort of bore the brunt of this and then when my brother had hit me, my brother or even her, she was the cuddle. She looked after us because my father was not a great sort of breadwinner so I suppose my mother did bring us up.

So she worked as well?

Not only did she work, but we had a big house there in XXX and she ran like a XXX. She worked during the year, but also during the summer months she would open the house as a XXX. So she was up at like 7.00 am cooking breakfast and my father would take money off her because he was socialising that night or something. So my mother did have the rough end of the deal by a long way.

As she was the caretaker and the breadwinner, did she ever contemplate separating?

Not to my knowledge, no. My mother is still alive and I think that my father is buried in XXX in...... One of her requests in her Will is that she wants to be buried with my father. I don't know why.

Have you ever asked?

Well I have explored what she wants done with her remains and this, that and the other. My mother has still got this sort of careful with money kind of attitude to life. She says I want to minimise costs, so just get me cremated and put me in your father's grave. That is a tricky one, so I have never really explored with her as much as, what is your final request, what do you want to happen to you. Maybe at the end of the day she did love him.

What is your relationship with your mother like now?

I think it is good. She doesn't know about my MS. This is an interesting one. My mother is a great worrier and she is eight-three and if she knew I had MS - occasionally she mentions about people in...... saying, he's got MS, he's in a wheelchair - so she has not got any
positive vibes about the condition at all. She has said to Jane (pseudonym) my wife, "oh John (pseudonym) is walking a bit funny today". What she has said to Jane, just before Christmas "do you think he's got what I've got". My mother has got arthritis, in fact she has got two artificial hips. Jane said, yes I think he has got a bit or arthritis.

There are two issues that come up as you were talking about this and one is that you might be afraid of hurting her to a certain extent at eighty-three about your condition. Another is that, you say that she doesn't have any positive feelings about this condition so, is it more that you don't want to be the target of her negative feelings if you tell her that you have MS. You don't want to be the target of her negative feelings if you tell her that you have MS.

Well I think that is partly true, that is right. Or even I don't want to be the target of her over the top sympathy, which she is well capable of. She is eighty-three she has got worse, but she cares for these as she calls elderly people, but she cares for this elderly chap, he is a retired XXX or something. He has gone blind and has got all sorts of problems with him. I feel so sorry for him and this, that and the other and so I will do an extra day for him cleaning. I thought God if she knew about my condition our life, myself and Jane, would be difficult in the extreme.

How so?

Well in terms of dealing with my mother's sympathy. The fact that my mother would worry herself into an early grave and I don't want to run the risk of that. As long as she thinks that I have got an arthritic hip or something, fine. If at the end of the day it did come down, touch wood, that I was more seriously disabled, then I would -

You would wait till you get there?

Absolutely right. So there is no point in saying anything to her at the moment.

I see your point. You mentioned that you have another brother - is that your only sibling?

Yes. I have got a couple of half siblings as well. I have got two elderly half-sisters because my father was married before he met my mother. Which I didn't realise - it was confusing at the time because I was like 7, 8, 9 years old and who were these people that came round and called my father, Dad. Because I was never told- hang on these are your children from your first marriage. The sisters I have got, the half-sisters who I have not seen since my father's funeral twenty-five years ago, we were not actually close. That came as another shock at 7,8,9, especially when they turned up with their son who called me Uncle John - who was this. Hang on, there's a little lad here, not much older than me who is calling me Uncle John, I don't understand this.

How did you find out?

I think by - the penny started to drop. Hang on there is something wrong here, so as I was getting older - because they only came around once a year or something anyway to see my father. There is something not right here, the penny is starting to drop. It wasn't until my father died, so we were late teens, I think that the question was was posed to my mother indirectly saying, so that is father's first wife or father's -XXX and his daughters. They are not in my thoughts on a daily basis -

Were you angry at your parents for not telling you?

No, no not angry, I was frustrated, that was with hindsight. I was not angry because at that age I didn't know anything - what is a half-sister. We didn't have a relationship so -

What was your relationship like with your brother?
Very good, well in fact it is an interesting story because my brother he dropped out of the family a few years ago because he got married and went to live in XXX where he had four children with this women. Eventually they split up and moved out and he teamed up with another girl. He was essentially ostracised by the family and self-ostracised as well because he realised what he had done -

*What to split up with his wife?*

And deserting her with four children, one of which was two and the eldest was thirteen, fourteen and disappearing which was, as he recognises now, was not a good thing to do. He therefore moved out of my mother's and my life for two years and moved house and everything. His first wife, to her credit, said "I'm not bringing up four children on my own" and she went out and found another man and was divorced one week and married again two weeks later. My ........ has only come back into our lives just before Christmas after a two year break because he has been out of reckoning for ten years, suddenly he came back in. he did come back in because my mother said, "I've got to be in contact with Daniel (pseudonym), we've got to get in contact with Daniel again before I don't know how long I have got -". Again it is my mother worrying herself into an early grave. Jane, to her credit, she started hunting around for the best way to find him. We knew that he was in the XXX area and he had moved to an XXX company. She phoned around every insurance company in the area and Daniel Jones (pseudonym), as you can appreciate, is a very common name. She phoned up XXX Borough Council and they said we have got nine Daniel Jones on our register and we can't give you the names and addresses of the people there. They said get your husband to write a letter to Daniel and we will send it to all these people. I did nine copies of the letter and they sent it to nine Daniel Jones' saying to John that he must get in touch with his mother. To cut a long story short, if you have not heard from Daniel within a fortnight, I will ring back again to let you know ... get in touch because I have been saying it to him for ages. The next day my brother Daniel phoned up saying "it's Daniel here". So the relationship has blossomed since then.

*What was it like when you were kids?*

It was always very good. We were always very close as children I suppose. Certainly in the early part of the teenage years we were and in late teens you know I was drawn to my group of friends as he was to his, but still we used to do things together.

*And he was younger than you?*

By eighteen months.

Very close.

I always had a good relationship with my brother.

*Tell me something. You mention that it was after your father died that your life began. Can you describe that to me a bit.*

It is the freedom for both myself and my brother, we suddenly had this new-found freedom. We were responsible for what we wanted to do. Also my mother because she was a quiet, sitting in the background sort of a person, was not going to take on my father's role. Interesting enough the day we heard that my father had died, myself and my brother went out to the local pub just to - I don't know was it to celebrate, to commiserate, I don't know. Anyway we were down the pub the day my father died, just sharing a drink with each other. Just to say life kicks off from here on in. So I suppose, the sense of freedom and the ability to take charge of what we were going to do with the rest of our lives.

*So it was like the feeling that you had weathered through a bad storm?*

Yes, it was.

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I was wondering what was happening in your life when you experienced the first symptoms of MS?

I was down in London then because I was twenty four, twenty five years and I was living in XXX. I remember going to the doctor because I had this odd sensation in my fingers. The doctor gave me lots of tests and pricked me with pins and needles and didn't make any connection with MS and said it could be heart flutter something like this. That passed and then the next thing, seven eight years later-

How old were you then?

Thirty something like that, thirty-two. I was living in XXX and I lost my sight in one eye and I went to XXX Hospital and I said I was losing sight in one eye. It was diagnosed as optical neuritis and I always remember there was a specialist there and an African doctor. I remember that the two of them, after they had both seen me, this consultant said to the African doctor he said, you've got it, yes that's it, you've got it. The penny didn't really drop and they took me to one side and said, don't worry it is going to clear up, give it a month or this that and the other and it did. I still look back in my mind thinking, I mentioned this to the neurologist the other week, whether or not the connection was made at that time or not. I know that optical neuritis can be indicative of MS. I don't know whether the connection was made then, but it is always in the back of my mind. That was the next time and this optical neuritis did clear up and I have never had any problems with it since. Even though in my right eye - the right side of my body is not as strong. My right eye is not as strong as my left eye.

What was going on in your life in terms of work, relationships. What was the background?

Work wise. I'll tell you what was going on in my life. It was quite a happy time work wise. I was working for the XXX, about time. I was with them for six years and in the end - I was an XXX consultant, but the XXX in its wisdom decided that it was going to dispense with an XXX service and therefore was going to take its requirement for any consultancy effort from the wider world. I was offered redeployment in the XXX which I took in the end and I became a XXX at the XXX for eighteen months. I was still effectively redundant; I had an eighteen month ....see whether you like it; I changed jobs twice in XXX whilst I was there. In the back of my mind I always wanted to go to university to do an XXX, but if I had six months more service under my belt my tuition fees for the year would be paid for. So I had a word with the senior personnel chap there and he said, we can keep you on for six months, all credit to the XXX, they did. So I left on very amicable terms. So I enjoyed my time with the XXX. I was quite sorry to leave, but I was pleased to be doing this course for twelve months. I suppose work wise, after the XXX, after my XXX - I started hunting around and thinking, what am I going to do with my new found ammunition. I found this small management consultancy practice in the City and I was with them for five years, but that was a stressful time; a)because they were small and b)because it is a bewildered management consultancy in the wider world? - it was chalk and cheese compared to what I was doing internally. At the end of the day if you don't deliver in the outside world, if there is no money coming in, you don't have your clients - I don't know, there is a lot more pressure which I found. There were periods there when there wasn't work coming in and the consultancy did go through a couple of bad times. That frustration manifested itself in all the consultants working there. So, yes - I enjoyed the actual consultancy work when I was doing it out and about and I saw people here, there and everywhere, but there were a couple of things I took to and didn't take to as easily. For example I found that I related more to people doing the core face jobs. If I was going in there and doing a piece of work - if I was selling myself, talking to senior directors and managers, I felt a bit out of my depth. This again is going back to where my father's influence affected me. If I was doing presentations, I felt that I was keeping myself in the background, wasn't selling myself well. So I found that really difficult, having said that, I found it easier as time went on.

How did it impact on your working colleagues; your reluctance to come forward?
That is interesting because - I think that colleagues were surprised because in the small confines of the office situation and away from the clients premises, I was very project managing which I found easy. Colleagues were taken aback a bit when I was pushed to the front and faced with senior directors and big organisations in the XXX; "hang on, I thought you just said something John, I thought you were doing this -". I was very slow at coming forward.

*How did that make you feel about yourself?*

It made me feel - I suppose I made excuses for it or rather I blamed my father.

*So you were aware of it then?*

Yes, that he had a lot to answer for here because he is like, in terms of my own self-esteem, my father knocked that on the head at a very early stage, so I have had to struggle with that I think. As I said, my experiences in the wider world have got better. In fact now, taking it up to the present day, firstly I still do a bit of consultancy work as an independent management consultant. Secondly I do two days a week at the XXX. I am still going through a training programme at the moment. The tutor said to me on a number of occasions that - I am still going through observed interview situations - I have someone come to the door with a particular problem -. She says you get on very well with people who come to the door, you get to the problem, you get a report as clients come in. I was aware that I did and I have done for a long time. I do make people feel at ease with themselves and this, that and the other, no problems there. But, having said that - as I said I do some consultancy work as well. A little while ago I did a sort of presentation to a major accounting body in the XXX and I didn't find that a problem at all.

*So what do you find a problem now?*

Well I think things that are MS related which are mobility or if I have to go up to the XXX or something like that. I have got to plan in advance how to get there and how I'm going to do this; how I'm not going to tire myself out.

*You are able to come forward with people now in a way which you weren't able to before?*

Yes.

*What do you think caused the change?*

I think that it is being forced into the situation there, a)for example, because I have been in work situations that - would you believe it, when I first came to London I worked for the XXX and I was a representative there. I am surprised they didn't lose more members because I wasn't pushing forward people's situations, cases whatever. I was very much stuck behind in a meeting, but I didn't do anything. Taking that forward now into action, I actually do conduct presentations with senior managers in prestigious bodies, that has been a very - Coming back to your question - what caused the transition. As I say, it has been like in at the deep end and having to sink or swim effectively because each bit - because my working life has moved one bit further forward. For example in my XXX work, I find that talking to people that come through the door no problem at all no matter what their particular cultural background is or whatever. I am not put off by that at all, whereas I probably would have been twenty odd years ago.

*Let's go back to twenty odd years ago because that is when you experienced the optical neuritis and you said that you had just met your wife?*

Just met; well in that timeframe, a year or so.

*How long have you been married?*
Sixteen years this year.

What would you say are the aspects about her which you value the most?

She is intellectually very bright. She is also very positive about my condition in a sense as well. She has got a very busy life as well. She likes to take over a lot of the things that I always took as being - like when we brought this kitchen...bit of help with the fridge as well. In fact yesterday she was busy tiling the place -

It looks very pretty.

This is all down to Jane, my wife. So, yes, Jane will not be defeated by anything and she is very - it is not just me as well Jane has a caring attitude towards friends and family. I credit Jane a lot.

What are the aspects that you find difficult about her?

I don't know if it is difficult with Jane or whether - I find it frustrating sometimes the way that Jane has taken over a lot of my sort of traditional male roles if you like. That is not really a criticism of Jane, that is more frustration at myself, with myself and my situation. I suppose that is me coming to terms with that.

How do you deal with that frustration?

Again I don't think that I am .......because - how do I deal with it, I keep out of the way effectively, but then I feel frustrated because I'm not doing something, making endless cups of tea for her or something like this - I don't know. I am not sure that I have happily resolved it.

So you are saying that you either withdraw or you become overly responsive to what you perceive are her needs?

Yes, I think that is right.

Do you ever get angry?

Very, very occasionally and I'll tell you why, it is because Jane will occasionally get angry with me because I haven't done something - not done something around the house, but done something regarding my condition - that I have not contacted this person or I have not done this. Talking about mercury fillings and stuff like that - "have you not phoned those people up yet, have you done this" no, I haven't done that yet because it was engaged, so she will pick the phone up and do the dialling and get through. She says that I don't take responsibility for my condition as much as I should do. I think she has got a fair point there because my wife has taken over a large responsibility for my condition if you like. Yesterday she was frustrated at something I had not done and I just found myself reacting, just anger-

What form did that anger take when you say reacting?

Well just a bit of abuse, saying "the reason I didn't do this, is because I can't do this, you would know if you had this bloody condition -" that is how my anger manifests itself, but it doesn't happen that often.

When you say that you withdraw when you feel frustrated, is it a similar withdrawal to the way you reacted with your father?

I don't know if it is. The reason why I can't give a 100% honest answer to that is that there is fatigue as a feature of the MS condition. So I don't know how much my wife busying herself I find sort of tiring, I find it intellectually tiring as well; having to think about why
I'm not doing what I should be doing. Therefore I find that a bit gruelling and tiring in its own way, therefore I don't know whether or not I had MS when my father was around.

**What makes you come up with that thought?**

Well because with the seeds sown of MS; it depends how you think of MS as a condition because I have said for many years that it is a viral problem, condition, therefore were the seeds sown at birth. So there is - I don't know -

**This is interesting because you are saying that you have always maintained that it is a viral condition, but at the same time what you are saying to me here is not, well I might have had it at birth. You are saying that, but you are also saying maybe it is something which is related to my father?**

I have sort of painted myself in a corner a bit here, but I take the point - It is like viewing the things completely separate, like my father, my fatigue and my anger today - I think that the only way that I can view them is as two separate incidents - because I don't know whether they just fall nicely into place in my life span time frame? ........my MS and my father, the seeds were sown in those early days, the seeds eventually the viral condition did manifest itself later on in life, but it didn't cause a problem in my father's day. There were other things going on I think like, as we said, my father's situation, his life, his career, his intellect and how he got round his frustration, ie by thumping my mother and his children. I have heard it said that when you come from abusive parents in your background you can go one of two ways. You either become aggressive or violent or you become a passive sort of person; I think that I have. I think that anger and aggression is not really part of my makeup, as it isn't with my brother either.

**But when you say that maybe the seeds were sown then, how do you think they may have been sown?**

I meant genetically or the -

**So you are saying that maybe the seeds were sewn then genetically, but it didn't manifest itself then, came out later, so you don't know whether your withdrawal with your father is connected with your withdrawal now which is related to fatigue.**

Yes, I'm searching around. I know that we have touched on this a little bit because you were saying in your relationship with your wife how roles have changed because of the MS, but I am wondering whether you would like to add anything to that in terms of how your relationship with friends and family has changed since your condition?

There seems to be more sympathy for me which I sometimes find difficult because when I go out with Jane and her friends this sort of thing, there seems to be too much care for my sort of situation and wellbeing and you know - sitting around somewhere or going out for a meal - "do you want to sit here John, is it alright for you?", "thank you very much ". In some way that jars. You could say that I am not taking responsibility because yes, I do want to stay here because, yes, it is handy for me, I can stretch my legs or whatever. Being directed, showing too much care for my situation I find sometimes that is tricky, awkward.

**But at the same time when you do need help, how easy is it to ask for help?**

It is easy now. Initially I found it difficult, but then again it was needs must I think because I have a flight of stairs to get up and no hand rail. I had to lean on somebody's shoulder or something like that. I don't find that difficult now if I need someone to hold the door open for me or something like that, I'll ask. That is not as much of a problem as it was initially.

**Initially how would you feel?**
As I said, it is like initially I felt that my power had been taken away from me and I felt beholden to other people which I never have been all my life.

But didn't you not feel, with your father that your power had been taken away from you?

Yes indeed, but as I said my life didn't really take off until seventeen and since then I have taken control of my life and this, that and the other. I had left home at age twenty-two from XXX (turn tape)

- stranger for help, rather than someone you knew?

Yes I think it is.

I think that you have addressed most of my issues in a very insightful way. Before the end, because I am a counselling psychologist, I am interested in whether you have ever had any psychotherapy or counselling?

No.

Would you consider going for it at any time; is it something that has crossed your mind?

I'll tell you why it hasn't crossed my mind; it hasn't because I don't think I appreciate fully the benefits of - in my situation, the benefit for me of actually going to a formal counselling session because I am not convinced that it would take me further forward psychologically. So I am not convinced by the wisdom of actually engaging in that.

Do you find it relieving to kind of talk as we did today?

Yes, yes.

I take your point that you are not sure what benefits - I think that you have covered all the issues, but I wonder if you would like to add anything at all that maybe I haven't covered and you thought I would?

......just a quick run through of my life, my situation; job wise, family wise. I don't really think that there are aspects that were not explored in any depth or were. There are a couple of issues which I thought that you might have picked up on, not picked up on, but explored in more depth. For example my - it's something that I've been thinking about lately - my half-sisters, should I find out more about them, should I make some sort of progress down the road of getting to know them; would they want to know me?

Is it something that you feel guilty about?

It is more curiosity than anything. Because we are related so - is that a part of the jigsaw to put in place-

You are saying, to come to terms with?

Yes, because - I don't -

What do you feel?

What do I feel about the whole sisters situation - I feel like it is probably best served with a let sleeping dogs lie situation because would I be opening a can of worms, for them, particular for me. So OK this is my half-sister, what has she done for the past thirty years and big deal. So how has my life or their life moved any further forward. I don't think it probably has, so let sleeping dogs lie. So that is what I am feeling, that niggling sort of should I perhaps or am I doing them a disservice. Is it incumbent upon me to take things forward and take the initiative and move things forward. There is a little hint of frustration
there, but I have always consoled myself in the fact that, let sleeping dogs lie. I will keep you posted on that one. One other thing that I'll mention now is sport has always been a significant part of my life and it is interesting actually because the day I was officially told that I had this condition, popularly known as MS, the next week I went out and ran the Snowdon Marathon within weeks - which is why the significance of the MS condition was lost on me at that stage. I have just run the Snowdon Marathon so it is obviously not a problem. So what have I done - obviously that was the last major marathon seven years ago. I used to do a lot of marathon running, football and cricket and all sorts of things. Effectively the sporting side of my life has been removed. So I have had to move it into other areas; what have I done? I have started writing and I read more; I am just moving things forward more.

You have changed your hobbies?

Yes, I have changed my hobbies. That was I suppose in theory a difficult thing to do. To give up sport is such a major feature - I used to go running every night and soccer - suddenly your interests in life are not going to be physical they are going to be intellectual from here on in. I am surprised actually that I found that very easy to give up or come to terms with. I thought it would be trickier. How do I feel if I see someone outside running past outside the house and I always console myself with; yes, been there, done that. So I don't get this feeling of frustration, that could be me-

You have a positive way of coping with it.

Hopefully. There is the odd moment when I feel it is frustrating, but generally speaking I feel that I have coped well with it.

That is definitely what your account implies.
NOTES FOR CONTRIBUTORS (ENGLISH)

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