A Portfolio of
Academic, Therapeutic Practice and Research Work

including a research report on

Developing a questionnaire to identify the possible need for preventative psychotherapeutic intervention during pregnancy

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This portfolio is dedicated to my father, MERVYN POTTER (24.10.1942 - 04.10.90) a truly great man, without whom none of this would have been possible.
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Introduction to the Portfolio

This portfolio represents a selection of work undertaken during training for the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey between September 1997 and September 2000. It contains three dossiers: Academic, Therapeutic Practice and Research.

The Academic Dossier contains papers concerning the theoretical underpinnings of Counselling Psychology, which arise from the following courses: Theoretical Models of Therapy, Advanced Theory and Therapy and Issues in Counselling Psychology.

The Therapeutic Practice Dossier contains descriptions of the three clinical placements and a personal account of integrating theory, research and practice.

The Research Dossier contains three research papers: a literature review and two empirical studies.
Academic Dossier
Introduction to the Academic Dossier

The academic dossier comprises four papers selected from work submitted for the following courses: Theoretical Models of Therapy, Advanced Theory and Therapy, Year 3 Options, Context of Counselling Psychology and Issues in Counselling Psychology. Three papers concern the contributions of theoretical models of therapy to therapeutic practice, particularly psychoanalytic and cognitive-behavioural approaches. The fourth paper concerns ethical issues about working with suicidal clients.
Describe and evaluate the work of one psychoanalytic theorist and illustrate the usefulness of his / her ideas for your own therapeutic practice.

This paper will discuss the work of Heinz Kohut (1913 – 1981). Kohut represents an important and necessary challenge to the discipline of psychoanalysis that was dominated by one man’s ideas. Though initially careful to insist that his theories were building on Freud’s, eventual expulsion from the psychoanalytic community and a terminal illness accorded Kohut the freedom that enabled him to develop into a polemical theoretician and reflexive practitioner. The presence of healthy internal challenging is necessary to any discipline that wishes to evolve and mature. Indeed evolving dynamics are central to Kohut’s hopeful and humanistic vision of the self. Kohut’s pioneering contribution to the practice and theory of psychoanalysis will be outlined and evaluated.

Kohut’s theories developed out of a classical Freudian psychoanalytical training and reflected a growing dissatisfaction with the limitations of the application of the classical theories to therapeutic practice. Kohut (1978) came to view classical psychoanalytic theories as experience-distant because of their apparent lack of concern with the individual patient’s subjective experience and over-concern with the perpetuation and maintenance of preconceived theories. He abandoned such rigidity for a more flexible experience-near approach. He ceased to explain away his patients’ denial of his interpretations as resistance, prioritising the importance of an open and empathic listening style in order to actually hear what the patient was saying. The aim of therapeutic practice was not to fit patients into rigid theories, but to reach an empathic understanding of the patient, out of which new theories could be formulated thus allowing psychoanalysis to continue to develop rather than to dictate and restrict. Empathy was regarded as the principle data-gathering tool available to practising psychoanalysts, and as an absolute pre-requisite for therapy. Indeed, Kohut has been accredited with bringing Psychoanalysis and Humanism together (Kahn 1997). This
requirement of the therapist to express their humanity and openness and to regard clients as experts on themselves is a crucial contribution to psychoanalysis. It encompasses a necessary power shift from therapist to client and promotes empowerment of the client and not defended, impenetrable, omnipotent status of the practitioner.

Kohut’s principle interests were metapsychology, narcissism and the method of investigation in psychoanalysis and during the 1960s he published several important papers on these subjects. He hypothesised that psychopathological development was a consequence of childhood trauma, which he described as overstimulation of affect (1963). Kohut argued that when frustrations of traumatic intensity are experienced, needs are shut off into the repository of the unconscious because of the anxiety and despair associated with them. Therapy could provide a safe setting for such childhood frustrations to be reworked, creating an opportunity for psychic structures to be built. These structures serve to neutralise such frustrations and therefore render them manageable. Hence psychoanalysis must aim to therapeutically revive and recover memories of traumatic experiences from the unconscious.

Accordingly, it was necessary to understand how and why such frustrations occur. Kohut found that his patients would not readily (or happily) fit into the inflexible, classical developmental theory centred on Freud’s sexuality/aggression drive-theory and the Oedipal Complex. In 1966, he challenged the centrality of the Oedipal Complex in the development of narcissistically disordered personalities. An alternative selfpsychology developmental theory was proposed, in which the self was conceptualised as a permanent but dynamic part of the personality, having three fundamental narcissistic needs: called mirroring, idealisation and twinship needs. These must firstly be satisfied by selfobjects in the environment in order that the individual may learn to satisfy them herself. Hence everyone needs someone who will affirm their existence and value as a person by being their mirror, someone who they can idealise and draw strength from or someone whom they feel is like them in some important way. Selfobjects, usually the parents, respond empathically to the child’s needs fulfilling soothing, tension-regulating and adaptive needs, and are experienced as
part of the self. Psychological structures, which take over these functions, are built following *optimal frustration* (explained below) with, and gradual withdrawal of, selfobjects. This process is termed *transmuting internalization*. An individual with a healthy self exhibits high self-esteem, is guided by a system of values and ambitions and will have the self-confidence to continue to develop and move towards reaching one’s full potential.

Moving away from Freud, Kohut outlined his alternative line of development - initially for narcissistic self-disorders. Later, identification of narcissistic needs, of a lesser or greater extent, in all individuals led to a more general application and a depathologising of narcissism. Kohut described narcissism as the libidinal investment in the self and saw it as arising from an early unconscious attempt to maintain the original perfection of the infant’s blissful, narcissistic state, which is disrupted by the mother’s inevitable failure to consistently meet the needs of the infant. Thus greater emphasis was placed on the individual’s external environment than had previously been considered in Freud’s intrapsychic theories. Kohut postulated that narcissism develops into the configurations of the *idealised parental imago* (the external perfect other with whom union is sought) and the *narcissistic self* (the internal perfect self who craves adoration: later to be called the *grandiose self*, 1968).

A therapeutic relationship could facilitate the communication and identification of patients’ outstanding developmental needs that had not been satisfied during childhood, via the *selfobject transferences*. Kohut described the *idealising* and *mirror transferences* in 1971, and added the *twinship* or *alter ego* transference in 1984. Empathy is the therapist’s most important tool in establishing a facilitating alliance with the client. If the therapist is able to successfully communicate their desire to empathically understand the client, a new opportunity for building the necessary structures, not built during childhood development, is created. In this way the therapist may become a selfobject of the client (1978).

The *idealised parental imago* is the child’s attempt to preserve the parental perfection, lost as a consequence of unavoidable disappointments in the carer’s qualities. When the
disappointments are not too traumatic or too frequent, *optimal frustration* occurs which allows the idealisation to be internalised and reintegrated into the superego and contributes to the formation of *ideals*, controlling of impulses and self-soothing.

The differences between childhood experiences of traumatic and optimal frustration are differences in degree. It is the difference between one mother’s harsh ‘N-O!’ and another’s kindly ‘no’. It is the difference between a frightening kind of prohibition, on the one hand, and an educational experience on the other. (Kohut and Seitz 1963, p 369)

Trauma obstructs reintegration and union, and causes the fragmented individual to search for an idealised omniscient object with whom to merge and thus experience the feelings of contentment, strength and wholeness, required for the self to develop fully. As illustrated, Kohut acknowledged the influential role that parents play in the formation of the self, and took into account varied parenting styles and responses. This is, in itself, an important progression from the uni-dimensional developmental approach assumed in more traditional psychoanalytic theories towards intersubjectivity, which emphasises the individual’s co-existential nature.

The *narcissistic self’s* exhibitionism is an attempt to be affirmatively viewed, as it views the idealised other, with admiration and respect: “*the child needs the gleam in the mother’s eye*” (Kohut 1966, p.252). This quotation describes more generally the need that each individual, throughout life, has to be valued and affirmed by an emotionally-invested external other, a process Kohut called *mirroring*. Again, severe trauma arrests the development of this structure, prevents its integration into the personality and perpetuates its archaic demands, which results in vulnerability of the self. This configuration is closely related to the drives and their tensions, and, under the control of the adult personality, contributes to the formation of *ambitions*. Kohut later described the ‘bipolar self’, which is led by ideals and pushed by ambitions (1977). However it seems that this theory was influenced by the very external scientific influences that Kohut criticised Freud for drawing from and trying to imitate. It is
disputable as to whether this is one of Kohut's major theoretical contributions as it could be construed as a confusing contradiction to his call for 'experience-near' theories gathered via the tool of empathy. As such the 'bipolar' theory will not be discussed at length here.

Kohut thus claimed that narcissistic needs must be satisfied if the self is to achieve its full potential. This is an optimistic view of the person reminiscent of the humanists, particularly Maslow's Hierarchy of Needs (1954). The judgmental, classical, psychoanalytic objective of replacing narcissism with object love was criticised for being motivated primarily by the interests of society and not by the needs of the individual. Kohut argued that therapy would be better geared towards the reshaping and integration of primitive narcissistic structures into the more mature forms of creativity, transience, empathy, humour and wisdom (1966). In order that narcissistic structures in disordered states be reordered and integrated into the personality, and that permanent psychic structures be built, the therapist must consider two fundamental questions: (1) what was it that the patient did not get from her parents? and (2) what could a therapist do about it? (Kahn 1997). This kind of straightforward fundamental approach to questioning and planning has been extremely useful to my work as a therapist, particularly when working within a time-limited approach, as it aids clear focus.

It is my experience that, certainly in brief therapy, the idealising need is the easiest to therapeutically reactivate, possibly because of the presence of positive transference involving idealisation of the therapist's role. Some traditional psychoanalysts may view clients' open expressions of gratitude and interest as such a transference distortion, or as resistance and therefore something to be broken through or deterred. But Kohut taught that such expressions should be treated with interest and respect, as evidence that, because of the continuing development of the self, the patient is still hopeful that his unmet needs will be finally satisfied.

As a trainee I was unsure of how to react to Ms D's overt gratitude. As a therapist, I felt that I should be deflecting compliments because of my value-laden hypothesis that
ulterior motives, such as not wanting to own the responsibility for her own success in controlling and overcoming debilitating panic attacks, motivated her overt gratitude. Fear of encouraging dependency and stepping onto the pedestal of omniscient helper abounded. However, as a person, it seemed perfectly reasonable to me that this client would be extremely pleased with our progress and I believed that rejecting her would achieve little more than hurting her and creating a distance within our relationship. Furthermore, it seemed likely that Ms D’s need to idealise and draw strength from a strong and confident selfobject, had not been met by her hypochondriacal mother, who was unable to accept and work with her existential fears in a calm, panic-free way. Had I not been able to accept Ms D’s need to idealise me, an opportunity to develop internal self-soothing and calming structures (transmuting internalisations) would have been denied and rather than discouraging dependency, this may have perpetuated the long-term, unmet need for external comforting.

In my own therapeutic practice, I can also identify encounters with mirror and twinship transferences. It is acceptable and reasonable to acknowledge that even as ‘mature’ adults, we all still need selfobjects. At the time someone seeks therapy, it seems likely that the therapist may be the client’s only selfobject, and the importance of the therapist’s openness and sensitivity to the client’s needs cannot be overemphasised.

An isolated and lonely Mrs K, feeling that her family did not understand her, finding her painful emotions intolerable and unacceptable, believed that she was going mad. Weeks of mirroring her in terms of affirming that, in view of her unsupportive circumstances, the way that she was feeling was completely understandable and that she had indeed displayed considerable strength in managing alone for so long, eventually resulted in a surprised “Really? I feel as if you are the only person on the same planet as me. I could hug you!”. The message to Mrs K was that it was really all right to need someone, and not that she was a failure because she had been unable to fulfil, what Kohut called, the false ‘maturity morality’ which emphasised being self-sufficient, self-reliable and self-responsible. Therapists who criticise dependency take over the roles of parents and teachers, by telling clients what they are doing wrong.
According to Kohut, this kind of victim-blaming does not encourage development but drives narcissistic needs further into the unconscious as the client is unable to trust the therapist and consequently unable to reveal their true selves.

Kohut noted that the neutrality, and often cold demure, of the classical analyst seemed to further frustrate narcissistic needs, producing inaccurate interpretations which commonly led to reactions such as rage towards the therapist (as described in *The two analyses of Mr Z*, 1979). Kohut argued that such reactions were legitimate and were a consequence of narcissistic injury encountered during therapy itself, and rather than being primary indicators of personality, actually served the much-needed purpose of protecting the self from further injury. Kohut suggested therefore that psychoanalysis spent much time dealing with secondary psychological phenomena and, because of its overriding objective of penetrating resistance, did not respect the fundamental need for protection of, and maintenance of, a cohesive and functioning self.

Kohut insisted that therapists acknowledge and express their own humanity in order to communicate their openness and willingness to empathically accept, and not to criticise. This, he believed was the only way to create an environment where hidden aspects of the self could safely surface. Therapists must abandon all defensiveness in their bid to truly understand and communicate their understanding. This can be illustrated by my experiences of working with Mr A.

Mr A had been adopted as a baby. His history was rich with frequent moves, breaks in relationships, an inability to commit personally and professionally and a tendency to diminish feelings. He communicated a strong twinship need wondering out loud about how he could know who he was, or where he was going, if he didn’t know where he had come from. He persistently questioned me about my experiences, looking for affirmation that because of common experience, I could understand. Keen not to distract from him, I did not gratify Mr A’s curiosity and at the end of one session, Mr A questioned me about my age saying he was wondering about how close to his own age someone would need to be to understand. Somewhat defensively, I interpreted Mr A's behaviour as being motivated by a need to maintain a distance between his
feelings and me. However I reflected upon my own role in producing such a reaction. I considered that if Mr A was feeling threatened at this time then I should acknowledge that and respect his need to protect himself. I did not want to be, what Kohut called, ‘an internal bull in a psychic china shop’ and so I endeavoured to communicate my openness to Mr A the following week by saying in an empathic and warm tone of voice:

_Last week when you left, I felt as if you were telling me that I wasn’t good enough to be your therapist. In light of what we’ve been discussing about your adoption and how that might influence a strong need to protect yourself, I can understand that perhaps you felt that if you rejected me first and kept me at a distance then you wouldn’t have to risk abandonment again._

I was concerned that I had not been sensitive enough to the threats that Mr A perceived to his self and hoped that through such a non-defensive, non-critical, empathic, understanding and explanatory statement that my warmth and interest would be conveyed. This was a therapeutic turning point and Mr A’s persistent curiosity about me ceased. I believe it was because even though I was unable to fulfil Mr A’s unmet twinship need, I was able to communicate my empathic understanding by way of non-defensive explanation. Kohut was careful to point out that it was not necessary to fulfil all three narcissistic needs simultaneously in order to promote psychological development.

As has been illustrated, Kohut made an incredible and welcome contribution to psychoanalysis. His theories are easily translatable into practice and the benefits of his insights, and openness to the influences of divergent schools of thought, are inestimable. His theories may lack the creativity of universal grand theories, such as Jung’s, but for the grounded practitioner who believes that therapy can be a corrective-emotional experience, Kohut offers the invaluable gifts of hope, humility and liberation. In short, he possessed the qualities of self-assuredness and humanity that permitted him to act as a real person in a real relationship. It seems that such
qualities are often underemphasised by psychoanalytic theorists but where they are evident they provide an inspiring source of energy.

References


What is the role of the psychoanalytic therapist?

The purpose of writing this paper was to survey theoretical positions concerning the activity of the psychoanalytic therapist in a bid to establish therapeutic intervention guidelines for myself. My position at the outset was one of confusion and unfortunately the research process entailed in writing this paper did not yield the clear directives that I had perhaps hoped for. This paper will therefore address the problems involved in defining the role of the psychoanalytic therapist with particular reference to the difficulties encountered in the endeavour to integrate theories whilst also selecting theoretically driven interventions which are grounded in clinically-based evidence.

Psychoanalytic theory has much to offer the student in terms of intellectual stimulation and emotional introspection. An integrative Counselling Psychology training does not favour one theorist above another and as such students are exposed to the work of its early proponents, beginning of course with Sigmund Freud, through to the more recent contributions of theorists, such as Patrick Casement. Personally, I have been enthused by the richness of the exploration of the unconscious and have energetically applied each new theory to myself. I was initially surprised that I was able to discover anecdotal validity for a multitude of supposedly conflicting conjectures evident across the range of psychoanalytic thought.

Hinshelwood (1997) discusses the changing nature of psychoanalysis and the emergence of divergent psychoanalytic thinking over the past eighty years. He states that the differences between the schools are such that the core set of psychoanalytic concepts is now limited to only the unconscious and transference. The differences between and within schools of psychoanalysis were researched by Hamilton (1996) who described them as revolving around the following concerns: (a) the concept of psychic reality and psychic truth; (b) the concept of analytic neutrality; (c) interpretation as either a hypothesis to investigate or a conclusion in the form of directive statements; and (d) the clinical applicability of the concept of the death instinct. As such work shows, the battling between theorists continues but with little
apparent movement towards the emergence of a 'best' or even 'better' theory based on clinical efficacy. Thus the validity of one theory over another is questionable.

Perhaps inevitably, my naïve enthusiasm was gradually replaced with informed confusion – how could they all be right? I expected that once I began working psychoanalytically with patients I would quickly ascertain which theories ‘worked’ and which did not. However, beginning clinical work brought the biggest dilemma so far. Despite copious reading, I had little idea of how I should be in the psychoanalytic encounter, when face-to-face with a person. The move from the theoretical to the practical was difficult to navigate for I had found value in the work of practitioners who held contradictory ideas about even the most fundamental aspects of psychotherapy. I worried that I would perform according to whomever I was reading that week and that such an inconsistent approach would not be beneficial to patients.

The psychoanalytic theorists have argued backwards and forwards about which therapeutic interventions are the most beneficial. Largely these arguments are polarised. On the one hand, the therapist is portrayed as a neutral container (for example, Bion, 1963) who offers insight through interpretations about derivatives of the unconscious revealed in free association (for example, Greenson, 1967). On the other, the therapist is regarded as a partner in a corrective emotional relationship (for example, Balint, 1952). Bateman and Holmes (1995) acknowledge the confusion about what the main task of the therapist should be in the analytic process and offer the following table of the spectrum of therapeutic interventions:

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<th>SUPPORT</th>
<th>AFFIRMATION</th>
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<tr>
<td>REASSURANCE</td>
<td>EMPATHY</td>
</tr>
<tr>
<td>ENCOURAGEMENT</td>
<td>ELABORATION</td>
</tr>
<tr>
<td>CLARIFICATION</td>
<td>CONFRONTATION</td>
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| INTERPRETATION   |              | (: 168)
It is suggested that the closer the interventions are to the interpretation end of the spectrum then the more ‘psychoanalytic’ the treatment. The interventions at the opposite end of the spectrum are more suited to humanistic psychotherapy as described by Rogers (1965) and are not generally considered to be mainstays of psychoanalytic technique. The tabulated spectrum possibly gives an exaggerated sense of agreement and division but there are many more differences in opinion at every level amongst psychoanalysts about valid technique. For example, Kleinian therapists emphasise interpretation whereas Kohutian Self-psychologists maintain that empathy is their most important therapeutic tool, but both camps gather under the umbrella of psychoanalysis.

Bateman and Holmes (1995) affirm that the dichotomy in clinical practice between interpretive work and supportive interventions is artificial and that it is the therapist’s task to ensure the correct balance. They state that in ‘reality’ all psychotherapists shift between the two despite their theoretical allegiances. Their assumption is questionable and would not be welcomed by all practitioners. The Communicative Psychoanalysts, for example, reject the “loosely defined, intuitive, and impressionistic” criteria for intervention found in “normal psychoanalysis” (Smith, 1991: 207) and list only frame management, interpretation, silence and, exceptionally, soliciting free associations, as valid interventions. Thus, in communicative practice interventions such as reflecting back and questioning are not acceptable. The therapist is consistent in her interventions and style and does not move freely or haphazardly between types of intervention according to patient or problem.

Let us now consider interpretation, for this is the most psychoanalytic of the possible interventions and, as such, could be said to be the primary activity of the psychoanalytic therapist. Alas, even those therapists who agree that interpretation is the psychoanalytic therapist’s main role do not necessarily agree about what the nature, the form and the timing of the interpretation should be. Freud (1923) heroically declared “where id was, there ego shall be” heralding interpretation as the method to make something conscious that was previously unconscious or preconscious. Freud asserted that interpretation would unveil repressed childhood
traumas and would consequently cause neurotic symptoms to disappear. The practical application of interpretation, the 'how to do it', is far less clear than the theoretical aim, for psychoanalysis has developed and diversified. Should it be, for example, an interpretation addressing the triangles of the person as theorised by Menninger (1958) and Malan (1979)? Or is an interpretation within the transference, as initially advocated by Reich (1928) and subsequently proffered by Strachey (1934), always appropriate? Is Stewart (1989) correct in the hypothesis that one should switch to extra-transferential interpretation in the case of an analytic impasse? What exactly is the correct balance between analyst-centred and patient-centred interpretations, as categorised by Steiner (1993)? And finally, how should one be during the process of doing?

The following anecdotal example will illustrate the practical problems of attempting an integration of such opposing ideas for the trainee therapist. After my first few sessions of working psychoanalytically with patients, I expressed my concern to my clinical supervisor that I felt I was trying too hard to work out interpretations and to fit narratives into theories and that this intense intellectual effort was curtailing my ability to empathise with my patients. Recognising intellectualisation to be one of my own biggest defences, I was worried that I was repeatedly valuing intellectual capability above feelings and that, of course, I would be, at best, communicating this to my patients and, at worst, passing on my own resistance. My supervisor, a Consultant Psychotherapist within the NHS (who describes himself as influenced mainly by Freud, Klein and Winnicott) frowned at my concern and replied, “I’m not sure that you’re supposed to be empathising with these people”. I challenged this viewpoint and expressed my affiliation with Kohut’s theoretical position. To this my supervisor informed me that Kohut had been contaminated by Carl Rogers. It is not difficult in this case to spot the defensive split in the feeling that Rogers was a contagious enemy and though I recognised the invested interest in protecting the profession of psychoanalysis from external attack, I was not yet a ‘fully paid-up member’. I was reluctant to simply accept the wisdom of my ‘guru’ and so I set about looking for research that supported his assumption that psychoanalysis warranted the position at the top of the psychotherapy hierarchy above person-centred therapy and
other schools of thought. I also hoped to find answers to the aforementioned questions regarding psychoanalytic technique which were not solely reliant upon expertly written, persuasive arguments that were based on conjectures but presented as science.

Many types of psychotherapy exist and they often seem to be similarly effective (Mair, 1992). Evidence of this has been growing steadily in recent years developing on from the work of Frank (1973). Frank concluded that leading theories of psychotherapy were alternative and not wholly incompatible and that it was therefore unlikely that any of them were completely wrong. He found that there were elements in psychotherapy that transcended theoretical orientation and that were also shared by all forms of healing. He describes four such components:

1. Patients feel that the therapist, whom they respect, cares about them.
2. The setting for therapy is designated as a place of healing.
3. Therapy is based on a rationale or myth which includes an explanation of illness, deviancy and normality.
4. A task or procedure is described by the therapy.

The success of psychotherapy therefore relies upon teaching patients to accept its therapeutic rationale or myth, which can only be achieved through a self-confident therapist who has mastered a particular set of concepts and accompanying techniques. Mair (1992) likens present-day psychotherapists to physicians at the beginning of the century in that their belief in their theories and practices is largely based upon their own observations that they work. Psychotherapy, like older-day medicine, claims to be based on knowledge but Mair suggests that they are both based on the myth of knowledge and the mystique of the expert healer.

...although psychotherapy can be a valuable means of helping people, its efficacy is not due primarily to the models and methods that it uses (which may be as irrelevant to a patient's problems as the application of leeches was to the curing of a fever eighty years ago)... (1992: 135)
Note that Mair is not dismissive of the efficacy of psychotherapy but she is sceptical about practitioners' assertions that their achievements are due to their scientific understanding of people and their skill in bringing about specific changes. Freud's claim that his theories would be validated by the efficacy of his therapy has not yet occurred and yet some psychotherapists still work within a traditional Freudian framework despite practical disappointments. It seems that an orthodox system can survive beyond faith in its individual practitioners. It may be that the disappointed patient who leaves one therapy to hopefully embark on another actually serves to support the survival of psychotherapy as a whole. The thinking of Freud has unequivocally influenced this century and at this point in our history the theories and goals of psychotherapy fit within and are shaped by our cultural belief systems. In order to earn a living, psychotherapists must serve community interests by acting according to cultural expectations and values. They must also maintain a position of authority, from where they appear certain and inspire confidence, to ensure that they are believed. To achieve this, psychotherapists claim that their practice is based upon scientific knowledge about mental processes and that their interventions bring about change in a predictable way.

If Mair's analysis is correct - and certainly overall there is more evidence to suggest the significant role of 'common factors' across psychotherapeutic schools in determining outcome than there is to suggest the consistent or overwhelming superiority of one specific framework or technique - it would seem that no theory is better or worse than another. Consequently the search for answers about the best kind of intervention to use, be it interpretation or elaboration, may be futile. It seems to be more important to select a theory that fits in with my view of the world, a theory that I can believe in and draw confidently from. A therapist whose head is full of questions, doubts and disillusions will not reassure patients who are unlikely to make use of an explanation about their difficulties that is not firmly presented. This is supported by recent research that showed that the patients of a general practitioner who admitted uncertainty about the cause of their symptoms took longer to get better than would normally be expected (Thomas, 1987). Whereas another set of patients whom had been given a firm but fraudulent diagnosis and confident prognosis for recovery fared
significantly better. Thomas concluded that in the first case honest doubt had contributed to the prolonging of patients' symptoms.

Frank (1973) also highlighted the importance of the relationship between the therapist and the patient for the effectiveness of psychotherapy. This has since been supported by numerous research studies. For example, Orlinsky and Howard (1986) reviewed 1100 outcome studies, spanning thirty-five years, and identified five factors, which are associated with successful therapeutic outcome, including the patient-therapist bond. Clarkson (1994) concludes that the relationship is consistently found to be more important than theoretical orientation in outcome studies, subjective reports and clinical evaluation approaches. This evidently relates to my earlier question about how to be with the patient.

Woolff (1971) and Winnicott (1971) describe 'doing to' (interpretation) and 'being with' (relationship) attitudes. All psychotherapies require 'being with' the patient before 'doing to' functions can be effective. This need for co-operation between patient and therapist is referred to as the 'working alliance' and is defined in psychoanalysis as:

...the relatively non-neurotic, rational, and realistic attitudes of the patient towards the analyst...It is this part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions. (Greenson, 1967: 29)

Therefore it seems that whatever the form of interpretation, however accurate (or inaccurate) it is, it can only be effective if given within a trusting, secure and empathic relationship. The requirement of traditional psychoanalysis that the therapist be neutral, in order to provoke and permit the patient's transference upon them, seems to downplay the importance of a warm therapist-patient bond (Mair, 1992). Freud, whilst acknowledging that the success of psychoanalysis depended upon the patient's positive transference towards the therapist, insisted that these feelings were "based on no real relationship between them" and reduced them to unconscious fantasies (1977).
Such indifference towards the person of the patient, coupled with the above-described incident with my supervisor, have left me feeling frustrated and wondering whether psychoanalysis is purely an intellectual exercise for the therapist. This is echoed in a criticism that Jeffrey Masson levels against Freud:

He had a superb intellect, but a small heart. And this means there were things he simply could not understand. Such as another person’s suffering. (1992: 18)

It seems to me that the absence of empathy on the therapist’s part towards the patient reduces the patient to a non-person, to an object of investigation. Papers have been written which document the insensitivity of analysts towards their patients’ feelings (for example, Sutherland, 1992). However, the ability of practitioners to take on board their patients’ accounts of the therapeutic process, to reflect upon their criticisms of their own practice, without pathologising the critic, is not always evident. There is surely a theory to explain away any therapist misdemeanour but how helpful or harmful this is to the patient, the one who is overtly seeking help, we can only know by listening to them. This is a view emphasised by Heinz Kohut.

Kohut (1977) criticised classical psychoanalytic theories because of their apparent lack of concern with the individual patient’s subjective experience and over-concern with the perpetuation and maintenance of preconceived theories. He adopted a more flexible experience-near approach by ceasing to explain away his patients’ denial of his interpretations as resistance, and, prioritising the importance of open and empathic listening to what the patient was actually saying. The aim of therapeutic practice was not to fit patients into rigid theories but to reach an empathic understanding of the patient, therefore ensuring the formulation of new theories and the continued development of psychoanalysis. He described empathy as the principle tool by which practitioners should gather data, and, as an absolute pre-requisite for therapy in which the establishment of a facilitating alliance with the patient was paramount. The therapist was thus required to express their humanity and openness and to regard patients as experts on themselves. This is a crucial contribution to psychoanalysis as it
encompasses a necessary power shift from therapist to patient and promotes empowerment of the patient rather than the neutral, impenetrable, expert status of the practitioner.

Kohut observed that the neutrality, and often cold demure, of the classical analyst seemed to further frustrate narcissistic needs, producing inaccurate interpretations which resulted in reactions such as rage towards the therapist (1979). He regarded such reactions as legitimate and as a consequence of narcissistic injury encountered during the therapy itself. They were not primary indicators of personality but actually served the much-needed purpose of protecting the self from further injury. Kohut maintained therefore that psychoanalysis spent much time dealing with secondary psychological phenomena and, because of the overriding objective of penetrating resistance, did not respect the fundamental need for protection of, and maintenance of, a cohesive and functioning self.

In conclusion, it would appear that the role of the successful psychoanalytic therapist is to practice consistently within a theoretical framework that explains and justifies what they are doing. It is essential to feel comfortable and confident within one’s therapeutic approach as it has been found that honest uncertainty can significantly encumber progress. This paper shows that common factors, such as the therapeutic relationship, seem to be more important than the theoretical orientation and activity of the therapist. For myself, I have identified a theory which permits self-assuredness whilst emphasising humility, openness and empathy. I am now confident of my role as a psychoanalytic therapist informed by a theory that fits with my viewpoint. It remains to be seen how this confidence weathers the storm of external criticism in a scientifically barren landscape.
References


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

The above statement raises many questions of definition. What is “cognitive therapy”? What might be considered to be its “active components”? What is implied by “faulty appraisals”? What is “therapeutic change”? And what is “the therapeutic system of delivery”? This paper will attempt to define these areas and discuss the clinical implications of each.

**Cognitive therapy**

Early cognitive therapy developed on from behaviour therapy in the mid 1970s. Behaviour therapy had been dominant from about 1950 until this time having gained status as a ‘scientific’ alternative to psychoanalysis. The behaviourists excluded subjective interpretation in the generation of emotion or behaviour whereas psychoanalysis emphasised individual meaning. Psychopathology was understood as a result of external events and efforts were concentrated towards developing problem-specific procedures and techniques (Power and Dalgleish, 1997).

Behaviour therapy was quite successful at treating specific phobias and compulsions but was generally less effective with depression and more general anxiety disorders. Ellis (1962) and Beck (1976) attempted to supplement the associationistic foundations of behaviourism with a cognitive component and re-emphasised the significance of personal meanings in the generation and maintenance of such problems. Therefore the investigation of individual thought processes became the main focus of the new cognitive-behavioural therapies, which viewed faulty reasoning as central to the creation of maladaptive responses and attempted to correct such incorrect meanings by the systematic application of logic (Brewin and Power, 1997). Cognitive therapies and theories have diversified since these early foundations and according to Reda and Mahoney (1984) it is possible to divide current cognitive approaches into two broad
schools: (1) the surface-structure associationistic and (2) the deep-structure constructivistic metatheory models.

The *surface-structure associationistic*, or rationalist, model adheres closely to the early cognitive model. The proponents of this approach (for example, Beck, 1976; Ellis, 1962; Goldfried, 1982; and Meichenbaum, 1977) suggest the goal of therapy to be the modification or replacement of maladaptive thinking, self-statements and behaviour. The therapist evaluates the rationality or irrationality of the client’s thoughts and beliefs. This relies upon the theoretical assumption that there is a true reality that is singular, static and external to humans and that rationality is static, absolute, formal and logical. These theoretical foundations permit the conceptualisation of a client’s problem as being generated and maintained by her own "faulty appraisals" — that is, she is interpreting and according meaning in irrational and inaccurate ways. This is well illustrated by Clark’s (1988) cognitive theory of panic which suggests that panic and anxiety occur because of the misinterpretation of physiological responses and symptoms (illustrated in the case below):

Mr A presented with problems of anxiety and panic attacks. He reported a variety of situations in which he experienced increased heartbeat, excessive sweating, knotted stomach and dizziness. He stated that he feared he would faint but had never actually fainted during the 28 years that he had been experiencing these reactions.

The meaning that Mr A attributes to the changes in his body, that he will faint, leads to the generation and maintenance of anxiety. As he has never actually fainted, this could be conceptualised as a faulty appraisal which feeds back into a vicious circle. This kind of cognitive approach is based on a somewhat static conception of a circular equilibrium regulated by feedback mechanisms. In order to help Mr A within this approach, the therapist would intentionally aim to show him his irrationality and correct his misinterpretation, through a process of repeated intellectual and experiential disconfirmations, in the hope of restructuring associations and modifying meaning thus restoring the lost equilibrium. Clients are helped to achieve this by a variety of strategies and techniques, both cognitive and behavioural, which are geared
towards aiding clients to assess the reality of their cognitions. As such, these could be termed the "active components" of this therapeutic approach.

Cognitive strategies include downward arrow, clarifying idiosyncratic meaning, labelling of distortion, questioning the evidence, examining options and alternatives, decatastrophizing, listing advantages and disadvantages, replacement imagery and cognitive rehearsal. Behavioural techniques include assertiveness training, behavioural rehearsal, graded task assignments, bibliotherapy, relaxation and meditation, social skills training and shame-attacking exercises (Dattilio and Freeman, 1992). Another important feature of cognitive therapy is that clients complete homework assignments in between sessions, which are tailored to the specific problem and may include any of the above techniques. The goal of engaging in homework tasks is to restructure meaning in association to varied contexts in order to increase the likelihood of these contexts subsequently accessing the alternative model (Teasdale, 1995).

The second school, identified by Reda and Mahoney (1984), within cognitive therapy is the deep-structure constructivistic metatheory, or constructivist, model which has been developed by theorists such as Guidano (1984, 1991), Liotti (1987, 1991) and Mahoney (1982, 1993). This approach has attempted to redefine cognitive therapy through its emphasis on the active, generative and intentional aspects of subjective knowing processes. Clearly this does not share the classical cognitive assumptions about truth and rationality. Truth is regarded as uniquely personal as each individual demarcates what is real and unreal to him. The self is construed as dialogical and as being constantly and purposefully revised (Hermans, Kempen and van Loon, 1992). Similarly, rationality is relativistic and interactive – that is, what is rational for the individual who actively construes their own reality. In this sense, rationalism is not only concerned with logical thinking but also includes tacit and emotional aspects (Guidano, 1988).

Through a process of explorative collaboration, the therapist aids the client to identify their basic assumptions, which determine how they order representations of the self
and the world, and experience reality. Past experiences and the client's interpretations of them are explored in an attempt to understand how they relate to the client's unhelpful assumptions, core beliefs, schemata, self-concepts and current behaviours (Matto, 1998). In contrast to surface-level negative thoughts, such levels are thought to be deeper and less conscious. Therefore constructivist interventions tend to be less structured and didactic, and more explorative, allowing clients to 'tell their stories' from the beginning, rather than testing their reality. The therapist conducts a historical and developmental analysis (Wills and Sanders, 1997) in an attempt to understand the individual's sensed meanings and "life-engaged consciousness", that is much more than reason alone (Greenberg and Pascual-Leone, 1995).

Therapy does not attempt to persuade clients to adopt other standards for truth by imposing a presumed universally-applicable content (Neimeyer, 1995). Rather than conceptualising the individual's thoughts and core concepts as being irrational or "faulty", the client is encouraged to understand their deeply-held personal beliefs, assumptions and rules as being useful when first developed but as hindering present-day understanding. The constructivist therapist attempts to offer ways of analysing and transforming (inter)personal meanings with the intention of facilitating the client's efforts at meaning-making and better conceptualising their own personal truth (Mahoney, 1991). This process can help to elaborate alternative models of the self and the world, which permit deep structures to become more flexible and adaptive (Guidano, 1988). This may permit a new interpretation of events or a new personal narrative which is internally consistent but mitigates the distress experienced (Brewin and Power, 1997). The client thus expands their constructs with alternative interpretations while retaining a strong sense of individual self and reality.

Within this approach, the client presented above, Mr A, would be encouraged to explore the meanings that he attaches to his symptoms of panic, his fear of fainting and his concept of himself as an anxious man. Time could be spent exploring how anxiety, and emotions more generally, were modelled and contained within his early relationships. He might be encouraged to consider how he would be if he were no longer anxious, and so on.
There are no specific techniques pertaining to this form of human interaction that revolves around the (inter)personal meaning systems of its participants, who engage together in articulating, elaborating and revising the constructions through which the client organises their experience. Rather, the therapist and client jointly attempt to 'sculpt' novel possibilities in language and explore their implications in behaviour, fluctuating between reflective conceptualising and experiential engagement (Neimeyer, 1995). However, existing cognitive and behavioural techniques may be used to destabilise the client's superficial beliefs and expectations and therefore allow deeper structures to emerge. Equally, the therapist may also 'invent' new techniques that complement their evolving, personal style and help the client to make their deeper, tacit processes explicit (Guidano, 1988).

**Therapeutic change**

Inherent in the descriptions above of cognitive therapy are conceptualisations about the nature and process of therapeutic change. The rationalist model emphasises the role of thinking and thoughts in the generation of behaviour and emotion and so targets Negative Automatic Thoughts (NATs) in order to modify faulty appraisals and 'maladaptive ideation' (Beck, 1976). NATs are automatic because they are perceived as if occurring by reflex and negative because they interfere with the person's well-being (Beck, 1976; Fennell, 1989).

The basic assumption is that one can identify such habitual thoughts (or images) and come to see them, through a process of 'distancing' and 'decentering', as exaggerated and unrealistic. The client is then encouraged to challenge their conclusions and test their reality by gathering evidence through experimentation in order to modify their faulty appraisals, or substitute them with more moderate or realistic thoughts. The theory maintains that the revision of 'faulty belief systems' is successful in influencing mood and behaviour (Beck, 1976). In short, the rationalists believe that symptom-alleviation and mood-enhancement can be achieved by changing the way a person habitually predicts and appraises 'reality'. Thus, Mr A would be directed towards repeatedly gathering evidence to disconfirm his prediction that he will faint
when anxious, until eventually he will surrender this belief and break out of the cycle of panic.

However, this style of cognitive therapy has been accused of being a “disembodied talking heads” approach (Neimeyer, 1995). Further, “intellectually concluding ‘I am okay’ is not the same as feeling or experiencing oneself as okay” (Bohart 1995: 322). Spinelli (1994) argues that clients may take on board the rational argument but still not feel better because their underlying dynamic conflict has not been fully explored and understood. He also draws attention to the danger of the assumption that the therapist is more rational than the client, which can result in a power struggle about who is correct. Newman (1998) suggests that therapists openly acknowledge to clients that everyone is prone to bias and that their opinions should be regarded as hypotheses to be tested.

The constructivist Liotti (1987) describes how cognitive change occurs through the evolutionary processes of ‘assimilation’ and ‘accommodation’. Through assimilation, new information is absorbed into existing meaning structures (schemata). Through accommodation, new cognitive structures grow out of the old. Mental life is an oscillation between these two processes which balance tendencies to maintain and tendencies to change old meaning structures. Cognitive structures relating to personal identity (self-schemata) order reality and centrally control these processes and tend to resist change in order to preserve the personal sense of self and reality. Guidano (1988) suggests that individuals are able to modify their understanding of aspects of reality without having to revise their self-image, as surface changes occur continuously in relation to life-span oscillations whereas deep changes require the reconstruction of sets of deeper rules, which govern attitudes towards reality and shape personal identity.

Further developing this notion of superficial (peripheral) versus deep (core), unconscious versus conscious, and emotional versus rational change, Power and Dalgleish (1997) have offered the SPAARS (Schematic, Propositional, Associative and Analogical Representations Systems) model of the generation of emotion. This
suggests that the processing of information involves a number of different representation systems and that there are two distinctive routes to the generation of emotions – ‘The Appraisal Route’ (Route 1) and ‘The Automatic or Direct-Access Route’ (Route 2).

Route 1 involves the conscious, or partly conscious, controlled appraisal of events and situations and quick, or slow, generation of emotions (depending on the ambiguity of the situation). Route 1 generates a schematic model from an interplay between controlled processes (for example, dynamics of the current situation) and automatic processes in other systems (for example, stored memory) which synthesise relevant information to produce a high-level, holistic representation whose content cannot easily be expressed verbally. Route 2 involves the fast and automatic processing of relevant events and generation of emotions. The emotions produced via Route 2 fail to reach consciousness as they are actively inhibited, although they do impact significantly upon other physiological systems, for example a person may experience tearfulness but then inhibit its expression by ‘swallowing it’.

An implication of this model, and others which emphasise the generation of emotion via two or more routes (for example Brewin, 1989), is that contrasting or compounding emotions can be simultaneously generated by the different routes. As with meaning, emotions can be both conscious and unconscious which is why it is possible to intellectually believe one thing but emotionally believe or feel another. Beck et al. (1979) recognised these two levels but suggested that they were part of the same process, maintaining thus that work on the thinking level produces changes in the feeling. SPAARS suggests that they are qualitatively different forms of emotion produced by two distinct processes. Nevertheless, clients may experience ‘intellectual’ change as preceding ‘emotional’ change and both are valid forms of emotional change. Within this model, NATs are not present in either route (but may feed into the Appraisal system) and do not necessarily generate emotions, which can be experienced as occurring ‘out of the blue’.
Crucially, in considering whether therapeutic change depends upon challenging faulty appraisals, Power (1997: 71) concludes that "many emotions do not involve NATs in their generation. Chasing NATs in cognitive therapy may be a fruitless exercise, because there are no NATs to be caught!". Thus cognitive therapy needs to incorporate the Automatic Route as an understanding of both conscious (surface) and unconscious (tacit) meaning and emotion seems necessary for the therapist to make progress and facilitate lasting change.

Questioning how therapeutic change may occur leads us to consider what kind of change is desired. Power and Dalgleish (1997) distinguish between fast and slow therapeutic change. They suggest that controlled (Appraisal) processes are readily accessible to consciousness and therefore easily and quickly modifiable whereas changes in tacit (Automatic) processes require the alteration of associatively-based representations which can only occur gradually. Therefore, our client, Mr A, may be able to decatastrophise his appraisal of his experience of panic quite quickly but his physiological symptoms may still be triggered associatively and only gradually start to change. Successful therapy should involve changes in both appraisal and automatic systems. It may be that different techniques are appropriate for different types of change (Power, 1997). Brewin et al. (1996) suggest that exposure of underlying, unconscious meaning systems helps the client to discriminate between past and current situations, thereby blocking overgeneralization, whereas cognitive interventions may be necessary to reduce secondary meanings and emotions arising from conscious appraisal of events.

**Therapeutic system of delivery**

Despite the focus of much therapeutic research on measuring quantifiable phenomena such as symptom reduction or the efficacy of a particular technique, it is simply not true that all therapists sharing the same theoretical allegiance act uniformly or that what has been found to work by one therapist for one patient with a specific problem will work for all patients with the same problem. That which is beyond the systematic application of theory and techniques may be termed the "therapeutic system of delivery".
Beck’s early cognitive approach (1976) emphasised collaboration in therapy whereby clients were encouraged to take responsibility and view themselves as thoughtful and active colleagues to the therapist. Activities such as the client setting the agenda for the session and mutually agreeing the pacing of the session and homework tasks were regarded as essential to encouraging this sense of partnership and rapidly giving the client a sense of mastery. This has been criticised as an “artificial” structure by Emery (1993) who urges therapists to see therapy as an “organic” evolving process in which they should “take risks, act spontaneously and let the sessions unfold naturally” (: 310). Emery maintains that the naturalness of the therapist allows clients to relax and be themselves. In this way the therapist acts as a role model showing the client what is possible. In my work with Mr A, I did not follow highly-structured sessions as his intolerance of even low levels of anxiety revolved around an idiosyncratic need to control all emotions. I therefore chose to model a different way of being with the aim of demonstrating that one does not need to be in control of everything for things to be ‘okay’. Mr A struggled initially with this lack of structure as he tended to avoid the ‘unknown’ but this prompted him to explore and understand his need for control and experiment with spontaneity.

As the application of cognitive therapy has widened, the difficulty that many clients have in forming relationships has been recognised. It has been argued that interpersonal schemas are the core cognitive structures underlying clinical problems (Safran, 1990). The therapeutic relationship is now regarded by many as integral, rather than a prelude, to the process of cognitive therapy (Newman, 1998). This may be because of such interpersonal observations, alongside the lack of research evidence to support the assumption that the active, challenging approach of cognitive therapies is more effective in bringing about therapeutic change than more relationship-oriented therapies (for example, Elkin et al., 1985). In a review of outcome studies, subjective reports and clinical evaluations, Clarkson (1995) concludes that the relationship is consistently found to be more important than theoretical orientation.

In order to embark on any positive conjoint exploration the therapeutic relationship must function as a “secure base” (Liotti, 1987) but therapy, as any relationship, is a
complex human interaction. Myriad factors influence the ability to establish a trusting, open and collaborative relationship. For example, research has long shown the interpersonal style of the therapist to be more important than methods. Following on from Rogers (1951) the therapist variables of non-possessive warmth, genuineness and accurate empathy have been repeatedly found to be significant in determining positive outcome (Sheldon, 1995). There is also research concerning the interactions between philosophical and psychological factors that suggests the role of personal epistemologies (described as empirical, rational or metaphorical fundamental styles of knowing) in the therapeutic encounter. It was found that individuals prefer a therapeutic approach that is congruent with their personal epistemology (Neimeyer and Morton, 1997; Vincent and Lebow, 1995). An implication of this finding is that the efficacy of a certain therapeutic approach with certain clients may be partly due to compatibility between theoretical and personal epistemologies. Research has also highlighted the importance of sensory features such as tone of voice to the qualitative meaning that we attach to what someone is telling us (Teasdale and Barnard, 1993).

There are many more variables in therapeutic interaction and it is important for the therapist to seek feedback from clients about how they are experiencing therapy, what they find helpful or difficult and so on. Active exploration of the relationship may help to ensure that whatever the therapist does, it is delivered in a sensitive and humane fashion.

Concluding comments
This paper has outlined the two main cognitive approaches to therapy and has shown that it may not be possible to wholly attribute therapeutic change to the active components which directly challenge the client’s faulty appraisals. Therapeutic change is complex and may occur at different levels. A combination of techniques encompassing constructivist-style exploration with rationalist-style experimentation may be best-suited to ensuring multi-level changes. Whatever the approach, the relationship between the therapist and client is all-important. Thus therapeutic change is achieved through a process which involves a complex and subtle interplay between what we do and how we do it.
References


Working with suicidal clients may raise professional and ethical issues. Discuss with reference to a clinical case example.

Introduction
The subject of suicide provokes passionate ethical arguments. A therapist is likely to work with at least one suicidal client during the course of a career (Brown, 1987; Kleespies et al., 1993). Suicide may be one of the most challenging ethical problems faced by mental health professionals (Clements et al., 1983). There are many different moral, theoretical and ethical understandings of suicide, which tend to fall into two fundamentally opposing positions, of either being for or against the right of the individual to choose to die. Applied psychological approaches are rooted in these viewpoints but professional ethical principles imply a duty of care to prevent suicides wherever possible. This paper will demonstrate how predominant attitudes towards suicide have developed historically. Principle opposing arguments will be discussed. A case example will be outlined in order to illustrate the difficulties that may be encountered by the trainee Counselling Psychologist who must attempt to reconcile personal beliefs, divergent theories and professional responsibilities.

An historical overview: Suicide as an immoral act
The meaning of suicidal behaviour has been interpreted differently according to time, circumstance and dominant belief system. It seems that suicide has existed throughout history in some form or another. Many primitive cultures encouraged acts of self-sacrifice in order to aid species survival. For example, Bromberg and Cassel (1983) describe how the elderly in primitive cultures were encouraged to seek voluntary death so as to decrease the burden of care on the tribe. Western history has emphasised self-killings for reasons other than altruism. A brief overview of the historical Western documentation concerning famous suicides has been collated by writers in this field (for example, Stillion and McDowell, 1996; Werth, 1996) and facilitates an understanding of how present day assumptions and theories regarding suicide have been shaped.
The Old Testament records (around 1000 BC) the suicides of Samson, King Saul, Saul’s servant and Ahitophel; each for different reasons and each without scriptural judgement. Therefore, the general attitude towards suicide at that time is unclear. Some centuries later, in 399 BC, Socrates killed himself ‘honourably’ when faced with the prospect of having to moderate or renounce his teachings. In 350 BC, Aristotle proclaimed the unlawfulness of suicide because of the secondary damage caused to the community, in terms of deprivation of services and talents. The development of philosophical Stoicism in Greece and Rome, between 300 BC and 300 AD promoted the individual’s control over all aspects of life, including death, and prioritised the quality of life above the quantity. The killing of the self was conceptualised by the Stoics in terms of a rational act but those individuals who might take their own lives in an emotional, or non-rational, state were not accounted for.

At the beginning of the Christian era, the suicide of Judas Iscariot, in 33 AD, is also recorded without judgement. The death of Jesus of Nazareth in the same year was viewed as an act of martyrdom in that he died at the hands of others for his beliefs. Jesus’ death was an important turning point in the historical development of suicidal behaviour as Christians sought opportunities for glorified martyrdom (Alvarez, 1970). Such behaviour was condemned by St. Augustine, around 400 AD, as deeply sinful contrary to the Sixth Commandment “Thou shalt not kill”. Organised Christianity upheld this view for the next 500 years and individuals who attempted suicide were punished.

The thirteenth century writings of St Thomas Aquinas (1265-1272 / 1975) combined Aristotle’s view, that suicide is harmful to the community, with the reasoning that suicide is contrary to natural inclination therefore violating the physical and biological laws of the Creator and disrespecting the most precious gift of life. As such, suicide came to be conceptualised as a mortal sin and in the years that followed suicidal behaviour was punished severely, for example bodies of suicide victims were denied Christian burial (Hutton and Valente, 1984) and were dragged through communities behind carts (Farberow, 1975).
Later, the work of John Donne (1644 / 1982) questioned the rigid church teaching about suicide. Donne, a devout Christian, asserted that Christ's death was similar to suicide because he did not choose to avoid it. This work provoked considerations about the moral differences and similarities between passive and active participation in one's own death. Significantly, Donne recognised that suicide takes many forms and occurs for many reasons. He believed that the intention of the suicidal behaviour must be decisive in determining its sinfulness or morality. He also suggested that humans have an innate wish to die as well as a wish to live. However, he only endorsed the kind of suicide that was carried out for the glory of God. In 1670, suicide was declared the triple crime of murder, treason and heresy and punishment increased in frequency and severity (Farberow, 1975).

In 1783, Hume argued against the severe punishment of suicide asserting that suicide was not a crime against God, community or the individual. Subsequently, suicide entered the writings of medics and scientists who began to conceptualise it as a result of a mental condition or insanity. The simultaneous rise of existential philosophy emphasised the freedom of the individual to act and the responsibility of the individual for that action. For the existentialists, the decision to suicide or not was fundamental for the individual who must balance both freedom and responsibility to self and to others.

Recent developments in thinking: Suicide as mental illness

During the nineteenth century, a rise in suicidal behaviour was recorded which was associated with dramatic changes to ways of life and the weakening of the extended support systems of the family, community and church brought about by industrialisation (Chesnais, 1992). Durkheim's seminal Le Suicide (1897) prompted the understanding of individual phenomena in relation to sociological factors and the classification of suicides according to typology. Shortly after, Freud conceptualised suicide in terms of an intrapsychic conflict in which the ego is attacked by either the id (1917) or the superego (1923). Suicide was thus increasingly being understood in terms of mental illness, which promoted the idea that the suicidal individual could be 'treated' and the act prevented.
In 1958, the first suicide prevention centre was opened in the United States, and was quickly followed by others throughout the Western world. The scientific method has been enthusiastically applied to the investigation of suicide ever since and has generated a wealth of epidemiological data (for example, see Clark & Fawcett, 1992). Consequently the wide condemnation of suicide, proliferated by the church, weakened as attitudes became more secular and less judgmental towards individuals whose motivations and state of mind were considered alongside the value system of the society and how isolated or integrated the individual was in the societal system.

As chemical and biological research into suicide gained momentum and medical intervention and treatments became evermore commonplace, suicide came to be regarded as preventable and treatable within the medical and allied professions. The medical model promotes physical well-being and endeavours always to fight disease and prolong life. Mental health professionals, employed within health services, may therefore find themselves acutely influenced by the medical ethos which prejudges suicide as a symptom to be immediately ‘treated’ with the aim of prevention. Ethical and legal standards of care, detailed in the ethical principles of the various professional organisations also direct mental health professionals to take immediate action to prevent self-harm (for example, The British Psychological Society Code of Conduct, Ethical Principles and Guidelines, 1998). Therefore therapists are professionally obligated to abandon the general guideline of encouraging autonomy and independence in clients and allowing them to make their own choices, in order to break confidentiality and inform others of suicidal intention. Therapists are encouraged to attempt to help the client overcome their ambivalence and to ‘choose’ life, or, failing that, to physically prevent them from carrying out the intended action through (sometimes involuntary) hospitalisation which can involve locks, drugs and constant surveillance (Fremouw et al., 1990).

The mental health literature in this field predominantly portrays the suicidal individual as irrational and calls for mental health workers to tackle this ‘problem’ more effectively (for example, see Elitzur, 1996). Although the problem of suicide is essentially ethical not legal (suicides have not been a crime in this country since the
Suicide Act of 1961), there is the increasing risk of malpractice litigation against implicated practitioners (warned against by Jakobi, 1995; Shapiro, 1997). As such, psychologists face the task of developing more effective techniques to assess and prevent suicide in order to protect themselves against charges of incompetence (for example, see Linke, 1995).

Thus the current drive for aggressive prevention is clearly rooted in history, religion and philosophy and reinforced by the medical ethos, mental health literature, professional ethical standards and corresponding trainings. Given the fluidity of such attitudes, it is not surprising that working with a suicidal client poses a dilemma for professionals whose personal philosophy may not fit easily with the purposive postponement of death. This unease with the current blanket ethos of prevention has been expressed by some who have explored the interface between psychotherapeutic theory and predetermined professional responsibility.

**Psychological perspectives**

The main schools of psychotherapy have developed theories around suicide according to their particular concepts, language and techniques. The major psychoanalytic position on suicide is that it is evidence of anger or unconscious hostility turned towards the self (for example, Bowlby, 1973; Freud, 1917; Freud, 1967; Horney, 1937). Psychoanalytic therapy might concentrate on providing insight to or strengthening the defence mechanisms of the suicidal individual. The humanistic school has understood suicide in terms of the individual having difficulty in finding meaning in life (for example, Frankl, 1963; Maslow, 1971; Rogers, 1951). A humanistic therapist might encourage aspiration for self-actualisation, which would help the suicidal individual to live a more ‘authentic’ and meaningful life. The cognitive-behavioural perspective proposes that the way we think about life effects our psychology and our biology. Thus the depressed individual contemplating suicide may have a negative self-regard resulting from mistaken inferences and learnt pessimism (for example, Beck, 1976; Seligman, 1990). This approach would focus on challenging negative beliefs in order to unlearn pessimism and learn to have an optimistic outlook by controlling depressed and suicidal thoughts.
However, not all mental health professionals accept that they should be actively challenging and attempting to ‘correct’ suicidal behaviour. Thomas Szasz (1979, 1993) challenges the current psychiatric belief that suicidal individuals are irrational or mentally ill and that suicide is an immoral act. He is against psychologists taking on responsibility for suicide prevention which he sees as moralistic, not medical, intervention. He maintains that “suicide is a fundamental right” of the individual who desires it. He regards involuntary psychiatric intervention and hospitalisation or, conversely, ‘non-action’ (avoidance of working with suicidal individuals) as manifestations of unconscious retaliation by the medical profession against those who challenge their basic values. In short, Szasz constructs suicidal behaviour as medical heresy and demonstrates how moral judgement determines that what was formerly vilified as a sin is now classified as an illness and thus controlled by medical professionals who have taken over the moral function of religion.

Hillman (1964), writing from a psychoanalytic perspective, argues that therapy is essentially an exploration and enhancement of the psyche, that is the soul, and, as such, is incompatible with any prejudicial preventative stance. He believes that breaking the therapist-client bond of confidentiality irretrievably damages the therapeutic relationship, and injures the soul whose attempts to honestly confront whatever comes up are blocked. Hillman sees the death experience, in psychological terms, as essential to analysis if the self is to be freed from a false life. Furthermore, at a recent psychoanalytic conference (Janmohamed, 1999) it was suggested that suicide prevention is a by-product, not the primary task, of good practice and that risks must be accepted if a balance is to be achieved between protection and autonomy.

In summary, moral, ethical, theoretical, professional and personal considerations abound for the psychotherapeutic professional working with a suicidal client. It is my experience that as an integrative counselling psychology trainee, who is exploring theoretical approaches whilst developing a personal belief system about such ethical issues, work may be further complicated by training with highly-experienced allied professionals who are governed by different professional bodies. An example of a
case of working with a suicidal client, which illustrates such difficulties, is presented below.

**Case example**

Ms H, a 36-year-old woman with a long-standing history of depression, had been under the care of psychiatric services for some seven years, since the break up of a relationship precipitated hospital admission in order to help control self-harming behaviour and suicidal impulses. There have been five subsequent episodes of inpatient care and two stays in residential communities. She has engaged in psychodynamic, music and cognitive-behavioural therapies, which have ended for various reasons including increased risk to self-harm. A six-month course of cognitive-behavioural therapy helped Ms H to control her self-harming symptoms, particularly the cutting of her arms with razor blades. Subsequently, Ms H requested further psychodynamic therapy in order to explore her relationship difficulties around fear of rejection and inability to extricate herself from abusive relationships. These difficulties seemed to be linked to feelings of worthlessness, triggered by her adoption at 6 months old and compounded by numerous episodes of sexual and physical abuse. The assessing psychotherapist expressed some doubt about her ability to make use of a psychodynamic therapy because of the risk to self-harm when faced with painful issues but Ms H reassured her that if she were talking about her feelings then she would be less likely to act them out in this way.

I met Ms H in September 1998 in order to discuss the possibility of her attending once weekly therapy with myself for a period of one year. I was on a training placement in a NHS psychoanalytic psychotherapy department in supervision with a Consultant Psychotherapist. In keeping with departmental policy, patients and outside professionals were not aware of my trainee status. At this meeting, Ms H conveyed to me her disappointment that the therapy would not be longer term but reiterated her commitment to it and her feeling that she would be strong enough to cope with its demands. She was wearing a T-shirt and extensive scarring on her arms and hands was visible. I enquired about this cutting behaviour but she reassured me that she was
still coping well with controlling her impulses in relation to that. Therefore it was agreed that we would commence therapy the following week.

I expressed my concern in supervision that what I was able to offer perhaps was not entirely suitable for Ms H, particularly in terms of the time limitations and risk to self-harm. I was reassured that there are risks in every kind of treatment or operation and that people who are in therapy do not tend to kill themselves and to expect the cutting behaviour to increase but not to pay too much attention to such symptoms. Regarding the time limit, the importance of permitting Ms H to make her own choices and accept responsibility for those choices was stressed:

At session 2, Ms H informed me that she was “heading for a downer”. At session 6, she reported looking at her “cutting equipment” every day and being worried that she would not be able to “win the battle” for much longer. The next week, she cut herself. At one point she said, “I can’t believe I’ve gone from feeling reasonable to very depressed”. After session 7, I strongly expressed my concern about Ms H’s decline in supervision and my belief that psychodynamic therapy was not the most suitable approach. I took in an article (Frances, 1981) which addressed issues around negative response to therapy. My supervisor was sympathetic to my concerns but reiterated that it was her choice to come and that the decision about suitability had been taken by the assessing psychotherapist, and that for my part, I should uphold the therapeutic contract for as long as she continued to come.

Therapy and supervision continued in this way. Ms H’s cutting intensified and increased and suicidal ideation began to emerge at first through dreams and derivatives and then more directly. I was most anxious and concerned that she needed, if not a different kind of help, then extra support outside of the sessions, particularly as we were approaching a one session break in January. In supervision, I expressed my honest concern that she would kill herself and that I feared that, given my reservations and that I was still training and had limited experience, her suicide could seriously affect my potential and confidence as a therapist. My supervisor agreed that
she may indeed “choose to kill herself” but that research suggested that trainees are often very effective in their work with such patients.

During session 11, she disclosed her suicidal intention directly. She agreed to me calling her GP. I arranged for her to see him that afternoon. After seeing her, he referred her to the CMHT for an emergency suicide assessment. It was ‘discovered’ that Ms H did not have a Care Co-ordinator (C.C.). The CMHT refused to take her on as they had a “full case load”. A member of the team contacted me and stated that it was my responsibility to be the C.C. as I was currently the only person seeing her regularly, and that as such it was also my responsibility to carry out any suicide assessments. My supervisor was adamant that I should not be the C.C. because of the conflicts between encouraging independence and autonomy and organising extra support outside of the therapeutic boundaries. Thus no further action was taken and I was told not to “worry about it”. I wanted to know if I had followed departmental protocol regarding contacting a medical professional following disclosure of suicidal intention. My supervisor agreed that it seemed that I had taken the correct action on this occasion but that there was no protocol governing the handling of suicidal patients and that next time it happened, I may decide to repeat this action or I may decide to take no action.

Ms H continued to come and to cut herself regularly and to suggest that she would kill herself. I considered the frequency of threats and history of unsuccessful attempts at overdose and the implicit message in supervision about non-action and I took no further action. I added the diagnosis of Borderline Personality Disorder to her file and began to work in a less interpretative way after researching how to work most effectively with this client group. I found myself increasingly anxious about my professional responsibilities and whether Ms H would survive until the next session. During a two-week break, Ms H was voluntarily admitted to an inpatient psychiatric ward where she remained for a further eight weeks. She continued to attend psychotherapy and was additionally supported by a Consultant Psychiatrist, a key worker and a co-keyworker. She was also finally allocated a C.C. after an embittered political battle involving my supervisor, the mental health service manager, the area
manager and an advocate from MIND acting on behalf of Ms H. We worked towards ending which Ms H found extremely difficult. Her cutting and overdosing behaviour continued during her hospitalisation. Before our ending, she was discharged from hospital by her consultant. There was some doubts about whether she would be able to attend her final session because of her reported strategy of absenting herself from relationships (including previous therapeutic relationships) in order to pre-empt endings. She did attend and was able to express her anxiety about ending and her anger towards me for “leaving her”. I expressed sadness and loss at ending, to which she seemed both surprised and relieved. She told me that she had been referred to see a clinical psychologist for assessment but realised that she may have to wait for some months. She described how she was building up friendships outside of sessions and felt that they were of valuable support to her. Despite her difficulties with the process, she was reporting some positive changes and I hope that she will be able to benefit from her experience of this therapy and her ability to confront and survive this ending.

Summary
It can be seen that working with suicidal clients is challenging in terms of philosophical beliefs around the right of the individual to choose to die or not, which are inextricably linked with factors, such as historical context and employment setting. As in the above case, there may also be the question of responsibility for making an informed decision about continuing treatment in the face of negative response. There are potential problems for a psychologist in training with a psychoanalyst because of differences in ethical codes and training around this issue which may vary in commitment to the therapeutic goal of independence and to a non-directive approach. There is also the practical undesirability of repeatedly referring a client who expresses suicidal intention almost weekly because related professionals may tire of such repeated alerts and because there is evidently a reasonable risk to be tolerated. Despite ethical directions, it seems that suicide intervention is far from being automatic and is unavoidably dependent upon the psychotherapist’s beliefs and attitudes in relation to the individual client.
References


Therapeutic Practice Dossier
**Introduction to Therapeutic Practice Dossier**

The therapeutic practice dossier concerns experience gained over the course of three years on three different clinical placements. It contains a description of each placement and a paper outlining a personal account of integrating theory, research and practice in Counselling Psychology.

Confidential files with further details of client studies, process reports, log books and supervisors' reports are kept in the Department of Psychology at the University of Surrey and are available only to examiners. Any information pertaining to clients within this section has been kept to a minimum or disguised in order to protect anonymity and confidentiality.
Year One Placement: Primary Care

My first year placement was within a general practice, located in a ‘new town’, which was built approximately thirty years ago to accommodate commuters to London. The practice covered the whole of the town and six surrounding villages.

The Primary Care team within this practice included three Doctors, two nurses, one part-time counsellor, five part-time receptionists, two administrative staff and a Practice Manager. A number of complimentary services were available including Health Promotion Clinics, Diabetic Clinic, Home Visits, Family Planning, Ante- and Post-natal Clinics, Vaccinations, Minor Surgery, Private Medical Examinations and Psychological Counselling.

The practice housed a “Counselling Room” on a separate floor to the other consulting rooms thus providing discretion and privacy. A Chartered Counselling/Health Psychologist/Family Therapist supervised my clinical practice. She no longer worked on a therapeutic basis in this practice but had been previously responsible for their Psychological Counselling Service. She was then employed by the practice to undertake supervision of trainees.

I gained experience of Integrative Brief (maximum 6 sessions) Therapy with a wide range of clients approximately aged between 8 and 60 years old presenting with a variety of difficulties. Supervision was individual and weekly and initially followed the humanistic approach. As the year progressed, some techniques from cognitive-behavioural and systemic approaches were integrated according to clients’ needs.
Year Two Placement: Psychotherapy Department

My second year placement was within a Psychotherapy Department, which had existed since 1982 at which time one Consultant Psychotherapist was employed on a part-time basis. The department had grown considerably over the last 16 years to employ 2 full-time psychotherapists and to oversee and accommodate the work of some 30 additional therapists. The two full-time employees of the NHS Mental Health Trust were a Consultant Psychotherapist and a Principal Adult Psychotherapist. The main body of therapists comprised trainees, who worked under the supervision of either the Consultant or Principal Psychotherapist, and also of other employees of the same Trust who are released to do psychotherapeutic work, for example Community Nurse Psychotherapists.

Psychodynamic Psychotherapy for individuals or for groups was offered. Referrals are accepted from General Practitioners, Community Mental Health Teams, mental health charities and the private sector. The number of patients referred to the service continued to grow. Waiting times for group therapy were usually less than 6 months but for individual therapy could vary from 6 to 18 months.

The department served the NorthEast area of a large county, located within easy reach of the town centre, with access for the disabled. It was closely affiliated with a local University where the employees had been involved with founding a Centre for Psychoanalytic Studies. Continuing education and training was a strong ethos of the department and therapists were encouraged to attend seminars held at the university which attract eminent psychoanalytic theorists and practitioners from the international community.

On this placement, I gained experience of individual and group work with clients with enduring mental health difficulties. I saw the same clients individually for the duration of my training in this setting (up to approximately 40 sessions). The group that I joined as a co-therapist was described as “slow and open” and had been running under the same analyst for some 10 years. Supervision was individual and weekly
with the Consultant Psychotherapist and separately with a Group Analyst. It followed the psychodynamic approach.
Year Three Placement: Community Mental Health Team

My placement within a Community Mental Health Team was located in a small town in a semi-rural, affluent area and covered surrounding villages. The team was headed by a Consultant Psychiatrist and consisted of a Counselling Psychologist, Community Psychiatric Nurses, Social Workers, Occupational Therapists and support workers. Referrals for adult, community-based interventions usually came from the clients’ GPs. Assessments were usually jointly conducted in the client’s home by the psychiatrist and another team-member, other than the psychologist. The psychiatrist then made referrals to the appropriate team member, or referrals were allocated at team meetings. Alternatively, direct referrals for psychological therapy can be made by the GP. The approximate waiting time for individual therapy was between 2 and 6 weeks. Some clients were seen at the team base and others were seen at their local health centre.

On this placement, I gained experience of working individually with clients for up to 16 sessions, although the majority were seen for less than 10 sessions. The approach adopted was predominantly cognitive-behavioural to begin and integrated insights and techniques from other approaches, particularly psychodynamic, as the year progressed. Supervision was weekly and individual with an integrative Counselling Psychologist. I also had the opportunity to present seminars on working with pregnant clients to colleagues on this placement.

OTHER PROFESSIONAL ACTIVITIES

Since October 1999, I have been the Trainee Representative for the course routes on the Division of Counselling Psychology committee.

In May 2000, I gave a presentation entitled “Working with pregnant clients: ethical issues and practical considerations” at the Division of Counselling Psychology Annual Conference.
A personal account of integrating theory and research into counselling psychology practice

Introduction
In this paper, I will endeavour to make explicit my current approach to integrative counselling psychology practice. The integration of theory and research into practice will be focussed upon and clinical examples will be offered to demonstrate my development as an integrative practitioner during training. What follows, by way of introduction, is a description of the nature of this training.

My training has broadly encompassed humanistic, psychodynamic and cognitive-behavioural schools. The concept of integration has been promoted from the very beginning of training and many other therapeutic approaches have been introduced alongside the three main schools, such as Systemic and Existential approaches. However, the training placements have been specifically humanistic (Primary Care), psychodynamic (a Psychotherapy Department) and cognitive-behavioural (a Community Mental Health Team) and I have thus been required to work accordingly. Having had the opportunity to clinically implement and evaluate my own work alongside, and within, each orientation, I have welcomed the influence of each model on my thinking and practice, whilst also ‘holding onto’ developing skills of critical and reflective thinking.

Each placement has had its own structural orientation to therapeutic practice in terms of duration, style, length of waiting lists, referral systems, assessment procedures, ethical protocols, the nature of supervision and so on. My three supervisors have had different backgrounds; a Family Therapist/Counselling Psychologist, a Psychiatrist/Psychoanalyst and an Integrative Counselling Psychologist. Inevitably, such context-specific factors have also influenced my style of practice considerably and adopting an integrative perspective has helped me to adapt flexibly to these varying placement cultures.
Integrative personal therapy has also been instrumental in my understanding of the therapeutic process and has highlighted issues such as the sensitivity of, and power issues within, the therapeutic relationship, the importance of appropriately timing interventions, collaboration and spontaneity, and the therapist's style. Above all, I have derived an empirical understanding of how it is to be a client and this has enhanced my empathic capacity whilst also reminding me of the subtleties and complexities in this intensely human interaction.

Foundations of my approach to integration

It is essential to explicate my personal theory about integration as arguments persist in the field about whether integration is desirable or possible and how it should be achieved. I believe that integration is desirable because human experience is multidimensional and widely varied. As such the ability of any singular theory to address this complexity and richness adequately is, at the very least, questionable. Moreover, research has shown that despite mainstream schools' supposed espousal of different values, the same values are consistently and positively present amongst practitioners regardless of orientation (Kubacki & Chase, 1998). This implies that differences between schools lie in emphasis, as these values are shared and therefore not incompatible or exclusive. I have come to view each approach as having concentrated on certain aspects of human experience, thus being potentially complimentary, specialised theories of specific areas.

At a technical level, it seems that there are very few, if any, purist practitioners and that technical integration is inevitably ubiquitous. Indeed, even Freud's actions did not adhere to the orthodoxy of his theoretical approach (Clarkson, 1995) and it has been suggested that all psychotherapies are products of an unavoidable historical integration (Norcross & Goldfried, 1992). Moreover, Rowan (1998) has argued that too big a distinction is made between techniques of different schools which actually produce similar effects upon the client and the therapeutic process. He suggests that all therapists inform themselves of all possible interventions to ensure that they are selecting by choice, rather than by training, in order to allow "an adequate expression of the therapist as a person" (Rowan, 1998: 240). I agree with Norcross (1986) that
these techniques need to be systematically appraised rather than haphazardly selected. Thus, I have adopted a reflexive approach to personal, academic and professional experience. This involves (individually, with peers, and in supervision) evaluating, critiquing, eliciting feedback and rethinking in order to ensure an ever-evolving and considered approach.

I also consider clients' idiosyncratic theories about their own and others' experiences (Wilkinson & Campbell, 1997) as research evidence suggests that personal epistemologies importantly influence therapeutic process and outcome (Vincent & Lebow, 1995; Neimeyer & Morton, 1997). "This indicates the possible importance of matching client and therapist 'styles of knowing' and it may be that an integrative approach, which flexibly encompasses different epistemologies, can most readily accommodate and incorporate divergent fundamental values of individual clients (Beitman, 1992). On the other hand, strict adherence to a singular school could restrict the practitioner's ability to enter into the client's phenomenological frame and the discipline of counselling psychology emphasises a phenomenological and interpersonal approach (Woolfe, 1996).

I have considered that such a flexible personal epistemology that permits different styles, between clients or with the same client, whilst modelling and encouraging flexibility and openness, could appear inconsistent or confusing. However, I conceptualise the self (of both therapist and client) as fluid and dialogical, and therefore believe that this approach can appear coherent as I am able to confidently present it through my self as therapist. Thus, "rather than being a solid form, the ideas of this approach [are] like the molecules of a liquid in that they fit the cognitive containers of their users" (Beitman, 1992: 203).

Also integral to my approach is an understanding of therapeutic change. I aim to provide opportunities to analyse, understand and transform (inter)personal meaning systems, and therefore for growth. Brewin & Power (1999) have suggested that at the core of any therapeutic endeavour is the inquiry into subjective meaning-making processes and that the central agent of therapy is the transformation of meaning (for
example, mitigating painful meaning). Different kinds of therapeutic changes have been described as appraisal, surface, superficial and conscious on the one hand, or, automatic, tacit, deep and unconscious on the other (Brewin et al., 1996; Power & Dalgleish, 1997). I agree that an understanding of both conscious and unconscious meaning and emotion may be necessary for the therapist to make progress and facilitate lasting change, and that different techniques are probably appropriate for different types of change (Power, 1997).

In my work, I also strive to look beyond the focus of much psychotherapeutic theory on individualistic phenomena to acknowledge the role of social, cultural and political factors in human distress, thereby attempting to place psychotherapy in wider social structures. In order not to ignore or obscure social and political issues, or maintain sexist, heterosexist, racist or classist inequalities, as required by the Guidelines for the Professional Practice of Counselling Psychology (1998), I draw from sociological perspectives and feminist models of therapy (for example, Kitzinger & Perkins, 1993; Strawbridge & Woolfe, 1996; Morrow & Hawxhurst, 1998).

Furthermore, “There are major political differences between a medical/organic/brain-defect model to explain mental disorders and a social/learning, stress-related model” (Albee, 2000). Counselling psychology, as a discipline, rejects the medical model and prioritises the subjective experiences of individual clients (Woolfe, 1996). Within my practice, I integrate the perspective that psychological distress may be caused or exacerbated by societal, cultural and political forces, and an awareness of multicultural perspectives and changing constructions of gender. I strive to incorporate characteristics of an egalitarian relationship within the therapeutic relationship (where therapists have traditionally been more powerful) through creating opportunities for collaboration and feedback and making explicit the limitations and possibilities of therapy. In accordance with the assertion that information is power, I encourage clients to reflect upon the nature and privilege of power relations and to recognise the process by which psychiatric diagnoses are transformed into ‘scientific truths’ (Morrow & Hawxhurst, 1998). My aim is to help clients not to blame
themselves and not to adhere too strictly to diagnostic labels as such processes can limit, rather than expand, one's possibilities.

Therefore I endeavour to assist clients, as appropriate, in exploring intrapsychic, cognitive, behavioural, interpersonal, cultural and political phenomena in order to articulate and contemplate alternative models of the world. This theoretically- and technically-inclusive approach addresses internal and external aspects of experience, and aims to facilitate changes by exposing underlying, unconscious meaning systems, thereby helping the client to discriminate between past and current situations (blocking overgeneralization) whilst also reducing secondary meanings and emotions arising from conscious appraisal of events.

**Integrating psychotherapeutic theories**

It may be impossible to micro-analyse the multitude of similarities and differences between schools because of the diversity of opinions and approaches to practice within each school. I believe that focussing on combining the approaches in a complimentary way facilitates a more holistic appreciation of the person which incorporates views of the individual as *creator* (humanistic), as *reactor* (psychodynamic) and as *learner* (cognitive-behaviourism) (Clarkson, 1996). As a developing integrative psychologist I aim to provide a flexible response appropriate to client's needs. Consequently, the theoreticians that have been most useful to me in my training are those who have also allowed themselves to be creatively influenced by other schools.

In my blend of theories I draw from the humanistic approach (Rogers, 1951) as a foundation which provides an over-arching attitude towards the therapeutic process. The experience gained working from this perspective enabled me to focus on facilitating positive and safe therapeutic relationships. The humanists prioritise the relationship, enhanced by the therapist communicating qualities of genuineness, warmth, accurate empathy, respect and permissiveness to the client, which enables learning that the client can then transfer to other relationships. This paradigm is deeply respectful of the client and has emphasised, more than any other approach, the
core qualities of the therapist and the importance of the client being active and directing therapy. This provides a basis for building a trusting and open relationship, imperative to any therapeutic approach. With any client, a prerequisite is the working alliance and the discipline of counselling psychology emphasises the primacy of the therapeutic relationship (Guidelines for the Professional Practice of Counselling Psychology, 1998).

However, I did encounter certain clients whom I felt needed more direction, structure and techniques. This can be exemplified by my experience of time-limited therapy (six sessions) with Ms D. The assessment followed humanistic guidelines and Ms D made use of the space and time to tell her story. She was presenting with debilitating panic attacks. Her life was becoming increasingly restricted as she was currently avoiding any physical exertion, leaving the house, being alone, and had recently left her job. She wept frequently as she described circumstances leading to the onset of symptoms including the deaths of her grandmother and Princess Diana. She described her mother as a “hypochondriac” who told her at an early age “we all have to die” whilst sobbing uncontrollably. She said her mother called her daily to discuss her ‘ailments’. Ms D stated that each time she experienced symptoms of anxiety, she believed that she was dying and that her symptoms were caused by an underlying organic dysfunction.

As I reflected upon how we could best work together to meet her goal of being able to engage with life again and stop constantly feeling scared, I could feel her desperation. I had limited experience and had never before encountered a client with panic attacks. Whilst, non-directive therapy could encourage Ms D to find her own solutions to her problems within a safe and facilitating relationship, I was very aware of our time limit. Her current crisis and immediate need for help prompted me to look to the research. Positive results had been found for cognitive-behavioural therapies (Clum et al., 1993) and generally a directive psycho-educational approach is considered to be best-suited to achieving maximum results quickly (Roth & Fonagy, 1996). I was wary of becoming too directive but my supervisor modelled how this approach could be handled sensitively and empathically.
Thus I formulated Ms D’s difficulties: as a child Ms D learnt that life and good health were fragile, that death was imminent and something to be feared. Her mother was seemingly unable to contain her emotions and fears and turned to her daughter for comfort. Consequently, she may have developed early beliefs about being physically vulnerable and the need to be hypervigilant about physical reactions. This is evinced by her catastrophising of normal physical reactions, such as breathlessness following physical exertion, by cognitively misinterpreting them as signs of ill-health and dying. Irrational and dysfunctional automatic thoughts, linked to core beliefs, intensify and accelerate her physical reactions, and so the cycle continues.

I tentatively offered my formulation to Ms D, who seemed to gain instant relief from being understood and being offered a framework which made sense to her. In our work together, we targeted her negative thinking about her symptoms, and also explored behavioural methods, such as deep breathing and relaxation, in order for her to learn to recognise her thought processes and offset her symptoms. Once she was able to control her reactions, I encouraged her to confront currently avoided situations in order to expand her functioning and to restructure meaning in association to varied contexts, to increase the likelihood of these contexts subsequently accessing the alternative model. We both worked hard within this collaborative approach, and Ms D was able to structure sessions and design self-help assignments, which helped to allay any fears about dependency upon the directive therapist and to increase her sense of mastery. She improved quickly and reported several positive changes, such as dismantling her beliefs about ill-health, returning to work, increasing her social activity and physical exercise, and becoming more challenging of her mother’s self-diagnoses.

Moving to a psychoanalytic placement posed significant dilemmas. Although I considered myself to be quite well-read in this field, I had little idea of ‘how to do it’ and my supervisor was not sympathetic towards humanistic techniques. Feeling ‘deskilled’, I attempted to follow guidelines to remain largely silent and neutral, but I felt somewhat detached within my relationships with clients. Conceptualising the rejection of any of my interpretations as resistance, which needed to be ‘broken
through’, made me feel uncomfortably omnipotent and authoritarian. However, I was learning an incredible amount from the detailed and broad psychodynamic model of personality structuring and functioning. I became more attuned to the centrality of early trauma, the role of the unconscious in determining behaviour, transference, countertransference, resistance, anxiety and ego defences. Theorists (for example, Smith, 1991) provided fascinating insights into the parallel world of the unconscious in the therapeutic encounter and frame. I found that attending to the internal dynamics of clients and their manifestation within relationship enriched and deeply-informed my perspective of therapeutic interaction and process. However, the majority of clients that I was seeing in this placement faced significant external challenges and disadvantages, such as long-term unemployment and socioeconomic disadvantage, that understandably could detract from the internal focus.

The traditional focus on biological and instinctual factors and internal dynamics largely ignored social, cultural and interpersonal influences and thus tended to locate problems exclusively within the individual. This is clearly unsatisfactory when applied to disadvantaged clients. As my ability to converse and practice within the traditional psychodynamic approach improved, I became increasingly enthusiastic about the polemical theories of Kohut (1971, 1977, 1979, 1984). Kohut introduced a greater emphasis on the individual’s external environment, than found in Freud’s intrapsychic theories. He also challenged the notion of the neutrality of the therapist which, he maintained, caused further narcissistic injury to the client. He theorised the selfobject narcissistic needs, communicated via mirroring, idealising and twinship transferences, and consequentially legitimised ‘normal’ narcissism to reject, what he called, the false ‘maturity morality’ of being self-sufficient, self-reliable and self-responsible. He questioned rigid theories, which he termed ‘experience-distant’, and insisted on an ‘experience-near’ approach, which involves openly, accurately and empathically listening to clients. Indeed, Kohut has been accredited with combining humanism and psychoanalysis because of the centrality of empathy to his approach (Kahn, 1997).
The influence of Kohut’s insights and guidelines on my practice can be exemplified by my work with Ms H, who presented for psychodynamic therapy to help her explore relationship difficulties around her fear of rejection and acceptance of mistreatment due to low self-esteem. She had previously engaged in various therapies, and had entered therapeutic communities and hospital several times. She tended to cut herself when upset and had taken several overdoses. At our first meeting, she described a troubled and traumatic past including her early adoption and episodes of sexual and physical abuse. She stated her dissatisfaction with previous therapists and how she had prematurely terminated in order to pre-empt endings. I hypothesised that her early abandonment and subsequent adoption into an apparently unsupportive and, at times, abusive environment may have contributed to fragmentation of the self as unfulfilled demands were hidden because of the trauma associated with attempting to satisfy them (Kohut and Woolf, 1978). However her current presentation seemed to indicate continued hope that selfobject narcissistic needs could be fulfilled (Kohut, 1971).

My priority was thus to facilitate an environment in which Ms H could feel safe enough to reveal, and attempt to meet, archaic, unfulfilled narcissistic needs. I did not therefore always match her frequent silences but would encourage her to articulate her experience. I empathised with her anger towards me about breaks and ending. I offered her a glass of water when she struggled to speak because her mouth was so dry due to medication. I did not interpret when it did not feel appropriate, rather I concentrated on responding to her ‘real’ need. I was honest and open about what we could achieve together and about my experience of her. I frequently asked her for feedback. In short, I was dedicated to strengthening our relationship and maintaining an empathic therapeutic alliance because I believed, like Kohut, that therapy could provide an emotionally-corrective experience. Indeed, even though Ms H found the process extremely difficult, an empathic approach enabled us to work through ruptures in the therapeutic alliance and she did attend and ‘survive’ our ending and was beginning to become more independent, for example by developing friendships outside of sessions.
The switch to the highly-directive cognitive-behavioural approach in my third year was quite problematic as it seemed too structured and I worried about encouraging dependency in clients. However, I found the abundance of techniques, particularly aimed at challenging and changing 'faulty' thinking, which is thought to cause disturbances, could be tailored to the individual client and easily incorporated into other mainstream approaches. I welcomed the emphasis on the collaborative working alliance, particularly the engagement in Socratic dialogue to identify 'dysfunctional' beliefs and the purposive goals of learning and practising new skills and changing unhelpful thoughts and behaviour. I found constructivist contributions particularly helpful in integrating cognitive-behavioural theory and techniques into my practice. The constructivists have incorporated contributions, particularly unconscious and intersubjective phenomena, from other approaches to overcome the limited focus of the traditional theory (for example, Guidano, 1984, 1988, 1991; Liotti, 1987, 1991; Mahoney, 1983).

Mr G, presenting with symptoms of Irritable Bowel Syndrome which were increasingly impinging upon his professional and personal life, was greatly helped by the cognitive-behavioural approach. By collaborative engagement, he overcame his initial embarrassment about discussing his symptoms, and, by charting in detail his bowel habits, he came to see a pattern to his distress. He identified key stress triggers and together we explored how he might change aspects of his lifestyle, which he then experimented with. In this case, the emphasis on teaching and learning was useful in avoiding the derogatory connotations of (mental/psychosomatic) illness but at times, it seemed to overemphasise thinking and action, whilst underplaying the role of emotions, underlying conflicts and the client's past. However, adopting a more schema-focused approach (Young, 1990) helped Mr G to identify beliefs, stemming from childhood, about being inadequate. He was able to see how much of his stress was self-induced, being linked to feelings about always having to push himself to work hard in an attempt to hide his 'deficiencies'. Exploration of how this phenomena was present within our relationship facilitated a greater intersubjective awareness in which he recognised his reluctance to reveal his 'true self' for fear of being judged.
Integrating research

A fundamental aspect of integratively applying psychology is engagement with research, both as an active researcher and as a consumer of others’ endeavours. There has been some debate about the incompatibility of the values of traditional scientific research and counselling psychology (Elton-Wilson, 1995). The scientist-practitioner model developed out of clinical psychology and emulates the medical model of illness which adopts a realist epistemology, whereas counselling psychology is based upon phenomenological and humanistic philosophies (Van Deurzen-Smith, 1990; McLeod, 1994). However ‘science’ is not exempt from cultural and temporal influences. In recent years there has been an increase in qualitative psychological research which seems better suited to complementing “the scientific demand for rigorous enquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship” (Guidelines for the Professional Practice of Counselling Psychology, 1998: 3). Counselling psychology adopts a broader view of the nature of science that incorporates phenomenological standpoints.

During training I have gained experience of interpretative, phenomenological, and more traditional, positivist modes of enquiry. This diversity enables an integrative approach to research based on selecting the method most suited to the research questions and phenomena to be investigated. In practice, the insight gained by having personally been through the research process means that I am able to recognise and reflect upon its contributions and limitations. This is particularly relevant when considering research relating to psychotherapeutic efficacy. For example, I appreciate that tightly-designed research trials are unlikely to fully capture the complexity of the therapeutic encounter. Therapists, clients, presenting problems, diagnoses and the content of therapy may be misrepresented as uniform and simple. On the other hand, evidence-based practice is geared towards developing protocols to ensure that clients receive the best-suited treatment available and whilst “we cannot be sure that treatment success was based on choice of therapeutic orientation...we cannot be sure that it was not” (Roth & Fonagy, 1996: 46).
I consider research evidence as essential as it provides a base and guidelines for practice, provides a forum for debate and has the potential to improve standards of care. For example, working psychodynamically with a client, carrying the diagnosis of Borderline Personality Disorder, did not seem to be helping. I considered the possibility that I was inflicting further narcissistic injury to an already fragile ego and questioned treating a client within a certain therapeutic frame when it was clearly having a detrimental effect upon her psychological well-being. There was some evidence in the literature that a more directive and confrontative approach had been found to be more beneficial than interpretative work (Sperry & Mosak, 1996). I therefore began to work according to these guidelines, which seemed to help the client gain a sense of stability. I understood this in terms of offering direction and containment for this chaotic and disordered client.

However, the shortcomings of psychotherapeutic research, the dearth of research into integrative practice and the proliferation of research suggesting the critical role of pantheoretical factors in determining outcome, indicates that it would be unsatisfactory to rely only on formal research evaluation to inform my selection of orientation and technique. Whilst diagnoses and research focus the content of the intervention, ultimately the process and style of the intervention is dictated by the cognitive style of the client (Clarkin et al., 1992). Resulting protocols cannot be seen as satisfactorily applicable to the variety of clients' presentations (Rush, 1993). Roth & Fonagy (1996) suggest that such shortcomings can be overcome through interpretation and that paradoxically evidence-based practice depends upon the skill of the individual therapist to see the relevance of specific discoveries to the individual client. They argue that clinical protocols represent the default option for treatment but that the practitioner's judgement must mediate its implementation. That is the therapist must decide whether a particular presentation is normative or whether factors exist that deter from the recommended treatment.

Treatment decisions are also informed by the broad research base of academic psychology, including developmental models and social psychology (Wilkinson & Campbell, 1997) but must ultimately be made within the context of a therapeutic
relationship and will depend upon the consideration of (inter)subjective factors. Research has shown the variables of the therapist and the therapeutic relationship to be significantly more important than theoretical approach in determining outcome (for example, Arnklok et al., 1993; Beutler et al., 1994; Clarkson, 1995; Gelso & Carter, 1985; Glass et al., 1993; Lambert, 1992; Luborsky et al., 1985; Orlinsky & Howard, 1986). Thus, I integrate treatment guidelines arising from the research base, into the context of the specific relationship with, and my understanding of, the individual client.

This is exemplified by some work that I undertook within a cognitive-behavioural placement. Mr L presented with a twenty-year history of anxiety-related difficulties. He had previously seen "untrained counsellors" and a clinical psychologist. He said that the psychological input had been helpful, as he had been able to successfully apply relaxation techniques to offset symptoms of panic. He described recent business meetings where he had "nearly fainted" due to anxiety, although he had never actually fainted. He alluded to traumas, separations and losses in a detached, uneasy and incidental manner, and stated that he was returning to therapy to look for additional techniques to control his reactions and rid himself of his anxiety.

Outcome analyses have generally suggested the efficacy of cognitive-behavioural treatment for anxiety disorders (Chambless & Gillis, 1993; Durham and Allen, 1993; Roth & Fonagy, 1996). Cognitive theories (for example, Beck et al., 1985) helped me to understand how Mr L's problems seemed to evolve out of a belief about needing to control anxiety and emotions more generally. His idiosyncratic coping style over the years appeared congruent with this. I hypothesised that his anxiety was an expression of underlying conflicts and denied emotion, and had been maintained by subtle forms of avoidance over the years (Butler et al., 1987). Therefore an important goal would be to normalise anxiety rather than to collude with any notion of eradication. Intolerance of even low-levels of anxiety seemed to be perpetuated by a deep-seated and unhelpful belief about uncontrolled emotions being dangerous, therefore teaching more techniques to control his symptoms could reinforce this. Further, there was no apparent need for crisis-intervention. I therefore avoided highly-structured cognitive-
behavioural techniques (such as agenda-setting) in order to model spontaneity (Emery, 1993) and encourage Mr L to experiment with emotional exploration within a safe, holding therapeutic alliance (Winnicott, 1965). This approach integrated psychodynamic and existential contributions into a cognitive framework.

Mr L originally found this more explorative, less structured approach difficult. I encouraged him to think about his desire for more direction and techniques, linking them to his beliefs about uncontrolled emotions. Had he not successfully learnt controlling techniques before, which he could still apply? He agreed but insisted that he had not been able to "completely get rid of" anxiety. I normalised anxiety and encouraged him to use the therapeutic space to explore his anxiety and to face his fears. With growing confidence, he explored his fears, particularly in relation to death. At times when he felt "blocked", I offered interpretations. He monitored his anxiety levels in and out of sessions. At ending, he saw anxiety as an integral part of human experience rather than a defect within himself. He no longer felt that he needed to always be in control and was actively experimenting with "dropping his guard" in his relationships, having begun an intimate relationship.

The need for this kind of case-by-case, ongoing reflection integrates the research process very clearly into the realm of practice. Attention to process issues, as well as outcome, translates each piece of clinical work into a case study whereby the practitioner engages in a disciplined reflective research process and the supervisor becomes co-researcher (Clarkson, 1998). Thus whilst I integrate the available psychological and psychotherapeutic evidence into my practice, I also regard myself as engaged in continuing research with each client. I see this as fundamental to my identity as a scientist-practitioner and to my continuing development as an integrative counselling psychologist for this ensures an ongoing process of evaluation alongside a purposively critical attitude towards my own practice which, in turn, enhances my selection of theories and techniques.

Microanalysis of sessions has greatly helped me to understand the process and progress of therapy and evaluate specific interventions and styles with individual
clients. A retrospective Communicative Analysis (Smith, 1991) of a session with Dr R, presenting with relationship difficulties for psychodynamic therapy, illuminated problems within our relationship, the therapy and myself. I came to recognise how I was narcissistically protecting myself from harsh but accurate derivative messages, that were possibly communicating dissatisfaction, and how my own value as a trainee was tied up with my perception of clients' progress in therapy. This led me to create more opportunities for feedback and my increased reflections upon our interaction encouraged Dr R to reflect upon his own intersubjective style and how he might sometimes appear critical to others.

Supervision also provides the opportunity for ongoing research at a micro-level. I reflected upon my work with Ms D, who presented with a phobia of medical procedures to a CMHT. She was highly intelligent and questioned many of my assumptions, for example the impact of early experience. I wanted to be more open to such challenging and create more reflective spaces for myself and between us but instead was matching her intellectualising style. Subsequent microanalysis of a transcript of a session helped me to see how when threatened I tended to gather evidence to support my assumptions and 'persuade' her of the validity of my version of 'reality'. I was also able to see how our strong working alliance survived clumsy interventions and helped both of us to continually challenge our beliefs and intellectual defences.

Concluding comments
The notion of integration continues to challenge me at this stage in my professional development. As such, my ideas about it still feel 'incomplete' and are therefore not easily articulated in the written form. Possibly, the permanency of 'black and white' script does not lend itself to report about such an ongoing, highly-complex task as integration. That is, recording statements could give the impression that integration has happened and that 'this is the way to do it'. In fact, I believe that one of the main assets of the integrative psychologist is flexibility and in this sense, certainly at this early stage in my professional development, I regard myself as integrating, rather than integrative. I aim to continue to assimilate new ideas from theories, research, clients,
colleagues and my own personal experiences and believe that my training and my experiences have equipped me with the critically-evaluative and reflexive skills necessary for the task.

References


Research Dossier
Introduction to the Research Dossier

The research dossier contains three separate pieces of work, each relating to therapeutic practice with pregnant clients. The research topic is contextualised within the first piece of work, the literature review, and is then further investigated in two empirical pieces which follow. One of the empirical investigations employed qualitative analysis and one employed quantitative analysis.
Pregnancy, psychology and patriarchy: Considerations for research and therapeutic practice

Abstract
The subjective experience of pregnancy, contextualised within the medical establishment, is discussed in relation to societal and cultural expectations centred on pronatalist ideology and gender-based assumptions. The traditional, positivistic psychological literature is shown to reflect the biological focus on foetal development whilst the woman's subjective experience of the process of pregnancy has largely been ignored. More recent qualitative approaches are considered. It is suggested that therapeutic psychologists potentially have much to offer in terms of collecting in-depth subjective accounts in order to challenge the dominant portrayal of the white, middle-class, heterosexual, married mother; understanding and alleviating psychological distress associated with being pregnant and becoming a mother; and, ultimately challenging subjective accounts which are confounded by oppressive (hetero)patriarchal discourses.

Introduction
Pregnancy and childbirth are experiences that are unique to women but which are firmly located within patriarchal discourses. The majority of women do become mothers but regardless of whether we have children or not, we are rigidly defined by our ability to reproduce. Societal categorisations of 'good mother', 'bad mother' and 'nonmother' (McMahon, 1995) permeate our psyches. The awareness of our potential to create another life is ever-present, perhaps from the overwhelming fears of pregnancy as a teenager through to the thirties, when a sense of biological urgency may prevail for those women without a child (Raphael-Leff, 1990; Walker, 1990). Despite apparent 'choice' and technological control over reproduction, choice for women still seems to be encouraged on the proviso that the 'right' choice - that is, to become a mother - is made.
As Walker (1990) has noted, it may one day be acceptable for women to choose never to have children but at this time it remains an issue both for them and for the world around them. One quarter of all pregnancies resulting in births are unplanned (Cartwright, 1989). Furthermore, many women find it difficult to explain the decision-making behind having a baby and often centre their explanations on the ticking of the 'biological clock' (Charles, 1998; Currie, 1988; McMahon, 1995). When people act in ways that are considered to be 'normal', they are rarely called upon to articulate their choices and reasons. Unsurprisingly therefore, research has focused on exceptions to the norm – that is, people who choose not to become parents (Veevers, 1980; Woollett, 1991). It could be argued that the frequency of unplanned births and the difficulty women often have in articulating reasons why they have chosen to have a baby may indicate acceptance of the wider cultural expectations and pronatalist ideology rather than choice.

We are acutely aware of the expectations, of the pressure. If we are at ease with 'our' femininity (attributed to us but defined by others, for example, Langer, 1992) then we may try to convince ourselves that we must be capable of selflessly loving and joyously nurturing a totally dependent baby and of assuming primary responsibility for childcare and for the next generation's moral development unquestioningly (Burman, 1994). Knowing that the majority of women do become mothers may ease our doubts. However, the fact that the majority of women do have children does not necessarily mean that the process of becoming a mother is unproblematic (McMahon, 1995).

Traditional psychology and social constructions of the white, middle class, heterosexual 'good mother' excludes black, working class and lesbian women (Homans, 1985; McMahon, 1995; Smart, 1992). Denied societal affirmation, their experience may be confounded by fears that they will encounter disapproval and that their (future) children will be teased in a rigid and unsympathetic society. It is essential therefore that psychotherapeutic practitioners, such as counselling psychologists, have a more inclusive understanding of pregnancy in order not to reinforce narrow (hetero)patriarchal ideology.
Informed and egalitarian psychotherapy may provide an opportunity to respectfully challenge the narrow idealisation of pregnancy and motherhood, rather than validating or colluding with women's taken-for-granted experiences -if constructed in terms of oppressive traditional perspectives (Kitzinger and Wilkinson, 1997). Ultimately, this may help to begin to free individual clients from the damaging expectation that 'normal' women, by virtue of their gender, are able to make the transition to motherhood, joyfully riding on the crest of a wave and never looking back. This paper reviews the psychological literature that relates to pregnancy whilst attempting to highlight contradictions and gender-based assumptions. It is hoped that this will prompt readers to consider their own belief systems about pregnancy and pregnant women.


Psychotherapy

Issues relating to mothering and nonmothering may arise in many different ways in psychotherapy with female clients. The following are several such issues that are reflected in the literature. Women who are unable to have children may raise issues that are provoked by feelings of grief and identity crises (Langer, 1992). Women who choose not to have children may present with feelings of guilt, reinforced by a society that constructs them as selfish and 'unnatural' (O'Barr et al, 1990). All mothers-to-be and mothers face the complex and difficult task of meeting the needs of a child whilst simultaneously addressing their own. Neglecting one's own needs may lead to feelings of frustration and resentment whereas perceptions of neglecting the child may lead to feelings of guilt (Walker, 1990).

In the future, the ubiquitous nature of antenatal care may provide the possibility of incorporating a "psychological check-up" (Offerman-Zuckerberg, 1980) and providing psychological and emotional support during pregnancy. In order not to pathologise women further, the opportunity for seeking help from a psychological professional should of course be made available rather than made compulsory. Any therapeutic interaction with pregnant women must be geared towards widening choices, encouraging acceptance of ambivalent feelings, the joy and the sorrow, associated
with being pregnant and becoming a mother, and collaboratively exploring alternative perspectives and interpretations. "An anti-hierarchical stance, awareness of cyclical and rhythmical processes, the interconnection of opposites and a recognition of the deep influence of society on everyone's psyche" (Chaplin, 1988: Preface) are essential to effective psychotherapeutic practice with women whose own experiences are confounded by the dominant discourses.

Pregnancy has been highlighted as an opportune time for psychotherapy. Psychotherapy, with individuals or with families, can help to prepare for and anticipate life with a baby. Hitherto, the literature in this area has been dominated by psychoanalysts drawing on clinical case studies (for example, Langer, 1992; Raphael-Leff, 1990, 1991, 1995; St André, 1993), (for accounts of working as a pregnant psychotherapist see Fenster et al., 1986; Gerson, 1996; Rosenthal, 1990). The accounts indicate that pregnancy alters the therapeutic setting because of the introduction of an other into the therapeutic relationship thus creating a triangle between client, therapist and foetus, which consequently affects transference and countertransference. Rosenthal (1990) suggests that such challenging alterations provide opportunities for marked advances in therapy.

Raphael-Leff (1990) has described how psychotherapeutic intervention can help 'disturbed' women to achieve better integration of internal resources and self-representations, and therefore to avoid postnatal distress and pathological mother-infant interactions. Risk-indicators are specified, such as 'conflicted pregnancies' (including unplanned), 'emotional sensitization' (for emotional difficulties in relation to the foetus, pregnancy or birth) and 'complicated pregnancies' (examining possible concurrent physical conditions, life events, socioeconomic difficulties and lack of adequate social support).

The developmental transformations during pregnancy provide a unique opportunity for brief, conflict-focused psychotherapy and clinical examples illustrate four psychotherapy themes: conflicts over dependency needs, narcissistic disturbances, reconciliative themes and working through losses while giving life (St-
Andre, 1993). For physical difficulties, Langer (1992) recommends that a specialist in psychosomatic medicine should attend pregnant women. Drawing on her own hospital practice, she maintains that weekly, thirty minute, psychotherapeutic conversations throughout pregnancy are sufficient for satisfactory outcomes in women who have previously experienced difficulties, particularly miscarriage, during previous pregnancies.

Whilst the above outlined literature may indicate the usefulness of psychotherapy with pregnant clients, it is biased in that it generally concerns paying psychoanalytic clients. Furthermore, psychoanalysis adopts an essentially individualistic, intra-psychic approach which underemphasises the necessary exploration of dominant cultural and societal ideologies that shape subjective experiences of pregnancy. Thus the wider psychological literature on pregnancy will also be considered.

Early Psychological Foundations
Early research and theory on motherhood is now outlined in order to understand how ideological assumptions about motherhood have permeated more recent research on pregnancy.

Until recently there were two main positions regarding pregnancy and motherhood within psychology, i.e., biologically-based and socially-based theories (Boulton, 1983). The former were closely allied with the medical model whereas the latter were concerned with dismantling the idealisation of motherhood. Two extreme, opposing views of motherhood resulted which permeated the psychological 'knowledge', i.e., women as 'natural' mothers who experienced their role as rewarding and women as socially engendered mothers who were 'trapped' within their deeply dissatisfying and oppressive roles.

The biologically-based theories (including psychoanalysis and ethology) emphasise the importance of the continuation of the species and the essential central role of the mother in the care of the young. Early psychoanalysts (for example, Balint,
1949; Deutsch, 1945; Fromm, 1967; Winnicott, 1975) equated being a woman with being a mother, representing the mother role as instinctual and naturally rewarding. Any dissatisfaction with the role was explained in terms of the individual's immaturity, developmental problems and rejection of the female psychosexual destiny:

The very fact that a woman cannot tolerate a pregnancy, or is in intense conflict about it, or about giving birth to a child, is an indication that the pre-pregnant personality of this woman was immature and in that sense can be labelled psychopathological. [...] Pregnancy and childbirth are the overt proofs of femininity. (Fromm, 1967: 210)

The ethological school (for example, Ainsworth, 1969; Bowlby, 1979; Leach, 1979; Trause et al., 1976) emphasises the bond between mother and infant and is based largely upon animal observations. This bond in humans is construed in terms of love (Bowlby, 1973). Love causes the repetitive tasks of motherhood to be experienced as intrinsically rewarding. Dissatisfaction is explained in terms of inadequate or maladaptive bonds, that is, that the mother does not love her children. Motherhood is argued to be a deeply emotionally satisfying experience, which may be impoverished or distorted by cultural prescriptions or organisation, such as the isolation of mothers from other adults and lack of support from older women (Blurton Jones, 1974). In summary, for the ethologists, motherhood for a 'normal' woman in 'natural' circumstances is fulfilling and unproblematic.

Psychoanalysis and ethology conceptualise women's experiences as mothers within a framework of endogenous and innate characteristics and impulses. Unlike psychoanalysis, the ethological school does take account of social and physical circumstances but these are secondary to the primary factors of the innate predisposition to form a bond and subsequently the nature of that bond in the mother. Both ethology and psychoanalysis explain women's experiences as mothers from an essentially individualistic stance. Observational methods of both schools have focused on the child and the child's interaction with the mother (for example, Bowlby, 1957,
1969). Children, however, like animals, do not have the language to explain their feelings, experiences and meanings. Writers such as Boulton (1983) and Burman (1994) have noted that such epistemological approaches led to a child-centred view of mothering in psychology. Thus, generally women have only been included in psychological investigation as mothers, in relation to child development, whilst their own development as women has been disregarded:

Her identity as a woman is absorbed into that of mother, she is treated as responsible for her child’s subsequent deeds and misdeeds through the emphasis on the importance of early experience and she is drawn into the discourse of developmental psychology through this positioning, as both originator and monitor of her child’s development (Burman, 1994: 58).

Child-centred investigation and the view that motherhood was unproblematic dominated until the 1970s.

Socially-based theories, rooted in sociology and social anthropology, whilst acknowledging biological foundations, maintain that we are able to rise above biological limitations to organise childcare culturally and socially (for example, Friedl, 1975; Oakley, 1972). A woman’s experience as a mother is therefore considered within her social context and it is argued that throughout a woman’s life society engenders through socialisation the desire and ability to look after children (Bernard, 1975; Oakley, 1974). The message that ‘to be a mother is to be normal and properly feminine’ (Oakley, 1974) is given and received on many different levels and is reinforced by rewards and sanctions to ensure ‘appropriate’ behaviour. Theories of dissatisfaction and distress offer explanations in external, societal terms and acknowledge the juxtaposition of the obligation imposed upon women to be mothers in order to be ‘normal’- that is feminine, mature and respectable - and the low-status of child care and consequential low self-esteem (Bernard, 1975; LeMasters, 1974). Such research highlighted the alienating conditions for mothers in the isolated nuclear family (Kitzinger, 1978); the overwhelming exclusive responsibility for childcare (Bernard, 1975; Comer, 1974); the incompatibility of child care and housework
(Oakley, 1974); the lack of psychological and emotional preparation for becoming a mother; and lack of support with and uncertainty about, the endless, unfamiliar tasks of mothering (Graham and McKee, 1980; Kitzinger, 1978). Thus there was a general consensus about the problems of motherhood being located in the social organisation of the role.

During the 1980s, feminist sociological explanations of motherhood largely replaced biologically-based, 'natural' explanations (for example, Oakley, 1981, 1984a, 1986). Such work emphasised the social nature and historic malleability of motherhood. The established position of women, as exclusive carers in nuclear families in Western society, was challenged. It was argued that this childcare arrangement – reinforced by the domination of the Attachment Theorists since the 1950s (for example Ainsworth, 1969; Bowlby, 1958) – was not ideal for women or for their children. This early feminist research was necessarily emancipatory but empirically women’s subjective experience was still largely ignored due to the emphasis on the work of motherhood and the oppression of women (for example, Firestone, 1970). Research investigating the oppressive nature of motherhood and women’s domestic work risks representing women as passive accomplices in their own subjugation, whilst the focus on the socialisation model reduces women’s commitment to motherhood to gender-role conformity (McMahon, 1995). The aims of the researchers - to refute the rewards of motherhood – resulted in a limited focus and sentimentalised any positive experiences.

The above overview suggests that neither socially-based theories nor biologically-based theories presented a holistic picture of the complexities and subtleties inherent in the experience of becoming a mother. However the influence of these theories is evident to this day. Pregnancy as a developmental stage for women has been absent from mainstream psychological texts (for example, Bornstein and Lamb, 1992; Honess and Yardley, 1987) and undergraduate courses. Where pregnancy is mentioned, it is too often analogous with prenatal development (for example, Kaplan, 1993). Previously, accounts of motherhood had predominantly focused on the child and currently, mainstream biological accounts of pregnancy focus on the foetus.
Little attention has been given to the female experience of pregnancy other than in medical and biological terms.

*More recent contributions: Towards a bio-psycho-social model*

Many women are able to make the transitions of pregnancy without experiencing long-term psychological problems (Smith, 1992) but research indicates that for some women pregnancy *is* experienced as a crisis (McMahon, 1995). Some women have detailed their own personal “psychic crisis” during pregnancy (for example, Rich, 1986). *All* pregnancies involve loss and entail significant psychological, social and lifestyle challenges as well as physical upheavals (Raphael-Leff, 1995). As such, it is necessary to understand pregnancy in terms of the interaction between social, psychological and biological factors (Hunter, 1994; Scott and Niven, 1996). What follows is a review of the more recent literature in order to heighten awareness of challenges and changes that a woman may encounter during the course of a ‘normal’ pregnancy.

*Identity*

Every pregnant woman experiences a shift in identity. As soon as a woman is visibly pregnant, she is perceived as an expectant mother. Lips has noted that in our culture the dominant image of pregnant women is as “happy, content, fulfilled, and glowing”, which is perpetuated by the media (1993: 226). This is quite contradictory to the medical and social-scientific focus on pregnancy as an illness, a disability or a trap. However, research shows that a pregnant woman is likely to draw actively from popular stereotypes to construct an identity for herself as overwhelmingly happy about the pregnancy and eagerly anticipating the arrival of her new born (Deutsch *et al.*, 1987). It has been suggested that feelings of guilt, failure or inadequacy may arise if the individual is unable to maintain this blissful state and live up to this unrealistic ideal (Lips, 1993).

Nicolson (1986, 1988, 1990a) has noted that whenever there is a major change in identity, as there is particularly with the birth of a first baby, there is a loss of self. She suggests that women are likely to lose power as they withdraw from the
workplace, as a consequence of pregnancy and childbirth, in terms of economic power (due to loss of paid employment), power in the home (as they become financially dependent and undertake more of the household chores) and through the influence on and infantilisation of women by the medical profession. Nicolson argues that grief and mourning for the old self are necessary reactions and part of psychological reintegration, and should not be automatically interpreted as indications of maladjustment or illness.

Research such as Nicolson's may help to free women from the victim-blaming, pathological model of pregnancy by challenging the depiction of 'glorious' motherhood and highlighting difficulties that women face in their transition to motherhood. The empathic communication of the recognition of issues of loss during pregnancy in psychotherapy (Nicolson, 1989, 1990b) could have a powerful normalising effect on the 'postnatally depressed' female client. The affirmatively understood individual may then be better equipped to challenge the sociocultural assumptions around her and reconstruct her 'madness' as understandable and 'normal' ambivalence. Condon (1987), Mauthner (1993) and Ussher (1991) have offered further more 'normalising' explanations of pregnancy-related distress, which is usually observed as postpartum distress. They note that it is actually during pregnancy that many factors occur (such as giving up work). There is also evidence to suggest that at least 10% of pregnant women are clinically depressed and that this depression is likely to worsen as pregnancy proceeds (Kitamura et al., 1993; Loudon, 1987; Martin et al., 1989).

Relationships
Major identity changes inevitably have consequences for the woman's social experiences and relationships. Most significantly the relationships with mother and partner will be affected (Raphael-Leff, 1995), and the pregnant woman may experience a "growing psychological connection with [these] key others" (Smith, 1995; 189). The pregnant woman may look to her family for support, particularly her partner (Carol et al., 1993; Collins et al., 1993; Scott-Heyes, 1984).
It has been found that antenatal support, particularly from friends and family, is very important for mothers' psychological health immediately after giving birth (Ball, 1987; Oakley, 1992). Low emotional well-being has been more frequently observed postpartum in women who report high levels of anxiety and depression during pregnancy (Sharp, 1989; Watson et al., 1984). A perceived lack of support by the pregnant woman from her family, most notably from her partner, has been found to be associated with poor maternal adjustment to pregnancy and prenatal depression (Collins et al., 1993; Scott-Heyes, 1984). Thus one could conclude that the developing and strengthening closeness of prospective parents is 'good' for the woman's psychological health.

However, not all research has replicated these findings. For example, the results of a prospective study of 48 women who completed psychometric measures at 34 weeks prepartum and 10-14 days postpartum suggested that certain types of antenatal support increased vulnerability to postnatal psychological disturbances (Wheatley, 1997). In this sample, 25% of the women were reported as fulfilling the diagnostic criteria for Postnatal Depression. Perhaps surprisingly, women who had received lots of emotional and practical support from their partners during pregnancy were found to be more vulnerable. Explanations for this included the accumulation of caring debts that the woman then feels unable to repay as a new mother, or, alternatively being "let down" by their partner (previously explained by Brown et al., 1986, as when women initially perceive their partner to be more supportive than they actually are in practice). Evidently the relationship with partners during pregnancy requires further investigation. Also required is empirical investigation of experiences that do not conform to the prevailing construction of the (heterosexual) woman with (male) partner, which remain virtually invisible within research.

Employment

The experiences of pregnant working women have been little investigated. However, abstinence from the workplace because of pregnancy or motherhood is indicated as a factor contributing to experiences of postnatal distress (for example, Ball, 1987; Nicolson, 1990a). However, in a country which does not offer pregnant workers the
support found in other European countries, such as Norway (Leira, 1992; Oakley, 1992), women still face incompatible structural choices that the majority of their male counterparts do not (McMahon, 1995). In a modern, developed society, much of each individual’s identity and self-worth is invested in work. Employment status certainly influences how others regard us and therefore employment restrictions encountered during pregnancy can create conflict and frustration (Walker, 1990). At this time, employment may be a more influential variable in the experience of pregnancy than has previously been acknowledged (Charles, 1998).

Physical changes
Alongside major identity and social changes, pregnancy involves physical changes which are also influenced by the interaction of biology, psychology and society (Hunter, 1994). The influence of psychology upon physical and emotional experiences relating to pregnancy is evinced by cases of pseudocyesis, or pseudopregnancy, with cases reported usually in sterile women but occasionally in men, and ‘couvade syndrome’ reported usually in expectant fathers (Condon 1987; Rabbuzi, 1994). Physical changes and symptoms associated with pregnancy, for example abdominal swelling and nausea, are experienced where there is actually no pregnancy. The physiological changes experienced are clearly determined by the expectations of the ‘sufferers’ and are thus better explained in psychological and social, rather than purely biological, terms.

Morning sickness is a negative physical reaction that, in our culture, is immediately associated with pregnancy, particularly during the first trimester. The frequency data is inconclusive having been reported to occur in between 24% (Lips, 1993) and 72% (Matlin, 1996) of women. Despite the widely variable findings, most incidence rates are reported as less than 50% and so it would seem that more women do not experience nausea and vomiting than do. Those women that do, rather than indicating a rejection of the foetus or the father (as had been a dominant psychoanalytic explanation; for example, Deutsch, 1945), may be reacting in a prescribed way according to their cultural ‘script’.
We also expect pregnant women to gain weight. In a society where women are valued by their appearance (Ussher, 1988) and where ‘slim is sexy’ (Leroy, 1993), the weight gained during pregnancy provokes a change in body image and sexual identity which may give rise to a host of ambivalent feelings (Oakley, 1986; Savage, 1981). The positive side of this socially acceptable weight gain is that women may experience a freedom with food and eating that they have previously never been permitted. Overeating (“eating for two”) and strange dietary requests are humoured for the most part. Pregnant women, like pre-menstrual women, are allowed, if not expected, to behave in ‘weird and wonderful’ ways because of their ‘raging hormones’ (Ussher, 1988). Hormonal explanations excuse and legitimate erratic behaviour, memory loss, irritability, tearfulness, impatience, and of particular relevance here, unusual cravings for foods – providing that they fall within the medical dietary guidelines of course. However, there is a downside to this aspect of changing body shape as eloquently described below:

I look like a sumo wrestler. In fact, I make a sumo wrestler look anorexic. I’ve had to let out my clothes a kilometre on each side. My birthday covers two days. My fingers feel fat. My eyelids feel fat. I don’t just have double chins, but double thighs, eyes, toes...I can no longer get in or out of a car without the aid of a crowbar. I can no longer do up my shoes. I’ve forgotten what my pubes look like (Lette, 1993: 187).

The humour in Lette’s writing relies upon the reader’s awareness of the narrow definition of a woman’s acceptable size and shape. A little deeper below the humour, is a woman coming to terms with, at the very least, a physical burden if not a sexual crisis.

Savage (1981) draws together existing research and theory to argue that pregnancy is a developmental crisis that potentially has critical effects on a woman’s sexual identity, which is composed of ideal image, body image, self-concept and self-esteem. She argues that positive body image is significantly related to sexual satisfaction and positively correlated to self-esteem. Therefore if women are less
satisfied with their bodies they are less likely to enjoy sex. Further, "feelings of loss of femininity may be reinforced by a change, decrease, or even cessation in sexual activity" (Savage, 1981: 154). The dichotomy for pregnant women is that pregnancy is an overt declaration of sexual activity and fertility, during which some women report feeling 'more of a woman' and heightened sexual interest (Charles, 1998; Raphael-Leff, 1995). However, our cultural definition is of asexual motherhood and so, in scientific research, sexual activity during pregnancy is usually constructed as problematic for the woman (for example, Hart et al., 1991; Hyde et al., 1996; Masters and Johnson, 1966).

The scarcity of literature indicates just how culturally taboo this area is. The empirical literature is so sparse on this very important psychological aspect of pregnancy that new research is still compared to research conducted by Masters and Johnson during the 1960s. Many advances have been made towards legitimising female sexuality during the past thirty years, and it is therefore unsatisfactory for this antiquated study to continue to be the mainstay of psychological knowledge about the effects of pregnancy on women's sexuality.

Overall the available research suggests pregnancy to be a time of physical discomfort, decreased sexual interest and activity, low self-esteem and negative body image worsening as the pregnancy proceeds. Whilst all of these indications may fit comfortably with our cultural script, they are not fully supported by women's own accounts. For example:

When a woman is pregnant, she can find it a hugely sexy time. There is no need for the hassle of contraception, and she and her partner have achieved a romantic goal, with the prospect of an even closer future (Figes, 1998: 34).

I feel very turned on and tuned in all the time, and want everybody to know I'm pregnant, even though it doesn't show yet. I feel round and abundant and wonder-full (sic) (Raphael-Leff, 1995: 66).
Such rich and detailed accounts seem to offer more insights than restricted responses to scientifically-compiled questionnaires, found in more traditional research, influenced by previous, similarly incomplete research and discourses of sexuality centred on heterosexual male pleasure and asexual motherhood (Leroy, 1993).

Sheila Kitzinger (1983) was one of the first women to address in detail, through her own experiences of four pregnancies and in-depth conversations with other women, the effects that pregnancy may have upon a woman’s sexuality. She outlines how breast tenderness, anxieties about miscarriage (reinforced by medical advice, founded on inconclusive research lacking control groups), tiredness and financial concerns are offered as explanations for decreased sexual interest during the first trimester. Leroy (1993) has suggested that as tiredness is often regarded as a viable ‘excuse’ for women to abstain from sexual activity, this implies that sex, for many women, is another demand and not something replenishing and fulfilling.

Kitzinger portrays the second trimester of pregnancy as a time of heightened sexual excitement and freedom. Psychologically, the woman may be more relaxed as she no longer has to fear pregnancy or worry about contraception. Physically she may be more sexually aroused because of a moist vagina, engorged vaginal tissues and pressure on the internal organs. Kitzinger explains male partners’ lack of sexual enthusiasm in terms of fears about hurting the baby. However exploratory research (Charles, 1998) indicates that the ‘slim is sexy’ (Leroy, 1993) ideology may also decrease a man’s desire for his partner:

I think my husband got quite a shock seeing my appearance change. [...] He found it quite strange when I started to get a bigger tummy [...] it hasn’t really affected me but he feels quite strange, like if we wanted to have sex he would feel a bit strange because of hurting the baby but obviously it doesn’t (Lucy, ex-midwife in Charles, 1998).

Lucy’s professional expertise was not enough to allay the fears of her husband who continued to explain his abstinence from sex in terms of concern for their unborn
child. However elsewhere Lucy says that this fear was not present during the first few months and it was only once her shape started to change that he became 'concerned'.

The third trimester may be physically uncomfortable because of heartburn and indigestion. Psychological stress may be experienced because of negative body image resulting from feeling fat, ugly and unattractive (Kitzinger, 1983). Despite Kitzinger's comforting words of reassurance to the contrary, it would seem that women's negative body image and decrease in sexual interest may be reinforced, or triggered, by their partner's, and other's reactions (Charles, 1998; Leroy, 1993; Savage, 1981; Ussher, 1988). Kitzinger suggests that medicalised antenatal care promotes women's distrust in the abilities of their bodies and invalidates their opinions therefore making it difficult for pregnant women to enjoy their bodies. A further confounding factor has been suggested to be the new sense of moral obligation and responsibility as a parent-to-be, particularly mothers-to-be who still bear ultimate responsibility (Burman, 1994).

The focus and aims of research during this century have been undeniably influenced by the medicalisation of pregnancy. This is evident in psychology where few studies have addressed the psychology of a 'normal' pregnancy (Smith, 1992). The emphasis has been on the pathological - for example “anxiety during pregnancy, ‘maladaptation’ to mothering, complications during labour” (Smith, 1992: 175), nausea, ‘Postnatal Depression’ and so on. Women experiencing ‘normative’ pregnancies and motherhood are largely invisible. It has been argued that this emphasis on the problematic has generated misinformed and distorted cultural expectations about pregnancy (Matlin, 1996). More recent researchers (for example, Hunter, 1994; Oakley, 1990) have elaborated the difficulties that pregnant women report encountering with their medical care and treatment, and the self-effacement and self-sacrifices required in order to comply with the medical handling of pregnancy within developed societies. Raphael-Leff (1995) has noted that the occurrence of postnatal depression is higher in the West than in more traditional societies. The cultural organisation of pregnancy and childbirth has profound effects upon how the individual subjectively experiences them. The high prevalence of postnatal depression seems to
be culturally specific, thus within our society it is necessary to consider psychological theories of pregnancy alongside the medical context in which it occurs.

**The medical context of pregnancy**

Traditionally, psychologists have reinforced the medical, pathological model of pregnancy, as an illness requiring intervention (Smith, 1990; Ussher, 1988). The medical handling of pregnancy and childbirth has been justified by emphasising the improved physical health of women and reduction of mortality rates during childbirth (Loudon, 1992). It has however also been argued that this ‘expert’ handling is politically motivated (Dalley, 1994; Oakley, 1975, 1981, 1984a, 1984b, 1990, 1993; Stacey, 1988). Oakley, in particular, has provided a thorough history and critique of the medicalisation of pregnancy. She describes how this has served to disempower women by taking away their control over what was once a natural phenomenon handled exclusively by women in the community, and placing control very firmly within the medical establishment, under the jurisdiction of predominantly male strangers.

Rabuzzi (1994) has eloquently argued that from the moment of conception, women are portrayed as passive in biological accounts, as an incubator whose contribution and essential role are underemphasised. Mass education teaches that the male sperm energetically races to seek out the female egg and penetrate it. However male bias may be evident even in shaping this scientific ‘fact’ as in the following account the egg plays a more active role than is implied in the traditional version:

You can clearly see the egg reach out and draw the sperm into the inner area. Then the egg penetrates the top of the head of the sperm and blows it up. Then [the sperm] explodes and its genetic material is distributed throughout the egg. Thus, the two merge into one, but the egg’s role is active, agentic (Rabuzzi, 1994:2).

The medicalisation of pregnancy has ensured patriarchal control of a uniquely female experience. In our society we emphasise the role that doctors play in giving
birth and not women. A most extreme example of this, debated to this day, is the case of the Dionne Quintuplets born in 1934, in Ontario, Canada (Soucy, 1997). The five girls, the first quintuplets to survive beyond infancy, were born to an uneducated and poor couple. The girls were made wards of the Ontario government under the supervision of the doctor who attended their birth, Dr Allan Roy Dafoe, who was lauded as a national hero. They were taken from their parents who were only permitted to visit them upon the rare approval and under the strict supervision of 'Papa Dafoe', until they eventually won a nine year battle for custody. This case, whilst clearly unusual, indicates the potential damaging and alienating effects of the external localisation of control over pregnancy and childbirth. The doctor, rather than the mother, was praised for his wonderful achievement. Mme. Dionne's low status and lack of power ensured that her rights were not prioritised and she and her husband were denied the experience of being parents to the children to whom she gave life.

Thus there are problems with institutionalised obstetric care. The medical handling of pregnancy involves close monitoring of the mother-to-be and the foetus. The ability of women to give birth successfully and to care adequately for their children is continually questioned and denied (Forna, 1998a, 1998b; Oakley, 1993). Pregnant women are increasingly bombarded with information concerning appropriate and forbidden behaviours, for example 'healthy eating' and abstinence from physical exertion. The medical model, however, gives little thought to the effects that this period of rapid physical and psychological change may have upon the woman who is actually living inside the 'body-as-incubator'.

Pregnancy involves two people living under one skin (Raphael-Leff, 1991, 1995). However the relentless focus on the foetus implies otherwise. Antenatal care is concerned with 'educating' rather than supporting and the pressure to comply with the 'scientific guidelines' by behaving 'appropriately' is overwhelming (Forna, 1998a, 1998b; Watson Smyth, 1998). Women are controlled by the fear that if something were to go wrong with the pregnancy or birth then they would be to blame (Balin, 1988):
...and sorry the expectant mother will be made to feel if there is anything wrong with her baby when it is born (Forna, 1998a: 4).

The case of Pamela Rae Stewart (Bonavoglia, 1987) indicates that pregnant women are right to be fearful. Stewart was arrested nine months after the death of her baby. She was considered to be a criminal because she had failed to follow her doctor's orders during pregnancy.

The medicalisation of pregnancy has rendered this a time during which women learn that their unborn child is more important than they are. Pregnant women become 'public property' and consequently lose control of their own bodies once they are visibly pregnant. This has influenced attitudes towards pregnancy and pregnant women (Graham and Oakley, 1986). Strangers may violate body boundaries and assume the right to touch and pat their stomachs. Ricki Lake, a chat show host, recently expressed her annoyance with the public invasion of her body by her audience whilst pregnant ('Light Lunch', Channel 4, December 1997). Strangers may publicly admonish pregnant women who are observed smoking or drinking alcohol (Forna, 1998a).

Foetus-focused antenatal care encourages women to sacrifice their own needs and desires – perhaps preparing for the patriarchal requirement to be a selfless mother. The ideology that necessitates 'good mothers' to attend antenatal classes and clinics, and unquestioningly follow their doctor's advice and instructions could also be argued to prepare women to meet the patriarchal prescription for self-effacement as a mother. Some women, however, are able to resist and challenge such control:

It seems to me that scientists come out with a different message every day and you never quite know how reliable their studies are [...] I drank wine in moderation all through my pregnancy and I think that science is just a way of justifying puritanism (Caroline Stacey, Food Editor of Time Out magazine, in Watson-Smyth, 1998).
Stacey is able perhaps to cast doubt upon the imposed dietary restrictions because of her own expertise in this area. Many women do not have such resources on which to draw with confidence.

Therefore, the current treatment and care of pregnant women within our society can often be experienced as alienating and insensitive (Hunter, 1994; Oakley, 1984b). However it is within the subjective narratives of women, (for example, Lette (1993; Rich, 1986), rather than the psychological literature, that rich and enlightening accounts can be found. Lette's voice is liberated in her fictitious account through which she is able to offer a frank and frightening portrayal of the experiences of a pregnant woman. She describes her character's dissatisfaction with antenatal care:

I'm feeling as though I'm being interviewed for a job I don't want (:1).

with her character's treatment by medical staff during labour:

He [the doctor] is speaking about me as though I'm not here (: 83).

and fear of childbirth because of the impersonal intrusion of the body (emphasised by the switch to the more distanced voice of third person narration):

The thought of having strangers peer up her privates sustained her in a permanent state of terror (:253).

It is possible that the guise of fiction permits the expression of such complaints and communication of a deep sense of alienation that has been silenced or largely ignored in academic fields.

Whilst the medicalisation of pregnancy may carefully monitor physical health, the biological focus has not adequately accounted for the psychological processes and societal context of pregnancy and for the high frequency of psychological distress associated with this stage of rapid physical, social, emotional and psychological change. Three diagnostic constructs of 'Postpartum Depression' occur in our society. 'Baby blues' occurs in up to 50% of mothers and lasts for the first few days following delivery. It is said to be characterised by emotionality and readiness to cry and is considered to be mild and self-limited. Major mood disorder postpartum, commonly referred to as 'Post Natal Depression', occurs in at least 10% of mothers and is said to last for at least two weeks and can persist well beyond the post-partum period. It is
portrayed as similar in character to Reactive Depression and is marked by loss of appetite, insomnia and low mood. Postpartum Psychosis occurs in less than 1% of mothers and usually requires psychiatric care because of an inability to cope, and delusional and suicidal thoughts (Stotland, 1996). The shortcomings and biases of such diagnoses are well-documented (Condon, 1987; Mauthner, 1993; Nicolson, 1986; Ussher, 1991). Feminist criticisms have highlighted how the medical model generally ignores social factors, is deterministic and therefore does not account for different meanings for different women, blames the individual mother and her 'dysfunctional' body, and, fails to allow women to talk and therefore to listen to their voices.

Stotland (1996) notes that postpartum psychiatric illnesses may be associated with symptoms related to other reproductive events and are likely to recur with subsequent pregnancies. This indicates a degree of predictability and the possibility for prevention. Despite this, psychotropic intervention is rarely considered during pregnancy (Loudon, 1987) even where indicated, because of the prioritisation of physical considerations for the foetus over the psychological needs of the pregnant woman. Thus research and intervention have been suspended until postpartum when a diagnosis and psychotropic correction are more ethically acceptable. Research suggests the probability of the aetiology of such depression or mood disorder being rooted in the process of pregnancy (Sharp, 1989; Watson et al., 1984). As such, psychotherapeutic intervention and support during pregnancy may help to alleviate or prevent such psychological distress and decrease the high rate with which psychotropic medication is prescribed and consumed in this country (Mitchell, 1984).

The reproduction of biologically-focused research within psychology has neither challenged nor advanced the unidimensional 'knowledge' about motherhood. Instead, it may have contributed to the perpetuation of unsubstantiated and misleading theories to account for frequently occurring unhappiness that pregnant women report at reproductive stages, such as pregnancy, in their life cycle (Macy, 1986). This has left women largely unsupported in the monumental task of challenging the medical establishment and scientific 'knowledge', for example when attempting to resist and
look beyond their doctors' unclear explanations about 'raging hormone' levels (Ussher, 1988) - and the incongruency of addressing this assumed (but not tested) 'hormonal imbalance' through the prescription of psychotropic drugs.

Antenatal care, biologically-based developmental guidelines, foetus-focused education, and the general medicalisation of pregnancy and childbirth can exacerbate rather than alleviate any unhappiness, anxieties, distress or confusion that a pregnant woman may experience (Kitzinger, 1983; Oakley, 1981, 1984b). Hunter (1994) asserts that counselling skills are essential for professionals working in the areas of gynaecology and obstetrics because of the sensitivity and skill required in helping women feel comfortable in consultations about their personal lives and intimate parts of their bodies. She suggests that employing counselling skills, is necessary "in order to redress existing bias towards biological explanations of illness and health by giving appropriate attention to the influence of psychological and social factors" (Hunter, 1994: 9).

The significant influences of sociocultural institutions, the medical establishment being of particular relevance here, tends not to be acknowledged in individualistic, biological accounts of psychological distress which emphasise the instability of women's emotional state and thus pathologise the individual (Mauthner, 1993; Ussher, 1988). Positioning women who experience difficulties during pregnancy as 'abnormal' allows the dominant "sugar-coated version of Motherhood" (Lette, 1993:7) to persist unchallenged. This may help to explain the relative lack of any meaningful exploration of pregnancy-related psychological distress within mainstream psychology. The kind of research that has begun to redress this imbalance is considered below.

Research

Feminist Standpoint Research (Griffin, 1995), emphasises the importance of experience and challenges the difference in power between researcher and researched in quantitative positivism. Research, consistent with this epistemology, is beginning to emerge and attempts to address the full complexity of the experience of pregnancy for
individual women. The work of two respected researchers in the field of pregnancy is discussed below.

Joan Raphael-Leff (1991, 1995), a psychoanalyst and social psychologist, has drawn upon her professional and personal experiences to pull together thousands of hours of therapeutic data, in-depth research interviews and supervision, personal experiences of pregnancy, personal analysis, discussion and group exploration to offer a multi-dimensional model of pregnancy. The boundaries between subjectivity and objectivity, so rigidly policed within positivistic approaches, are blurred as Raphael-Leff's insightful work suggests the appropriateness of the psychotherapeutic setting to gather rich, subjective data. She is concerned with the individual's responses to pregnancy and stresses the infinite variety and range of those responses whilst offering a flexible model which encompasses certain trends and tendencies in mothering that begin during pregnancy. Raphael-Leff defends the self-selective middle-class bias in her work by emphasising the value of exploring pregnancy-related distress amongst a sample who tend not to be constrained in socioeconomic terms. Whilst this may indeed be revelatory, one must be mindful that:

A woman is never only a woman: multiple other social relationships of race, class, ethnicity, or sexuality shape the lived meaning of being female [...] Gender, race and class relationships are thus implicated, albeit not always consciously so, in our deepest sense of ourselves (McMahon, 1995: 24).

As such, much work remains to be done if we are to address the multivariate individual voices in their individual contexts adequately. However, each case study, whilst not a representative account from which generalisations regarding all women can be made, does offer in-depth personal dialogues which help to demystify and increase our understanding of the subjective experience of pregnancy.

Jonathan Smith has pioneered qualitative investigative methodology and grounded analysis of identity transition and adaptation to pregnancy and motherhood, which he has termed Interpretive Phenomenological Analysis (Smith, 1991, 1992,
Adopting a case study approach, he is concerned to capture the individual woman's meaning of her own experience of pregnancy. It is interesting that a man has chosen this area of female experience in which to employ and develop quite radical research methods. But, as shown, pregnancy had not been satisfactorily addressed, investigated or portrayed within the positivistic tradition of psychology. Therefore it could be surmised that this area of female experience could not fit within the patriarchal organisation of psychology. Understandably then, pregnancy was of appropriate interest to a researcher whose aim was to challenge positivistic methodology.

Such emerging emotionally-rich qualitative data has the potential to challenge established stereotypes surrounding pregnancy, previously reinforced by more traditional research concerned with depersonalised correlational conceptualisations and statistical averages. There is a need for further empirical research in order to understand the complex inter-relationships of biological, psychological and social variables during pregnancy.

Conclusion

There is no necessary contradiction between pleasure and pain, between the construction of becoming a mother as 'depressing' or 'naturally rewarding' (Boulton, 1983). However institutionalised antenatal surveillance and intervention has created a mechanical and alienating experience of pregnancy for many women (Corea, 1985; Davis-Floyd, 1993; Hunter, 1994; Rautava et al., 1990). This has led to the sentimentalisation of any positive or rewarding experiences women may have as mothers (Leroy, 1993) and the pathologisation of any negative experiences (Ussher, 1988).

The experience of pregnancy is moderated by cultural, social and psychological factors. Medical intervention and (hetero)patriarchal prescriptions of female desirability confound and complicate the physical experiences of pregnancy. Many women may find themselves dependent upon the patriarchal institution of medicine
and constrained by damaging ideologies that are "located within a socially or culturally organised framework for understanding which prescribes women's identity and conduct in terms set by gendered social institutions and relationships" (Henwood, 1993: 306). Pressure to conform, to behave or react in the prescribed way may be overwhelming for some women, who may feel obliged to renegotiate their own interpretations and deny their own insights and understanding.

The lack of current, structured, psychological provision for pregnant women implies an expectation that women are able to make the necessary identity and role transition, whilst negotiating major life changes and multiple psychological and social adjustments, without the need for such support. The reality may be different but, despite growing research interest, contradictions, conflicts and inconsistencies in the 'knowledge' and the discourse continue to mystify this uniquely female experience. The need for grounded research and affirmative and challenging psychotherapeutic practice is paramount in order to create a less rigid and controlling psychological framework of pregnancy. In order to avoid the mistakes of previous researchers, research must be flexible and 'friendly' and theory must be grounded in the accounts of those whom it concerns. Therapeutic psychologists potentially have an important contribution to make here, in terms of collecting data from clinical case studies.

However, it is debatable as to how much therapeutic psychologists, relying on traditional, academic psychology, would be able to help their clients' explorations of the psychological demands and processes of pregnancy, or challenge assumptions about biological destiny and (hetero)patriarchal duty. Not only do clients encounter powerful sociocultural forces which may erode and undermine any therapeutic reframing of perspective, but, traditional psychology itself appears to be embedded in patriarchal discourses that are restrictive and potentially damaging to pregnant clients.
References


APPENDIX

*Feminism and Psychology*: Notes for contributors
AIMS AND SCOPE

General policy: Feminism & Psychology aims to provide an international forum for debate at the interface between feminism and psychology. The principal aim of the journal is to foster the development of feminist theory and practice in — and beyond — psychology, and to represent the concerns of women in a wide range of contexts across the academic—applied 'divide'. It publishes high-quality, original research and debates that acknowledge gender and other social inequalities and consider their psychological effects; studies of sex differences are published only when set in this critical context. Contributions should consider the implications of 'race', class, sexuality and other social inequalities where relevant. The journal seeks to maintain a balance of theoretical and empirical papers, and to integrate research, practice and broader social concerns.

Feminism & Psychology encourages contributions from members of groups which are generally under-represented in psychology journals, and individuals at all stages of their 'careers'. The journal has a policy of not publishing sexist, racist or heterosexist material. The journal encourages positive reviewing, which aims to provide supportive and constructive feedback to authors.

Feminism & Psychology publishes:

- Theoretical and empirical articles
- Research reviews
- Reports and reviews of issues relevant to practice
- Book reviews
- Observations and Commentaries
- Special Features
- A 'Spoken Word' section

Special features are designed to highlight the views of women who are the clients, students, survivors or general users of psychology, and to present debate on a wide range of contemporary issues surrounding feminism and psychology. The Spoken Word features topical contributions (discussions, interviews, profiles) which rely primarily on the spoken rather than the written word.

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NOTES FOR CONTRIBUTORS

1. All submissions will be peer reviewed. Papers written in English are invited for consideration, provided they have not been published, nor are currently under consideration, elsewhere. The journal also aims to include translated pieces which have been published previously elsewhere, in languages other than English.

2. Manuscripts should be typewritten, double-spaced throughout, on A4, or 8.5'x 11', paper with generous margins, and not right-justified. References should be Harvard system, and in the following style: e.g.


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

3. An abstract of approximately 150 words should be included with each submission; but need not be supplied for observations or commentaries.

4. Authors' names, titles and affiliations, with complete mailing addresses and telephone numbers, should appear on a separate cover page. Authors are invited to provide any biographical information they would wish reviewers to take into account on a separate sheet. The aim of this information is to avoid discrimination against those without standard academic backgrounds or institutional support. All submitted articles will be reviewed anonymously.

5. Submissions are welcomed for Special Features and The Spoken Word. These will normally be developed in conjunction with a member of the Editorial Group. In the first instance, suggestions should be sent to the Special Features Coordinator of the Editorial Group.

6. Authors should avoid the use of sexist, racist and heterosexist language. Manuscripts that do not conform to these specifications will not be considered. Authors are encouraged to use clear language which avoids unnecessary jargon.

7. Twenty-five offprints of the article, plus a copy of the journal, will be supplied to article authors on publication.

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

9. Six copies of all manuscript submissions, including the original, should be sent to the Editor, at the Department of Social Sciences, Loughborough University, Loughborough, Leicestershire LE11 3TU, UK. A copy on disk will be required before publication, but should not be included with the initial submission. Further information may be sought from any member of the Editorial Group.
Abstract
This paper reports a qualitative investigation into psychotherapeutic practitioners’ subjective understandings of, and attitudes about, working with clients who are pregnant. Semi-structured interviews and interpretative phenomenological analysis were employed to enable exploration of individual therapists’ social representations, concerning pregnancy and pregnant women. The analysis presents salient themes arising from the data, grouped according to three categories (i) therapists’ understanding of pregnancy; (ii) therapists’ understanding of how training influences their understanding and (iii) how therapists understand the impact of a client’s pregnancy upon their therapeutic practice. It is suggested that this research highlights how social representations influence the subjective understanding of individual practitioners, which impacts upon the therapeutic encounter, particularly in relation to a client group who receive little attention in the literature and training courses.

Introduction
‘Knowledge’ and attitudes about pregnant women evolve alongside reproductive technology, societal values and cultural ideology. One hundred years ago women’s reproductive processes were linked to mental weakness and instability (Showalter, 1987). Indeed, pregnant women were not considered to be suitable clients for psychotherapy before the 1970s (Kahr, 1998). More recently psychoanalysts, such as Langer (1992), Raphael-Leff (1990, 1991, 1995), and St André (1993), have highlighted pregnancy as an opportune time for psychotherapy, with individuals or with families, to help to prepare for and anticipate life with a baby.

Traditional psychology has largely ignored pregnancy as an area of interest and research (Burman, 1994). Until recently two extreme, opposing positions regarding pregnancy and motherhood permeated the psychological ‘knowledge’ – biologically-based and socially-based theories. Biologically-based theories, including
psychoanalysis and ethology, were closely allied with the medical model and portrayed women as 'natural' mothers who were satisfied in their role (for example, Bowlby, 1979, Fromm, 1967, Winnicott, 1975). This view dominated until the 1970s when socially-based theories began to dismantle this idealisation of motherhood and portray women as socially engendered mothers who were 'trapped' into their deeply dissatisfying and oppressive roles (for example, Bernard, 1975; Kitzinger, 1978; Oakley, 1974). However, the emphasis on the work of motherhood and refuting any rewards also ignored women's subjective experience and sentimentalised any positive experiences.

Pregnancy as a developmental stage for women is still absent from mainstream psychological texts (for example, Bornstein and Lamb, 1992; Honess and Yardley, 1987) and courses. Where mentioned, pregnancy is often analogous with prenatal development (for example, Kaplan, 1993). This biological focus on the foetus does not address psychological and emotional aspects of pregnancy for the woman nor capture the complexities and subtleties inherent in the experience of becoming a mother.

More recent work has highlighted pregnancy as a major life event for many women involving rapid biological, psychological and social changes. Research has begun into the psychological impact upon pregnant women of factors such as a changing body image (Savage, 1981), abstinence from the workplace (Ball, 1987, Nicolson, 1990), changing relationships and identity transition (Smith, 1991). Further, the medical handling and control of pregnancy has been described as confounding the experience of pregnant women (Oakley, 1984, 1993). Such work has acknowledged the potential for psychological difficulties at this time and gone some way to challenging the assumption that becoming a mother is unproblematic.

Furthermore, there is a high frequency of reported psychological distress, particularly postpartum, associated with pregnancy and childbearing. There are three major diagnostic constructs of 'Postpartum Disorder' in our society; 'Baby Blues', 'Post Natal Depression' and 'Postpartum Psychosis' (Stotland, 1996) and there is some
evidence that the aetiology of post-natal depression is rooted in pregnancy (Sharp, 1989; Watson et al., 1984).

A high incidence of depression has also been reported during pregnancy (Barnett et al., 1996; Mercer and Ferke, 1988). It is estimated that 10% of women experience depression during pregnancy and that this depression is likely to worsen as the pregnancy proceeds (Loudon, 1987). This may be an underestimation as antepartum depression often remains undiagnosed because of the similarity between symptoms of depression and somatic complaints of pregnancy (Klein and Essex, 1994). Antepartum depression has been found to be a substantial risk factor for Postpartum Disorders (Green and Murray, 1994; Pfost et al., 1990) and postpartum psychiatric illnesses may be associated with symptoms related to other reproductive events and are likely to recur with subsequent pregnancies (Stotland, 1996). Thus a degree of predictability is indicated and consequently the possibility for preventative intervention.

Psychotropic intervention is rarely prescribed during pregnancy because of the need to consider the potential adverse effects on the developing foetus as well as the psychological needs of the woman. There are no published studies that provide information on the long-term effects of in-utero exposure to psychotropic medication because pregnant women are excluded from pre-marketing experimental studies on ethical, medical and legal grounds (Weissman and Olfsen, 1995). Therefore, such research and intervention are generally suspended until postpartum when a diagnosis and psychotropic intervention are ethically acceptable. Nevertheless, epidemiological data evinces the need to consider alternative treatment issues during pregnancy.

Raphael-Leff (1990) argues that psychotherapeutic intervention can help ‘disturbed’ pregnant women to achieve better integration of internal resources and self-representations, thereby avoiding postnatal distress and pathological mother-infant interactions. Others have noted how challenging alterations in the therapeutic setting and relationship, brought about by the presence of an other, provide opportunities for marked advances in therapy and how the developmental transformations during
pregnancy provide a unique opportunity for brief, conflict-focussed psychotherapy (Rosenthal, 1990; St André, 1993).

Despite such possibilities for preventative, proactive therapeutic intervention in this area of apparent 'need' for psychological support, Spinelli (1997) recently claimed to have conducted the first clinical treatment trials of antenatal depression, in a 16-week pilot study with 13 pregnant women who met DSM-III-R criteria for major depression. These women engaged in interpersonal psychotherapy and rates of depression experienced by them were found to significantly decrease. Thus there is some evidence that psychotherapy could be an effective alternative to pharmacotherapy during pregnancy.

The literature suggests that this area of psychological theory and practice is under-researched and present in the mainstream largely in biomedical and foetus-focussed terms. Opportunities for the potentially preventative application of psychological therapies with pregnant women do not seem to be being fully exploited. However, some psychotherapeutic practitioners (referred to as 'therapists' for simplicity from this point on) are evidently working with, and advocating the benefits of practice with, pregnant clients. It is suggested therefore that an initial way of increasing our knowledge of practice with this client group would be to investigate how therapists understand pregnant women and practice with pregnant clients.

In the absence of substantial theory and research, it would be interesting to consider how therapeutic practice is influenced by social processes, and the consequences of this, for example in decisions about what treatment the client receives (Tyrer and Steinberg, 1993). Thus, it is suggested that an appropriate theoretical framework within which to conduct this research is Social Representations Theory (SRT). Social representations are thoughts, images, ideas and knowledge structures which are socially constructed and shared by members of a group (Augoustinos and Walker, 1995). 'Knowledge' is defined as factual information, shared belief systems and taken-for-granted social practices (Morant, 1998). SRT considers the communicative and interactive processes in which knowledge is produced and emphasises the
influence of both the agency of the individual and the power of society on psychological processes, such as knowledge (Flick, 1994; Moscovici, 1984).

Social representations exist at both individual and collective levels and serve to render unfamiliar social objects, persons or events meaningful by contextualising them within familiar categorical concepts. This occurs through the processes of ‘anchoring’ and ‘objectification’. Anchoring involves categorising and naming processes by which unfamiliar elements of knowledge are linked into other, pre-existing, familiar spheres of knowledge. For example, by naming psychological distress as ‘mental illness’ this phenomenon is understood as an illness that should be treated in similar ways to physical illness (Morant, 1998). Objectification then transforms the abstract concept into a tangible, ‘real’ object or image, which serves to make it more accessible (Augoustinos and Walker, 1995). For example, the psychoanalytic objectification of the ‘ego’ is evident in everyday discourse and ‘common sense’ knowledge (Moscovici, 1984).

This research explores the ways in which therapists understand pregnancy, and how such understanding, which may be generated through the processes of anchoring and objectification, ultimately affects therapeutic practice. It is hoped that this will permit consideration of the potential for therapists to work with this client group and the identification of any relevant training and research issues.

**Method**
As this research is concerned with individual therapists’ understandings, a qualitative approach was adopted. Qualitative methodology is suited to the investigation of the dynamic and implicit qualities of social representations as they occur in social interaction. It also has the scope to attend to the complexity of both individual and collective levels of meaning. Semi-structured interviews were conducted in order to obtain rich and detailed information about therapists’ understandings and experiences of working with pregnant clients, which may not have been fully captured by narrower, more structured methodologies.
Participants

Participation criteria was that participants had experience of psychotherapeutic practice with pregnant women and were Counselling or Clinical Psychologists, (identified from the British Psychological Society register of Chartered Psychologists) or Psychotherapists (identified from the United Kingdom Council of Psychotherapists register). Both registers were used with the aim of broadening the scope and variety of training, theoretical orientation, experience, and practice setting amongst participants.

Invitations to participate were limited to therapists in the London and SouthEast areas because of geographical accessibility for interviewing purposes. An initial sample of 50 potential participants was selected randomly by selecting the fifth name from each register. A letter outlining the study and inviting participation (Appendix I), a brief participation form (Appendix II) and a Stamped Addressed Envelope were sent to each. This yielded a sample of only 4 participants who fulfilled the criteria. 3 further therapists expressed their interest in the project but had no relevant clinical experience. The response rate (n = 4; 8%) was very low (Fife-Shaw, 1995).

The recruitment procedure was repeated and obtained a further 3 participants (n = 7; 7%). Time limitations restricted the extent to which invitations to participate could be repeatedly sent out, and due to the still small sample size, a snowballing strategy was employed but only 1 more participant was obtained via this method. Finally, invitations were sent to 2 acknowledged authorities on the topic who, it was hoped, would be willing to participate and be able to draw upon their own experience and their knowledge of general trends and patterns in this area of practice. They agreed. Thus a final, workable sample of 10 practitioners, with experience of working with pregnant clients, was obtained through direct random, and purposive, invitation and snowballing.

Procedure

Following an extensive review of the relevant literature, a semi-structured, open-ended interview schedule (Appendix IV), attentive to the processes of anchoring and objectification, was designed in order to allow comparison across participants’
responses whilst permitting in-depth exploration of individual meanings and idiosyncratic responses. The schedule was tested and refined during a piloting stage. The main areas covered in each interview concerned understanding of pregnancy and conceptualisations of pregnant women, views about and experiences of therapeutic practice with pregnant clients, and opinions about the potential for work with this client group. All the interviews lasted between one and two hours, and took place at the participants’ place of work and, with each participant’s written consent (Appendix III), were audio-taped and later transcribed when any identifying information and names were omitted or replaced to ensure confidentiality.

Data Analysis
A method of analysis, described as ‘Interpretative Phenomenological Analysis’ (IPA) (Smith et al., 1997, 1999) was chosen in agreement with the aims of the research. IPA, whilst concerned with individual perspectives and beliefs, also recognises the active influence of the researcher’s interpretative framework upon the dynamics of the research process. This method was informed by SRT (Moscovici, 1984), which adds the recognition of the interaction of individuals’ beliefs with historical, social and cultural factors to the analysis. Both frameworks are consistent with the critical realist epistemological position, adopted here, in that a relationship between participants’ accounts and the actuality of what they speak is recognised.

IPA is concerned with understanding what participants believe or think about a particular topic and explores participants’ perceptions through language, whilst acknowledging that bias and distortion are integral to recall and that thoughts are not transparent in verbal reports. The analytic process involves a dynamic interaction between the researcher’s interpretative framework and the reports whereby the researcher is actively involved in trying to make sense of the accounts. SRT claims to study the ‘thinking society’ and is concerned with how people make sense of their worlds, highlighting the significance of communication, and therefore language, in the creation, continuation and transformation of representations. As this research aims to investigate through interviews how therapists understand and make sense of pregnancy and therapeutic practice with pregnant clients, both frameworks were
considered appropriate and complimentary and their combined use was hoped to produce a more comprehensive analysis of the participants' accounts.

**Stages of Analysis**

Initially the following procedure was followed for one interview transcript. Subsequently the other transcripts were analysed individually in the same way and finally the results across transcripts were combined, allowing for the significance of individual variation.

The first stage involved repeated readings of the transcript in order to become intimate with the text. Notes were made alongside the text which identified statements of particular relevance or importance to the individual. Summaries, associations with other aspects of the interview, initial interpretations and, eventually, emerging theme titles (key words capturing the essential quality of what was found in the text) were also noted.

The preliminary themes were then listed and clustered to form thematic categories whilst the transcript was repeatedly checked in a cyclical process. This ensured that clustered themes and developing interpretations were grounded in the phenomenology of the individual accounts whilst also allowing for the emergence of new connections and categories. A table of major themes and subthemes, which best captured the participant's concerns, was then produced and corresponding revelatory phrases and significant statements were indicated within the text.

After close analysis of each separate account, patterns of similarity and diversity were identified across the data set comparing the themes arising from the individual accounts to modify, elaborate, and bring together the theme lists. Finally, the most significant themes (in terms of the aims of the research) were listed with illustrative quotations from the data set. These were then subjected to further analysis in order to consider how participants anchored and objectified pregnancy and pregnant women.

**Evaluation of Analysis**
Evaluations of the subjective analysis involved in qualitative research depend upon criteria such as transparency, persuasiveness and coherence. The position of the researcher, as a trainee Counselling Psychologist who is interested in developing psychological services for women, must be considered in terms of the themes constructed, the categories identified and the sense made of the wider social context. That is, there may be a tendency to elaborate certain features of the data set. However, the external method of validation of 'Investigator Triangulation', involving presentation of the data to another researcher to reflect upon interpretations, was employed throughout. Further, presentation of raw data (quotations), as evidence of the researcher’s interpretations should permit the reader to assess internal cohesiveness and consistency of the analysis (Smith, 1996).

**Analysis**

7 participants described their ethnicity as white or Caucasian, 2 as Jewish and 1 as Scottish. 9 said they were British, of whom 1 had dual nationality (Canadian). The number of pregnant clients worked with varied greatly between participants and ranged from 1 to 150 (Mean = 20, Standard Deviation = 46) as did the length of therapeutic practice which ranged from 3 to 33 years (Mean = 17, Standard Deviation = 8). Further demographic information about the participants is presented below.

*Table 1: Demographic Information of the Participants*

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Job Title</th>
<th>Theoretical Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beryl</td>
<td>70</td>
<td>Family &amp; Couple Therapist</td>
<td>Systemic</td>
</tr>
<tr>
<td>Brendan</td>
<td>44</td>
<td>Child &amp; Adolescent Psychotherapist</td>
<td>Psychoanalytic</td>
</tr>
<tr>
<td>Christopher</td>
<td>53</td>
<td>Psychotherapist / Counselling Psychologist</td>
<td>Integrative</td>
</tr>
<tr>
<td>John</td>
<td>62</td>
<td>Clinical Psychologist</td>
<td>Rogerian / CBT</td>
</tr>
<tr>
<td>Laura</td>
<td>59</td>
<td>Psychotherapist</td>
<td>Transpersonal</td>
</tr>
<tr>
<td>Mark</td>
<td>54</td>
<td>Child Psychotherapist</td>
<td>Psychoanalytic</td>
</tr>
<tr>
<td>Michelle</td>
<td>50</td>
<td>Psychotherapist / Trainer</td>
<td>Gestalt</td>
</tr>
<tr>
<td>Rachel</td>
<td>57</td>
<td>Professor of Psychoanalysis / Psychoanalyst</td>
<td>Psychoanalytic</td>
</tr>
<tr>
<td>Sarah</td>
<td>47</td>
<td>Senior Lecturer / Clinical Psychologist</td>
<td>Eclectic</td>
</tr>
<tr>
<td>Valerie</td>
<td>39</td>
<td>Counselling / Health Psychologist</td>
<td>Integrative</td>
</tr>
</tbody>
</table>
This paper presents salient emergent themes presented around (1) therapists' understanding of pregnancy, (2) the influence of training upon therapists' understanding and (3) how therapists understand the impact of a client's pregnancy upon their therapeutic practice. Overall, participants discussed pregnancy as a challenging time, involving life-style upheavals and restriction for the woman, which could be complicated by cultural dictates and social pressures.

In the exemplar quotations, empty square brackets indicate that material has been omitted, and material within square brackets has been added to clarify meaning. Emphasis in speech is illustrated by bold type. Pauses and silences in speech are indicated by a series of three full stops.

*Therapists' understanding of pregnancy*

Throughout the interviews, there was an overall sense of pregnancy as a difficult and challenging life stage:

It's such an immense upheaval in the whole way of living [ ] It can mean a whole change in complete everyday living. (Laura)

Pregnancy was represented as a time of interpersonal and intrapsychic conflict, which necessitated significant external and internal changes. In particular, the participants discussed how pregnant women experience changing relationships:

[ ] women report that you become a non-you, you know, people can come up and touch your stomach, you know strangers can come up to you, and anyone, people in the supermarket, people behind the counter, they can give you advice. (Sarah)

Sarah describes how a pregnant woman may be regarded as an object to be touched and advised by insignificant others who compromise her personal space and autonomy, thus depriving her of individualised status. Graham and Oakley (1986) have also noted this violation of body boundaries during pregnancy.
Another important change to emerge across accounts involved the representation of pregnancy as incompatible with a career:

"Thinking about women that [ ] perhaps slow down because they are able to financially, so they are able to slow down and move out of their career in time to be able to relax and have the final stages of pregnancy in a more relaxed way. (Brendan)"

This withdrawal from work is not represented as problematic but as desirable, finances permitting. Work is portrayed in terms of extrinsic gain only. This seems to rely upon the social representation of pregnancy and motherhood as the ultimate fulfilment and "natural role" (Mark) for a woman, which can be found in psychoanalytic theory (for example, Balint, 1949; Fromm 1967), and is more clearly articulated in the following account:

"This could come across as patronising but analysts have the idea that men get their identity from their professional role, from their job, and women get their identity largely from their gender, from being a woman, [ ] a fundamental aspect of that is the biological capacity to give birth. So I tend to that view, you see... (Mark)"

Mark’s expression of theoretical allegiance and the objectification of women as mothers seem to permit him to represent pregnancy and motherhood as fundamentally fulfilling for women, despite his awareness that this viewpoint could be regarded as patronising. The above accounts imply that employment for women is a stopgap, satisfying in extrinsic terms only, before motherhood. This is at variance with the majority of female participants who discussed career interruptions occurring because of pregnancy as potentially problematic because of boredom, isolation and detrimental effects on future prospects:

"Her employment prospects and progression, whether it’s through gradings, the promotional scale, radically changes. (Valerie)"

For Valerie, pregnancy is an obstacle to an advancing career as she implies that employment is an important part of a woman’s life before, during and after pregnancy. The fact that the women in this study were professionals may have
influenced the importance that they themselves attach to work. However, research has suggested withdrawal from work is a significant factor in Post Natal Depression (Ball, 1987) and that for many women the professional self is the primary self (Davis-Floyd, 1994). Today, many women are employed thus theories of human development, generated at a time when few women were in the public workplace may no longer be appropriate. However, some therapists appear to anchor their postulations within familiar, but dated, theoretical frameworks which do not fully address the complexity of the contemporary life of women. The variance between male and female accounts of social changes and the psychological consequences for pregnant women seems to evolve out of an interaction between personal experience and theoretical understanding, with personal experience being emphasised more within the female accounts.

All participants represented women as experiencing an identity and role transition during pregnancy and some elaborated to suggest the significance of a changing body image:

Women who are very caught up in their self-esteem or their self-image suddenly having to adjust and accommodate a new one [body]. [ ] Pregnancy’s like forever really because your body changes and the balance of your body changes [ ] living in a society that values one body shape and many women have that body shape until pregnancy comes along. (Sarah)

Sarah acknowledges that the social representation of attractive women as slim women may be difficult for pregnant women. Thus pregnancy is constructed as having negative consequences for a woman’s body shape, which will no longer be regarded as attractive. Two participants addressed the implication of this narrow representation of female desirability, suggesting that pregnancy necessitates a woman to give up her identity as a sexual woman:

Can a woman be a mother and also be sexual? For some women, it’s very difficult. (Christopher)
Christopher implies that there is little space in society and consequently in women's minds in which to accommodate sexuality alongside pregnancy and motherhood. Sarah also discussed the social representation of non-sexual motherhood and described the paradox involved in being pregnant:

[ ] pregnancy is the ultimate admission 'I'm having sex, I've had sex'. (Sarah)

These accounts suggest that an absence of sexual activity is culturally equated with 'good' motherhood. Pregnant women are often assumed to aspire to be a 'good mother'; this is implied within the accounts but not defined. Nevertheless, a picture of mothers as heterosexual and successfully employed is already apparent. The definition of a 'good mother' and how social constructions (and traditional psychology) deny affirmation to working class and lesbian women has been explored elsewhere (for example, McMahon, 1995; Smart, 1992).

Therapists were generally easily able to discuss the physical processes of pregnancy but when asked to consider the woman's subjective experience, there was more hesitancy as if, for some, there was little space for the woman in their own thinking and understanding about pregnancy:

What you're helping me to focus on is the difference between in-utero development and pregnancy. (Mark)

This response exemplifies the absence of dialogue around women's subjective experience of pregnancy. Generally, participants anchored their understanding of a woman's subjective experience of pregnancy in their own personal, or their partner's, experience:

[ ] I had very little support during my own pregnancies.[ ] I was very fortunate myself in not having any difficulties in pregnancy.[ ] In some ways I did have support but pregnancy was pregnancy and you just got on with it. [ ] It just makes me remember the kinds of anxieties that I had and that I just perhaps, I actually kept to myself and it would have been a great relief to have been able to share them with someone. (Laura)
Laura reflects on her anxieties and lack of support during pregnancy whilst also stating that she was fortunate not to have had any difficulties, despite later mentioning her untold anxieties. Laura therefore seems to be alluding to a lack of physical difficulties as no physical problems is equated with no problems. When pregnancy is represented as a primarily physical experience, there may be little recognition of emotional and psychological aspects. Indeed, pregnancy was overwhelmingly discussed within a medical context and Valerie suggested the medicalisation of pregnancy reinforced the idea of it as "semi-illness":

There is this checking for disease and being treated as though they are unwell and the woman herself becomes anonymous on a conveyor belt of medical practice. (Valerie)

John stated that "reassurance and support from medical professionals can help a great deal" but others also felt that the medical approach could be "dehumanising" (Brendan) for pregnant women who became "part-objects" (Mark) as the 'baby' is prioritised:

[ ] they also ran, in the pregnancy, the mother also ran, but the baby was the winner because the baby got the better attention. (Brendan)

Sarah suggested that "the helping profession becomes the hindering profession" as women are required to make the "unbelievable sacrifice" of silently accepting often irrational and ever-changing antenatal advice. Valerie also described this process in relation to personal experience of questioning the necessity of a test for diabetes during pregnancy:

To resist is like saying 'I don't care about my baby'.

Valerie described feeling that that she was selfish and irresponsible for not following medical procedures unquestioningly. This tremendous medical presence seems to maintain the social representation of pregnancy as an essentially physical event because "the physical safety and the emotional safety aren't given the same level of
attention" (Sarah). Feminist writers have challenged this approach (Oakley, 1993; Forna, 1998).

Nevertheless, there was a general attitude amongst participants that, psychologically, pregnancy could “stir up a lot” (Laura) or act as a “catalyst for disorder” (Brendan), to accentuate any pre-existing psychological problems or unresolved issues within the woman. Pregnancy was thus represented as destabilising and pregnant women implicitly as vulnerable and volatile. Pregnancy-specific problems were described as linked to anxiety and panic reactions “about becoming a mother, about what’s happening during the course of pregnancy in terms of the changes in her life and her relationships” (Rachel), and psychological distress resulting from multiple and rapid psychological, physical and social changes. Some felt that these problems were more likely to occur in particular circumstances, for example with a first pregnancy, an unplanned or unwanted pregnancy, if the woman had previously experienced pregnancy-related difficulties, or felt isolated or unsupported:

And for so many women, they had support previously through family and now because of the mobility in our society [ ] They might be [ ] isolated and [ ] it’s just expected that because they wanted this baby that this is all going to be something that they can cope with. And it can be an immense jolt for people and a very anxious time. (Laura)

Laura suggests that there is a general lack of recognition of pregnancy as problematic in the absence of extenuating circumstances and this seems to be linked to her own personal experience (see above). Indeed, other participants sought abnormal or exceptional reasons to explain why a woman should experience psychological distress in relation to “a biologically absolutely normal event” (Michelle). This thinking may evolve from the cultural idealisation of motherhood and pro-natalist ideology:

People’s immediate assumption is that if somebody tells them they’re pregnant, they should congratulate that person where it might be an absolute disaster for the person. (Rachel)
Therapists perceived this societal idealisation of pregnancy as restricting the expression of discontent or distress, "you cannot talk about certain things" (Brendan). It was suggested that as a woman endeavours to live up to this idealised social representation of pregnancy, her ability to accept her own reactions, for example "stress and frustration" (Christopher), the "normal concerns" (Sarah) and "the strong sense of loss" (Valerie) may be compromised. In contrast to this, therapy was generally represented as "safe and unconditional" (Valerie) where a woman could "say some of the unsayables like 'I don't always want this child'” (Michelle).

**The influence of training**

No participants reported having studied pregnancy from a female perspective as part of their training, and Rachel reported being excluded from undertaking training herself at a well-known institution because of her own pregnancy. Where pregnancy did feature on training courses, it was apparently incorporated into child development programmes which focussed on the foetus. This is consistent with Burman's (1994) observations that there is a child-centred view of mothering within psychology and women only enter the discourse in relation to their child's development. However, there was an assumption amongst participants that training syllabuses would be different now and that pregnancy would feature in a structured way where women were a central rather than a peripheral focus.

I'm a bit out of date but I do think women by and large are treated more as individuals, as people, than sort of a baby carrier. (Beryl)

This seems to be anchored in common representations about modern-day sexual equality but others suggested the perpetuity of a gender bias within psychology:

It's certainly men who have written most of the books. (Christopher)

The implication here is that male theorists have little interest in pregnancy, a female-specific experience. But Mark offered this alternative explanation for the continued
"ignoring of roughly fifty per cent of the population in a very, very significant life stage" (Valerie):

The male envy of the woman gets displaced onto concern for the baby rather than the male just simply being able to wonder at the capacity of a woman to be able to give birth. The emphasis always gets shifted to the baby away from the mother. [ ] I think there's a lot of envy. (Mark)

This explanation found resonance in other accounts where participants discussed pregnancy as heightening:

[ ] the identification with a shared woman-ness because whatever else men can do they can't do this one. (Michelle)

Some of the participants expressed being drawn to this study as they saw this as an opportunity to consider their own beliefs and preconceptions about pregnancy and pregnant women, implying that this opportunity had not arisen before:

I was interested because I know I have a value system about pregnant women and I would be interested partly to hear myself explore it [ ] look at how that influences my work. (Michelle)

I could be here all day. These are very, very deep, deep, very profound questions. [ ] I know you think I'm giving you the opportunity but thank you for giving me the opportunity. (Mark)

When considering training issues, it is acknowledged that the value of research-based practice varies across therapeutic orientations. For example, the psychoanalytically-oriented participants tended to give individualised accounts and reported feeling uncomfortable with generalisations (belying the generalised, psychoanalytic, theories of 'normal' development). Conversely, the 'scientist-practitioner' model of chartered psychologists requires practice to be generated by research and theory, as articulated by Sarah:
anything untrained has the potential to do harm \[ \] I think you would be ill-equipped, you would go into the situation poorly. I do think you need evidence and you shouldn't do things just because you think so.

Prompted by the absence of training and general invisibility of pregnancy as a female experience within psychology, therapists reported basing their understanding and 'knowledge' on personal experience and to a lesser degree their professional experience:

I have to say it's less the theory out there because there's a real dearth of material out there on pregnancy and seeing it as a life change or developmental stage in women and it's [understanding] far more on both personal experience and experience of working with clients. (Valerie)

All participants had some professional experience of working with pregnant clients, but they suggested that the degree to which this informed their practice depended upon the quantity and variety of this work. It could be argued that these therapists are better informed than those with no experience. Nevertheless, even here a bleak picture emerges in which 'experts' seem to practice in a field lacking in theory, training and research as the accounts are filled with representations generated by socially-influenced personal experience and professional encounters with pregnant clients.

Despite the lack of structured training, the values of participants’ professional background underpinned their accounts and there was some recognition of this:

[ ] my training gets into the thinking about pregnancy. (Brendan)

Another participant suggested that accounts of ‘normative’ pregnancies are rare within psychology:

The literature is a bit worrying because [ ] they look at poor outcome and then they look at emotional state. So for example they find a woman who’s miscarried and then they look at anxiety and they find, guess what? Raised anxiety. (Sarah)
This may go some way to explaining why there was a disproportionate amount of extreme clinical examples across the accounts (in which pregnant women were objectified as violent towards their baby, as very young or very old, or as pregnant as a result of rape). It seems that responses to questions about the unfamiliar notion of a ‘physically-normative’ pregnancy posing psychological difficulties for a ‘normal’ woman were anchored into the more familiar focus of psychology on the pathological, the abnormal and the traumatic. Thus, psychological and emotional experiences of the woman tend to be considered as part of the process of trying to understand why something has ‘gone wrong’ during pregnancy. Psychology has certainly been criticised for reinforcing the medical, pathological model of pregnancy as an illness requiring intervention (see Ussher, 1988; Smith, 1990). Other participants also reflected upon how this emphasis on the pathological influenced their thinking:

[ ] we have a biased population to start with [ ] (Valerie)

[ ] if you’re symptom-free, you virtually get no attention. (Mark)

This biased focus is further reinforced by professional experience of working with people presenting for therapy because of a problem. However, this gloomy portrayal is curiously dichotomous with the endurance of the wider social representation of pregnant women as “joyous” (Christopher). The accounts of personal distress encountered during their own (or their partner’s) pregnancy, offered by the majority of participants, seem to give a clue about how therapists are able to reconcile this dichotomy. That is their awareness of the potential for psychological or emotional difficulties during a ‘normal’, commonly considered ‘joyous’, pregnancy seems to evolve out of personal experience.

Thus personal experience, professional contact, societal values and the historical biases of psychology and psychotherapy appear to contribute to therapists’ understanding of pregnancy. Despite a therapeutic emphasis on individual meaning,
these factors will inevitably colour the face-to-face encounter with a pregnant client and will be discussed below.

How therapists understand the impact of a client's pregnancy upon their therapeutic practice

The strongest theme to emerge across accounts of therapy with pregnant women concerned the change in relationship between therapist and client with the introduction of a third - commonly referred to as the "baby". Therapists reported thinking and working more systemically as they now had a responsibility for two clients in therapy. For example:

I think I work much more psychoanalytically with individuals, I'm much more relaxed, much more human with [...] with families. I would suddenly think I'm working with a family now. I think I would have an appreciable change in attitude. I would be thinking family. (Mark)

Mark spoke about himself as becoming "more human" and less psychoanalytic with a pregnant client, as he would with families as compared to individuals. He had also talked earlier on about how he "would want to think of protecting the mother during her pregnant period". Others similarly reported being more supportive, less confrontational, more sensitive, more maternal or paternal, and generally more careful in their approach to pregnant clients. Two expressed reservations about their own behaviour:

To be honest...probably, I feel bad saying this...but to be honest...I'm more sensitive, more tentative. (Christopher)

Christopher had previously spoken at length about the "enormous social pressures" which "infantilise" pregnant women and treat them "as if they've lost their marbles" but he recognises his own biases here. Despite a sociopolitical awareness, it seems he cannot extricate himself from the dominant social representation of pregnant women, encapsulated by the dictate "handle with care" (Beryl). This indicates that practice
with pregnant clients is affected by representations of pregnant women rather than being solely tailored to individual need.

The need to be more sensitive and more human also portrays therapists as unkind and cold, and therapy as a potentially abrasive process, that must be ‘watered down’ for pregnant women. Perhaps even more strongly, John stated his expectation that once a woman becomes pregnant, she would leave psychotherapy to “resume at a better time”. Other participants seemed to feel that psychotherapy during pregnancy would intrude upon “a private and intimate experience” (Mark). This seems to rely upon a representation of pregnant women withdrawing from the public world into a private space, implying restriction. Pregnant women were objectified in case examples as being restricted in further ways by their pregnancy in terms of what they could do. Several used bereavement and pregnancy to objectify this attitude:

[ ] knowing that you can’t grieve fully when you’re pregnant. It makes me also interested in what else you can’t do when you’re pregnant. (Michelle)

This participant ‘knows’ that pregnant women are unable to grieve but the social construction of such ‘knowledge’ is exemplified by the following different opinion:

Bereavement during pregnancy arouses issues that need to be dealt with, the sorrow that needs to be dealt with along with the joyfulness. (Rachel)

Rachel recognises the difficulty of holding two opposing emotions but she represents this as a necessary part of life and not as impossible or beyond the remit of pregnant women. These two opposing attitudes permeated the accounts. Some represented pregnancy as restrictive and disabling because of the multiple changes and thus implied that therapy was inappropriate during pregnancy, as the woman would be unable to cope with any extra demands. The need to “back off”, “lighten up” or “work at a more appropriate level” was expressed repeatedly. Intrinsic to such opinions seem to be issues about responsibility for the unborn child, mentioned earlier, and not wanting to upset the ‘baby’, which may rely upon:
Thus there is evidence that some therapists believe that exploration of any painful issues during pregnancy could upset this otherwise peaceful experience. This tentative stance was justified by a number of participants who anchored and objectified their attitudes in scientific 'proof':

...the Central Nervous System is functioning reasonably well by sixteen weeks. And they've done these very simple tests with pregnant mothers. They'll be interviewing them and then they'll insert a question which will elicit an emotional response from the mother. In the meantime, they have a monitor strapped you see and the baby reacts to the mother's emotional state. So the mother's affect gets transmitted to the baby. I think the psychological experience gets transmitted to the baby.

This indicates that the same prioritisation of the foetus, recognised by some therapists and represented as occurring elsewhere, “out there” or within the medical profession, also occurs within the therapeutic space as social representations come into play. Here we encounter the familiar representations of mothers as responsible for their children’s unhappiness and problems. Through the process of anchoring, the emotional experience of the woman is categorised as that of a “mother” and is absorbed into the more familiar “baby”-focussed context. The process of objectification occurs when observable evidence that the “baby” is distressed by the woman’s distress is offered. Women may be controlled by the fear that if anything goes wrong with the pregnancy then they would be to blame (Balin, 1988; Forna, 1998).

In addition, it seems discussions around physiological response and affect of the foetus bring up issues for therapists about their own responsibility for the physical viability and positive outcome of a pregnancy. Therapists may be scared of also being implicated in a climate of increasing litigation when “pregnancies don’t always end in a wonderful baby” (Rachel). This fear may be particularly strong when personal experience shapes awareness of a ‘life-at-risk’ during pregnancy:
I've had three children, all of whom [ ] have been really quite at-risk at birth and I had known they would be at risk during the pregnancy. But it clearly influences me in terms of seeing the vulnerability of other women or reverberating with the anxieties and the investment that some women have in the unborn child. (Michelle)

This fear suggests that maintaining the pregnancy, 'holding the baby', may be a therapeutic issue. Indeed, therapists' fear of potential disaster is evident elsewhere where working with a pregnant woman is anchored into dialogues about trauma and the need to "protect" pregnant women (Mark) or compared to working with a suicidal client:

I do some checking that is certainly pre-configured so in a way I'm more careful in a changing process. You know I might be careful with a client who's suicidal or who I thought had quite fragile process. (Michelle)

All participants did not share these sentiments. Others referred to supervisory experience of such dilemmas encountered by therapists when working with pregnant clients:

[ ] both analysts and therapists [ ] become quite alarmed by the changes in the woman [ ] they are part and parcel of pregnancy. And what some people feel is a psychotic breakdown happening but it's not, it's something about this reappraisal of identity and opportunity for change. (Rachel)

This alternative representation of pregnancy as "a prime opportunity" (Laura) for reappraisal and change has quite different implications for therapy which, because of the time-limited factor, could make "the whole process [ ] much quicker and beneficial" (Rachel). Some therapists objectified, through clinical examples, the possibilities for preventative psychological care as well as crisis-intervention with this client group. Overall, it was suggested that therapy could fill the need for increased attention to the psychological and emotional aspects of pregnancy. Therapists believed that this could benefit pregnant women by alleviating anxieties, fears, guilt and depression, preparing for the reality of being a parent, facilitating the relationship
between mother and infant, preventing postnatal disorders, breaking cycles of abuse and dysfunctional parenting behaviours, and ultimately by “making social and political change” (Valerie);

However, no participants felt that all pregnant women should engage in therapy and this seemed to be linked to a fear of further pathologising women through the formalisation of emotional support systems:

I suppose my concern is if we start providing for it we might mess it up. Maybe we’ll leave well alone. (Sarah)

This is understandable when considered in the context of ubiquitous antenatal care which marginalises women who choose alternative pathways (Browne, 2000). The hope would be to create space not to further restrict it and Sarah and Valerie, who both have extensive experience in this area, suggested that therapists could use their time to maximum effect by educating obstetric professionals. However, psychological assessments or referrals could be easily incorporated into existing antenatal structures, as in Sweden where psychological screening is routinely administered to pregnant women (Verney, 1981). Participants felt that risk factors for psychological problems during and after pregnancy could be identified but that there was a reluctance to address anything psychological until postpartum.

There are some studies that try to look at what are the predictors of Postnatal Depression and people seem to have some understanding and yet there’s no action [...] You know quite categorically that somebody who experienced Postnatal Depression before is at risk of subsequent...just like suicide so there’s a great big funding and enormous initiatives to try and provide for people who’ve already self-harmed. There’s no such intervention for women who’ve experienced a previous Postnatal Depression. (Sarah)

These data suggest that there may be some cultural resistance against psychological provision for pregnant women. An interpretation of this, suggested by the analysis of these accounts, could be that, even though professionals seem to have an awareness of the social dictates restricting the activity of women during pregnancy, such dominant
social representations appear to compromise the 'neutrality' of the consulting situation. It seems that therapists are no less influenced by social pressures and representations than are their clients.

Overview

Working with pregnant clients evidently raises issues and concerns for therapists. The findings from this study attend to social representations and are therefore socially, culturally and historically specific. Difficulties were encountered in obtaining a working sample. This may be interpreted in several ways; for example, few potential participants perhaps were sufficiently interested in this study, or, few had experience of working with pregnant clients. It may also suggest that those who did participate have a specialised interest in, and passionate views about, this area of practice. Thus the findings do not arise from a representative sample but, nevertheless, do demonstrate diversity in opinions about how to work with pregnant women and how a client's pregnancy impacts upon the therapeutic process.

The participants in this study emphasised the potential restrictions that women may experience during pregnancy. The analysis illustrates that the particular meaning attached to this notion of restriction during pregnancy impacts upon the therapeutic encounter. That is, participants tended to feel that restriction was either desirable or detrimental during pregnancy and this was seen to affect the level and depth at which they conduct therapy, in some cases determining whether therapy ceased or continued.

This difference in opinion seemed to arise out of an interaction between personal experience and a variety of social representations of pregnancy – for example, as a physical event, as unproblematic for a 'normal' woman in 'natural' circumstances. Participants who felt that modifications to, or restrictions on, therapy were desirable during pregnancy tended to represent pregnant women as psychologically fragile and there was an implicit suggestion that any difficult or painful exploratory work could jeopardise the well-being of the unborn child. Others saw pregnancy as bringing about multiple changes for the woman and within the therapy but, rather than being restrictive to the therapeutic work, was represented as a creative opportunity for
reappraisal and preventative intervention which could benefit both the woman and ultimately her child.

There is evidently a lack of consensus about what kind of therapeutic work is best-suited to this client group and this suggests the need for more clinical research and theory in this area. Whilst this study has gone some way to revealing meanings within human interactions, and is helpful in highlighting the role of personal experience and the absence of training as determinants of therapeutic practice, SRT is a multi-level theory and therefore would benefit from a range of methods in order to obtain further perspectives and analyses (Morant, 1998). Therapists could have an important contribution to make here in terms of their own reflexive, process work (Elliot and Shapiro, 1992) which enables them to examine their own behaviours and challenge their own thinking, whilst collecting in-depth accounts of the subjective experience of their individual and group clients. This could enable a critical analysis of the core assumptions about pregnancy within psychology and psychotherapy where it is largely an unexplored phenomenon in terms of female experience. The ability to do this, of course, will be affected by, and will affect, the relevant trainings, where pregnancy is not yet incorporated. All therapists may potentially encounter a pregnant client and thus could benefit from opportunities to examine their own biases and assumptions, in order not to communicate them to their clients.

The analysis of the accounts in this sample suggests that subjective opinions of individual therapists affect the treatment process and have significant consequences for the client. Further research is indicated to examine the relationship between therapeutic understanding and action, and to consider how ‘professional’ reactions are influenced by personal experience, particularly in relation to overlooked areas of human experience and therapeutic practice, such as pregnancy (Jarman et al., 1997). It may be that critical reappraisal of practice will be necessary in order to exploit the possibilities for intervention and prevention, and to provide for the isolated psychological distress experienced by significant numbers of women during pregnancy.
References


APPENDICES

Appendix I: Letter to participants

Appendix II: Research participation form

Appendix III: Research consent form

Appendix IV: Interview guide

Appendix V: An interview transcript

Appendix VI: *Counselling Psychology Quarterly*: Notes for contributors
22 April 1999

Dear Ms X,

Thank you for taking the time to read this letter.

I am currently undertaking a three-year Doctoral training in Psychotherapeutic and Counselling Psychology at the University of Surrey. During my training I have developed an interest in the preventative possibilities of psychotherapy. As such, I aim to conduct research into psychotherapy with pregnant women.

As a psychologist / psychotherapist you may have experience of working with pregnant clients / patients. For this study, I will be interested in exploring your views and in considering the potential for therapists to work this client group. I believe that this is a valuable area of research and I would be most grateful if you would consent to take part in this study. Participation would involve a single audio-taped interview lasting no longer than one hour. This would be conducted at a time and place convenient to you. In order to assure confidentiality your name and any identifying information will not appear on the transcript and the audio recording will be destroyed. Whilst extracts of your responses may appear in the final study, your name or organisation will not be identifiable.

If you are interested in taking part, I would appreciate it if you would fill in the enclosed form and return it in the stamped addressed envelope by 4 May 1999. If you would like any further information or have any queries please do not hesitate to contact me.

I would like to take this opportunity to thank you in advance. Looking forward to hearing from you soon.

Kind regards.
Yours sincerely,

Linda Charles
Counselling Psychologist in training
APPENDIX II: RESEARCH PARTICIPATION FORM

Individual details:

Name: ............................................................ Title: ...........

Contact address:

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

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

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

Telephone number: ...........................................

Email address: ................................................

Gender: MALE or FEMALE (please circle)

Age: ............................................................

Professional Details:

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

What is your job title? ........................................ (please state)

What is / are your employment setting(s)? (eg GP Surgery, NHS Dept., Private, etc)

.................................................................(please state)

How would you describe your theoretical orientation? (eg CBT, Psychodynamic, etc)

.................................................................(please state)

Have you had any experience of working therapeutically with a pregnant patient / client? YES / NO (please circle)

If yes, approximately how many pregnant patients / clients have you worked with?

.................................................................(please state)
APPENDIX III: RESEARCH CONSENT FORM

This research is being carried out as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey by Linda Charles. The aim of the research is to explore the views of psychologists' and psychotherapists' views about working with pregnant clients / patients and to consider the potential for psychotherapy with pregnant women.

You will be asked to take part in an informal interview. The interview will be recorded on audiocassette so that, in writing up the research it is possible to cite your responses directly. In order to protect confidentiality, no identifying information such as names or locations will be quoted. Therefore, in making the transcriptions your name will be replaced by a pseudonym and names of other people or places that may arise in the interview will be omitted or replaced. In any write-up of this research, or any submission for journal publication, these confidentiality precautions will be maintained.

If you have any questions or feel you would like further information about this research please do not hesitate to ask before reading on.

I agree that the purposes of this research and the nature of my participation on this research have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my views about psychotherapy and pregnant women. I also consent to an audio recording of this discussion and to all parts of the recording to be transcribed for the purposes of this research.

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

On behalf of all those involved in this research, I undertake that confidentiality will be ensured with regards to any audio recording made with the above interviewee and that any use of the audiocassette, or transcribed material from the audiocassette, will be for the purposes of research only. The anonymity of the above participant will be protected throughout.

Signed........................................................ Date .....................
APPENDIX IV: INTERVIEW GUIDE

This research is concerned with exploring how therapists understand the processes of pregnancy and how such understanding may be integrated into practice. A particular focus is to explore your views and your perceptions rather than the quantity of your knowledge or your face-to-face experiences of working with pregnant clients/patients.

If you have any questions at any time during the interview, please feel free to ask.

(Instructions for the interviewer occur as italics within parentheses)

(1) Additional Demographic Information

I just need to ask a few demographic questions.

a. What is your nationality?
b. How would you describe your ethnicity?
c. Which professional registration bodies are you affiliated with? (eg BPS, UKCP)
d. How long have you been in therapeutic practice?

(Order and omit questions as necessary allowing for the participant to direct discussion)

(2) Motivation to Participate

a. Perhaps now you could tell me why it is that you consented to take part in this research?

Well I’m very happy that you did consent to participate and I would like to thank you again for that.
(3) General Associations

a. I wonder whether you could describe your associations to this topic, to pregnancy and psychotherapy. Generally, off the top of your head, what kinds of thoughts come up for you in relation to this research topic, to pregnancy and psychotherapy?

(If further prompting is needed use questions below)

*What areas would you consider to be important to look at in relation to pregnancy and psychotherapeutic practice?

*What kinds of things do you imagine I may ask you about?

(4) Pregnancy

Right I’d like to move on now to consider the processes involved in pregnancy. As you know, pregnancy may necessitate significant changes in a woman’s life.

a. What do you see as some of the... say, challenges or changes that a pregnant woman may experience?

b. What effects might these have upon a woman’s well being?

c. Right so you have mentioned (summary of the participant’s points) X, Y and Z, is there anything else that you might add?

(If needed to elicit data on social and medical context)

c.i I’m wondering about the significance of the ways that a pregnant woman might be treated by those around them...significant others, health professionals...wider social influences I suppose. Do you have any thoughts about how such influences might effect a woman’s subjective experience of pregnancy?
d. Is it possible for you to say what has influenced or informed your understanding of pregnancy and pregnant women? (for example, theory, experience, training, the media)

d.i. I would like to explore the sources that you mention a little more in depth. You mentioned X (substitute each source mentioned by the participant individually). Could you explain how you see yourself as having been informed or influenced by X?

(probe to explore how X effected their conceptualisations about pregnancy and pregnant women, for example)

Are there any aspects in particular about X which stand out as being influential?
Could you give me an example of that?
What was that like for you?
How did you respond to that?

e. You did / did not mention training as having informed your understanding, do you recall having specifically studied pregnancy during the course of your training?

If yes: How important do you think that was?
What aspects, if any, did you find helpful or unhelpful?

If no: Thinking about that now, are you surprised?
Any ideas about why it wasn’t covered?
How important or how relevant do you think it would be to consider pregnancy-related issues during a psychology or psychotherapy training?

f. You indicated on the research participation form that you had experience of working therapeutically with pregnant clients / patients. In what way, if any, has your actual professional experience contributed to your conceptualisations of pregnant women? (prompt as above in d.i)
g. Would you say that your understanding of pregnancy and pregnant women has
developed, evolved or changed in any way over time?

(Prompts)
g.i. Could you describe how that has happened?
g.ii. What do you see as shaping or influencing that change?

(5) Psychotherapy

Thinking some more about psychotherapy now then... I would like to ask you some
questions about therapeutic practice with pregnant women. You might know about
this from your own professional practice, from friends or colleagues (for women only)
or possibly from being a client yourself in therapy...

a. There are various opinions about how opportune or appropriate a time pregnancy
   is for psychotherapy... What is your opinion about that?

(For the following questions prompt to elicit specific examples of general points,
taking care to enquire about the source of information)

b. How might psychotherapy during pregnancy be helpful, if at all?

b.i In your opinion, are there professional practices which may be especially helpful in
    psychotherapy with pregnant patients / clients?

c. How might psychotherapy during pregnancy be harmful, if at all?

c.i In your opinion, are there professional practices which may be especially harmful
to pregnant clients / patients?
d. What kinds of emotional problems might you expect a woman presenting for psychotherapy during pregnancy to be experiencing?

(If needed)

*What is your understanding of presenting problems that may be specific to pregnancy, that only occur during pregnancy? (e.g. ambivalence)

*What is your understanding of how pregnancy may effect or impact upon psychological problems that may also occur at other times? (e.g. depressive symptoms)

e. Are there perhaps differences between working with a woman who becomes pregnant during the course of therapy and working with a woman who has been referred because her problems have begun during pregnancy?

f. In what ways might a client / patient’s pregnancy have an effect on the therapeutic process?

f.i How would you respond to those changes? In what ways would your practice be affected?

g. Generally then what would you say are the major differences or similarities in working with pregnant clients / patients as compared to any other client / patient group?

h. With regards prevention, do you think that it is possible to identify women who are most likely to experience emotional disorders during pregnancy? (elicit understanding about risk indicators)
i. How might psychotherapy have a preventative role to play here?

i.i What has influenced your opinion about prevention based? (e.g. experience)

(6) Conclusion

a. Okay that’s it except to ask you how it felt being the interviewee here?
b. What are your reactions to this experience?
c. Is there anything else that you would like to add?

Thank you again for your help and for your time.

Prompts: to be used as and when needed during the interview alongside reflecting back, summarising and paraphrasing to encourage further explanation and elaboration

What makes you say that?
Could you give me an example of that / of what you mean?
Could you say more / something else about that?
What do you think about that?
What are your thoughts / feelings about that?
Is there anything else / anything more that you would like to add / say?
APPENDIX V: Interview E LAURA Transpersonal Psychotherapist

Right just a few demographic questions to begin. What is your nationality?

British.

How would you describe your ethnicity?

It’s not a word that I’d use. I think of myself as British, European, but actually culturally being a Scot, I feel very much a Scot.

Which professional bodies are you accredited by?

BAC, UKCP.

How long have you been in therapeutic practice?

3 years...I’ve had my own private practice and before that I worked in a counselling agency, and before that a Child Guidance Clinic for 13 years. And before that I was a Medical Social Worker in a psychiatric ward...so total one-to-one experience is...what? Approximately 25 years.

Right...Moving on...Perhaps you could tell me why it is that you consented to take part in this research?

Well I think within recent years, I’ve done more training, doing a transpersonal course in London, and I’ve called upon other people to help with my assignments when I was a student and I think it’s an opportunity for me to give something back. And also I felt that what you were doing was quite important and something that I have some experience of and something that I am interested in.

I’m very happy that you did consent and I’d like to thank you again for that. I’d like to move on now to consider some of the processes involved in pregnancy. As you know pregnancy may necessitate significant changes in a woman’s life. What do you see as some of the say...challenges or changes that a pregnant woman may experience?

I think particularly for a woman, more than the partner, it’s such an immense upheaval in the whole way of living, from having been someone in charge of herself, being able to be earning, being able to be out in the world. It can mean a whole change in complete everyday living and it can mean a drop in income, a gap in the earning power and a gap in perhaps the career structure. For someone who hasn’t ever been used to being at home, it may necessitate being at home, although I now feel that women are much more able to continue with work and have children cared for at home but this can involve so much decision-making for women. Although, speaking from my own family, I now realise that the male, the father of the child, now participates much more in support during the pregnancy and support in the very early stage which before was
seen as the mother-baby, now it’s mother-father-baby very much more. And it makes it much less isolating a situation for the mother.

*How do you think that the changes that you mention might impact upon a woman’s sense of well-being?*

For some women it can enhance their state of well-being because for many women, they, and I hate generalising...

*I’m afraid that I am asking you to generalise but please draw on specific examples or your own experiences...* 

Yes, yes. Well I can say that when I worked in a Child Guidance Clinic, because I was a mother at the time and we covered an area that was a bit remote from the clinic, and I had a very good working relationship with Health Visitors. Health Visitors referred a lot over to me because they were having difficulty coping with the idea of pregnancy. And really I was very interested, I’ve always been very interested in doing preventive work rather than working with people when they’ve reached a crisis, and therefore I was very willing as a preventive piece of work to help women who felt that they were lacking support during pregnancy. And for so many young women, they had this previously through family and now because of the mobility in our society, very many young pregnant women are a long way from parents, from in-laws, siblings and their own family, husbands move around with work or away with work. They might be in a nice little modern box but isolated and that was fine in the modern box when they were out at work. Then suddenly although they want to be pregnant, they’re isolated, they’re having medical appointments and it’s just expected that because they wanted a baby that this is all going to be something that they can cope with. And it can be an immense jolt for people and a very anxious time. And not necessarily because there are any children with abnormalities in their family, but really because now it somehow seems to me, it seems a lot more technical. And there’s the idea of having scans early on for abnormalities and amniocentesis. Thirty years ago when I was pregnant, you were pregnant and I held my breath for the first 12 weeks because I’d never had German Measles, I just hoped for the best, and now there’s all this terrific monitoring. But at the same time, I think that can make people very anxious. And should I have an amniocentesis or not because there is a slight risk that it could make me have a miscarriage? But the doctor says it’s important because it can show up a chromosome abnormality. So I feel that pregnancy has become a lot more pressured although the doctors would see it as giving a lot more care. And if someone has a choice of having a hydrocephalic child or not, then that won’t be the abnormalities at birth because someone may be able to have a therapeutic abortion. But what an onus that puts on a person. A lot of the young mothers I worked with, it was because of anxiety and lack of support, lack of family support, this sense of isolation having been at work and then at home, and sometimes feeling very unwell, not everybody thrives in pregnancy and it’s a time for a lot of women when, I think, when a lot of anxiety comes to the fore. Somebody may have had a series of miscarriages and be anxious about sustaining a pregnancy, may wonder if they were meant to have children and I don’t think GPs and Health Visitors actually have the time to deal with wider issues. And this was why Health Visitors really valued my being able to...sometimes I’d see somebody once or twice and other times I saw them once a fortnight right through pregnancy and gave
them a chance to feel that it was actually valid to express fears and anxieties. And someone who could bridge what they had in feelings along with the medical knowledge that they were given.

Is it possible for you to say what has informed or influenced your thinking about pregnancy and pregnant women?

Well I think I felt myself that I had very little support during my own pregnancies...and made me much more aware through my own life experience what it is like. For example for a mother to be pregnant with already a 2 year old and being up a lot at night and having very little sleep and coping with a pregnancy plus maybe another child or several other children. And that for someone who could actually understand what they were saying when they were saying “I love my children but I also feel like bashing their head against the pillow because I am just so exhausted”. And to feel that this didn’t make them a bad mother but that this was something that actually was very real. And that being a mother and being pregnant was not just what the glossy magazines said but had very real potential for difficulties. And to have this accepted and made valid...

So you mentioned firstly your professional experience...

Yes and I think my training and the very great importance of the child’s very beginning. And when I say the very beginning, I’m not just feeling and I’m not just talking about whether the child is breast-fed or bottle-fed and the very early bonding, that is vital but I’m also feeling, thinking about the mother’s attitude when the baby’s in the womb. Whether the mother is relaxed about this or whether the mother is very tense. And I feel the influence is on this growing foetus right from conception. And I really am quite convinced that this is really very, very important and so many times, and I speak both from professional and personal experience, the first child seems highly strung or seems very active and seems much more tense. The second child, so many times, seems very quiet, more placid. Well of course, this is not a new experience for the mother, she’s been through this, she knows much more what she’s about and I’m really sure that this influences, is one big factor, in how the baby, the child is the personality.

You mention your training. About your training, are there any aspects that stand out as being influential or helpful?

Well I think perhaps the quality of some of the lecturers that I had. For example, when I was doing Applied Social Studies and we were doing early development, I was fortunate enough to have Winnicott who lectured a LSE. And I really just never forget his sheer compassion, understanding, the way that he could impart that. And I felt that any mothers that he worked with in the mother-child relationship must have gained immensely from his knowledge, his compassion, his sheer vital interest in what was going on in the mother-child relationship. And when I read his books I just felt that I got so much more out of them because I was aware of him as a person and I think I had a great respect for the work he did.

Do you remember having specifically studied pregnancy as part of your training?
I don’t think, I’m talking now of the early 60s, and I certainly don’t think it was something that was focussed on as a very first stage. I think it was much more circumstances of birth and the early bonding. When I was working with a psychotherapist in W Hospital, which I did as something I was interested in when I was working at the Child Guidance Clinic, and this was the 80s, when talking of taking a very detailed history, I think by that stage actually the circumstances of the pregnancy was something that was much more taken into account and that would be a difference in 20 years that I think is significant. I think by the 80s there was much more consideration of the circumstances of the mother that I wouldn’t have been aware of at an earlier stage.

You indicated on the research participation form, and you’ve mentioned already today, that you’ve had experience of working therapeutically with pregnant clients, in what way if any has your actual professional experience contributed to your conceptualisations of pregnancy and pregnant women?

With having worked with so many mothers during their pregnancy, I would say I have a much greater awareness...of how a pregnancy, in itself, can be very important but how much it can throw up, or bring to the fore, or connect to mothers’ own early experiences. And rather then being seen just in terms of a life-happening event that is in itself significant, it can relate to “Well how was it when my mother was pregnant? I wonder what sort of birth I had”. And it can be a great time of integration for that person with their own very early life experience. If, I think this is something that doesn’t necessarily happen but it’s something that certainly can happen and I think it can be a very good means of integration in their own life and their sense of themselves, if they have an opportunity of being able to look at this.

Would you say that your understanding of pregnancy and pregnant women has developed, changed or evolved in any way over time?

Perhaps because of the professional work I’ve done, I’ve been aware that it can be a lot more of a fraught situation than just something that happens naturally. I was very fortunate myself in not having any difficulties in pregnancy. But through my work, and I think it has become much more complex, I can think of one particular situation. I had worked with a client who very much wanted to be in a relationship and have children and wasn’t and I had finished a work with her. And then 2 years later she came back to me in a different situation which was that she was in a relationship and she very much wanted to have children, found that they were unable to. And we went through great agonising sessions together when she considered IVF. This has been in recent years another area for women to think about and this threw up immense feelings of trauma for this young potential mother. Whether she could have the money to do this and if she did have the money, could her relationship stand the idea of a donor and how important was it for her to have a pregnancy which involved a donor? And she decided eventually, and we talked through this at immense length, to consider this and then she went through the great panics of pregnancy of whether it would mean that her relationship would break up, about how her partner would feel about somebody else fathering the baby. Would the baby be okay? What really was the donor like? Would the baby look like somebody extremely different from her, or her family? And it’s one
of the most dramatic pieces of work that I feel I’ve ever done. And she eventually brought the baby to a session. And having gone through terrific ups and downs, sustained the pregnancy and all was well and the partner as far as I know, the work concluded shortly after the baby was born. But I don’t think I’ve ever given as much support to anybody as through this and it made me realise that the great medical advances actually throw up their own problems and can make a pregnancy, I would say that she had a very stressful pregnancy, even though she very much wanted to be pregnant. I wouldn’t say that that is an exception because since then I’ve known a number of people who have been through the IVF procedure and in fact if that fails, then that also needs a lot of work. So I would say pregnancy with medical advances becomes more and more complicated and perhaps needs to be recognised as an area where a lot of support and work is needed.

Do you feel that at the moment it isn’t recognised as such?

Well it was just chance that because this IVF person had already had, what she felt was a good experience, in a psychotherapeutic relationship that she was able to bring this additional stress and have support. I truly do not know if GPs would see this as a focus for help, and need for help. I think Health Visitors have become a lot more aware of social issues. I don’t know if they feel they can give help but I do know that at least many more Group Practices have got a counsellor and I would imagine that anyone who was working as a counsellor in a practice would be able to help educate the GPs if indeed they needed educating on this sphere. And I think medical students now have so much more social input in their trainings and for example if they’re going to be GPs then they need to have a 3 year traineeship with a practice. And in doing that would be much more likely to understand, because they’re seeing people in their everyday life, some of the stresses of women undergoing, that they underwent in pregnancy rather than just working in a hospital and delivering babies and not knowing what has led up to that. I do hope that, and I would feel that because you’re doing this kind of work, that this is going to help in this field.

Thinking about the kind of help that psychotherapy could offer, do you feel that psychotherapy could have a preventative role to play here?

Yes, very definitely. And I think the more relaxed, the more the pregnant woman can feel that she is happy with her situation, the more this foetus will thrive. This is to me is as important as not drinking, not smoking, having a good diet but actually it’s a recognition of the mother’s emotional health.

With regards prevention, do you think that it is possible to identify women who may experience emotional distress or disorders during pregnancy? Are there perhaps risk indicators?

I’m sure there are. I think when a woman will first go to her doctor and says she’s pregnant, she may say “And I’m not wanting the baby”. Or the doctor may know that she’s a woman on her own or that she’s living in overcrowded conditions, or that she’s got a bad medical history or a bad psychiatric history. I think that there are a lot of circumstances that the GP may know that perhaps would raise a query in his mind. And the GP is the one who would have the continuity of knowing...Or if somebody
didn’t come to the surgery until they were 5 or 6 months pregnant, he might wonder why and question that. And then it would be a question that if the GP didn’t have the time or expertise himself, of knowing who could give help.

**What has influenced your opinion about prevention?**

Perhaps early on in my training when I was doing a Social Science Diploma and I had done my first degree in X in the Gs Hospital. And that really was working with what was called then ‘problem families’, and that was overcrowding, low income, unsanitary conditions. To me that was so hopeless and trying to prevent families from being evicted and I thought ‘Well this is all much too late. Why can’t help be given at a much earlier stage?’ And at a later stage when I had qualified and come to Y, to work in a Public Health Department, and the local Medical Officer of Health really didn’t know how to use me and wanted me to work with problem families. I said that I would be much more interested in working with families before they were at that stage and asked permission to go round and meet all the local GPs because I felt that GPs were often the first contact, and with their continuity of contact, they could provide intervention at a much earlier stage. And while I was still in Z, I had worked along with a Medical Social Work who had got a Nuffield grant and gone and worked as a Social Worker in a Group Practice in W. And all this was written up because this was late 50s when this was a new idea that there would be a social work input into General Practice. I felt absolutely that this was where the work could be done. I’d initially worked in hospital, and again in a psychiatric ward it was people who had taken overdoses, it was people who were in a state of crisis. And I could only work with them while they were in hospital and then once they were out of hospital they were beyond my brief and there was nobody to help them. And I felt then hospital is not where I want to work I want to work in the community. And so this evolved in me, I came down to S from Scotland to work in the community. It so happened there had been TB clinics with Social Workers in the TB clinics, then the TB clinics had closed and the Social Workers had then been part of Public Health Departments and so S was one place where there were actually Social Workers working in the community not in Social Service Departments but to do with health in working in Public Health but they were called Divisional Social Workers. And so I came an decided that really this was an area where preventive work could be done. So it’s through my own experience with problem families that I have grown on...

*Yes, and gone to look beyond crisis intervention...*

Yes, yes...

*There are various opinions about how opportune or appropriate a time pregnancy is for psychotherapy. What is your opinion about that?*

I’d say it was a prime opportunity for preventive work.

*What makes you say that?*

I think because it is such an immense time of upheaval, for a woman, for a partnership, for a marriage, for a whole life situation and this can throw up as I said, so many issues
going back to the person’s own development and create immense problems. And if those problems are not resolved then there is this terrible chain of problems being repeated in the next generation which could be prevented if the chain is broken by the mother being able to have an intervention to prevent her then repeating the problems, for example, that her mother may have enacted with her.

In your opinion are there specific professional practices which may be especially helpful when working therapeutically with pregnant women? When you say “an intervention”, what kind of intervention might be helpful?

An opportunity for alleviation of anxiety and a recognition that anxiety doesn’t mean that you’re this terrible person but in fact anxiety may be very valid, and that this is real, that this can be listened to. I think the prime thing about psychotherapy for me is someone who has an ability to listen and I think women during pregnancy can be told “This is what you do. That is what you do.” And may not actually find someone who will be prepared to listen and when I say listen, listen therapeutically to what may need to emerge.

How might psychotherapy during pregnancy be harmful, if at all?

I can’t see that it would be harmful, in that somebody would only be having psychotherapy if they felt they wanted it. I can’t see psychotherapy as being something that…for example the Doctor or the Health Visitor would say “Before you come back for your next appointment, you must have had 2 sessions of psychotherapy”. Really it’s rather the reverse, it’s so difficult for people to have psychotherapy. I know for example that in hospitals in Southampton, psychotherapy is part of the NHS but where else? I don’t know actually of anywhere else where you can have psychotherapy without having to pay for it privately. I still feel that psychotherapy is something that people have who can afford to pay for it. Except that now counselling can be part of the NHS within a Group Practice but generally people find that they can have 6 sessions and the counsellor may have to apply for them to have 12 sessions. It is something that is rationed. And I think if someone had psychotherapy and it was rationed, that might be the circumstances in which it could be damaging because in 6 sessions, something might come to the fore or somebody might get in touch with some early traumas in their life, when they were very little, or to do with their mother’s pregnancy and then not have the opportunity for giving voice to it.

Within the actual therapeutic frame, are there any therapeutic practices, in your opinion, which may be especially harmful to pregnant clients?

I think it is a foreign idea to me that psychotherapy could be harmful. I’d feel that that wasn’t good practice, there was something going on that shouldn’t be going on. It’s almost saying that it’s not psychotherapy if it’s being harmful.

Well, there are stories of bad practice I suppose…maybe that’s what I was meaning.

I see, yes. Well I think particularly in a vulnerable situation it has publicly to be known that it is very necessary for the potential client to ascertain that the person is qualified, is ethically sound.
What kinds of emotional problems might you expect a woman presenting for psychotherapy during pregnancy to be experiencing?

Well I’ve talked a lot about fear and anxiety.

So that would be fear and anxiety that was specifically related to the pregnancy?

Yes, yes. And for somebody who may be very well able to cope with life, suddenly here is something that may be beyond their control, and I said about the medical interventions and their being told about risk of abnormality and the whole change in life from being an individual in charge of yourself to the idea of having to cope with new life. And can I cope? Have I got it in me to be a good mother? Sometimes people don’t feel particularly maternal during pregnancy and worry that they’re not going to bond with the baby. But again this is getting back to anxiety, fear of abnormality. Sometimes people’s self-esteem is very bound up with how they look, with their figure, and they may suffer great loss of self-esteem through losing their figure, through wondering if they can regain it. And this may be important in terms of the relationship with their partner and it may give rise to anxieties about their sex relationship with their partner, about their attractiveness both in terms of their own self and in relation to their partner. And this is something that is very real and should be able to be explored.

What is your understanding of how pregnancy may impact upon psychological problems which may also occur at other times, that aren’t specifically related to the pregnancy?

Just as I’ve heard and seen written that if someone for example has got dormant cancerous cells in their body, because of all the chemical changes it can actually make the cancer flare up in pregnancy and this is something that has become much more recognised. In the same way, somebody may just be able to be coping with themselves, with their own lives and their relationships and through all the bodily-chemical, biochemical changes of pregnancy, I think it can tip someone perhaps who may have quite a delicately sustained mental health actually to become quite unwell because of all the changes going on and I think this may be both due to emotions and the changes in the body. And so I think it can make somebody who is already vulnerable in personality more vulnerable.

Are there perhaps differences between working with a woman who becomes pregnant during the course of therapy as compared to working with a woman who presents, or is referred, for psychotherapy because her problems have begun during pregnancy?

Well perhaps in the first instance more preventive work can be done and perhaps at the stage when the woman was really going through the great agonies - is this the right moment to have a baby or not? – I think it is something about which people have a lot more choice than they had in the past and choice and option can both be a good thing and something that causes stress, depending on the personality of the person. And so I would feel that somebody in psychotherapy could perhaps work through a lot of their anxieties and the pros and cons of pregnancy, even though it was a decision that
ultimately they would have to make for themselves, and then of course nature would have to be involved as well. But that would be more preventive because someone who is actually referred because they’ve already problems. But it could also of course be a bit more focussed if someone was being referred, but it might just be a bit different.

In what ways might a client’s pregnancy have an effect on the therapeutic process?

I think there are times when, as a person’s pregnancy advances that they actually need to go into themselves and perhaps not be focussed on wider problems. If they’re happy with pregnancy, it’s almost like being in touch with the earth, being in touch with the very physical, and perhaps if they’ve got anxieties about the pregnancy, being able to air those but if they haven’t, then just being able to focus on this very particular big change going on in their body and not concerning themselves with other big agonising life decisions about...for example, career. I think it has to be appreciated that a woman has to perhaps let life become quite...when I say limited I mean focussed just on what is happening and coping with that. I know I have found this in working with people. There comes a time when anything else is almost too...distracting. The very immediate needs attention and focus.

How would you respond to those changes? In what ways might your practice be affected?

Perhaps just understanding a different level of working with somebody for that duration of time and respecting this, that the client would be withdrawing from wider issues. It’s something which I think nature necessitates because I think it’s something that the woman really needs to concentrate on.

How would that effect you?

I think that I would understand that just to be there and to be giving support and perhaps not to be working at a deep level...but appreciating...containing rather than exploring at that particular time.

Generally then, what would you say are the major differences or similarities in working with pregnant clients as compared to any other client group?

I think I would be holding an awareness of the changes going on for the person over the months. It would depend on how big an issue the pregnancy was being in the person being in therapy. It might make the work actually focussed very on the present but on the other hand it could also mean that it was an opportunity for that particular person to be in touch with their own early life experiences. So I think it’s something that would very much, as I think in all my work, would be individualised to that person. I think it’s very difficult to generalise on.

Is there anything else that you would like to add?

I can’t think of anything right now.
That's it then except to ask you how it felt being the interviewee here?

I feel that there may be long pauses in my response because of trying to get in touch with experiences...and be articulate in something which is really a very vast subject, and really relating it to memory, to experience, to...could be something really that was important from my own experience.

What are your reactions to this experience?

I feel I'd like to know, I'd very much like to know, if it were possible what you do write up and what you find. Because really, having had 2 grandchildren in the last 2 years and feeling the whole continuity and the sheer joy of the following through of generations and seeing similarities and of course there's nothing like a pregnancy for putting me back in touch with my own experience and seeing it and being able to give support and in that way giving someone else what I felt I didn't particularly have. In some ways I did have support but, pregnancy was pregnancy and you got on with it. I was fortunate in that I was married, I had good accommodation, I wasn't short of money and any problems that I had were really very small compared with what I feel people can have. But I also know from myself, it just makes me remember the kinds of anxieties that I had and that I just perhaps, I actually kept to myself and it would have been a great relief to have been able to share them with someone.

If you would like I would be happy to send you a copy when it's finished. Thank you so much for your time and for your help.
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Developing a questionnaire to identify the possible need for preventative psychotherapeutic intervention during pregnancy

Abstract

Recent research has suggested pregnancy to be a time of increased susceptibility to psychological distress for many women. Symptomatology has been found to be constant across pre- and post-natal periods. Despite increased recognition of pregnancy as a challenging life event, it seems that more proactive psychotherapeutic work could be undertaken to prevent postnatal complications for the individual and her relationships. This paper describes the initial stages of development of a self-completion questionnaire ('Placental Paradigm Questionnaire' – PPQ) for use during pregnancy. The PPQ is based on Joan Raphael-Leff's work, which explores how the individual's appraisal affects her emotional experience of pregnancy and postnatal interaction. An initial questionnaire of 40 rating-scale items was devised after a thorough review of the theoretical base and consultation with experts and members of the intended population. This generated 6 subsets of items relating to positive or negative feelings about self, baby and pregnancy. 54 pregnant women completed this first version of the PPQ, a demographic information sheet and the GHQ-12. Item analysis was used to reduce the number of items and improve the reliability of the PPQ. The results of the refined PPQ subsets, after item deletion, were compared with the results of the GHQ-12. As hypothesised, some PPQ subsets were found to correlate with the distress detected by the GHQ-12. Although valuable as it stands, with the potential to identify more specifically the roots of the individual's psychological distress, further development of the PPQ is indicated. Methodological limitations are discussed and future research suggested.
Introduction

Recent work has highlighted pregnancy as a major life event for many women involving rapid biological, social and psychological changes. The belief that women are protected from psychological distress during pregnancy, maintained for example by Brazelton and Cramer (1990), has been questioned as evidence accumulates suggesting that pregnancy is a challenging time of increased susceptibility to psychiatric disorders (Spinelli, 1997). Research has given attention to the psychological impact upon pregnant women of factors such as a changing body shape (Savage, 1981), abstinence from the workplace (Ball, 1987, Nicolson, 1990), identity transition (Smith, 1991) and the medical handling of pregnancy (Oakley, 1984, 1993). Among the possible effects of negotiating this important period of upheaval, depression has been studied in particular.

An increase in incidence of depression during pregnancy is now well documented (for example, Barnett et al., 1996; Campbell, 1988; Mercer and Ferketich, 1988). Epidemiological findings suggest that among women aged 18-44 the rate of DSM-III major depression is 5% and of dysthymia is 4% (Oakley-Brown et al., 1989; Weissman et al., 1988) whereas the majority of studies have found incidence rates of antenatal depression and disorders in excess of 11% (for example, Kitamura et al., 1993; Kumar, 1982; Martin et al., 1989; Watson et al., 1984; Zajicek, 1981). The high frequency of reported psychological distress during the postpartum period has long been acknowledged (for example, Cox et al., 1987; Stotland, 1996). Now, there is some evidence that the aetiology of post-natal depression is rooted in pregnancy and that antepartum depression is a substantial risk factor for the postpartum disorders (for example Bernazzani et al., 1997; Green and Murray, 1994; O'Hara et al., 1991; Pfost et al. 1990; Sharp, 1989; Watson et al., 1984). On the whole, therefore, there is now better recognition of the potential for psychological difficulties and emotional distress during the childbearing year and the constancy of symptomatology across the pre- and post-natal periods. It is foreseeable that future research will show this finding to be also true for disorders other than depression.

However, it seems that the opportunities for preventative, proactive psychotherapy are
not being fully exploited. In a recent qualitative investigation looking at UK-based psychotherapists' accounts of working with pregnant clients, Charles found that some therapists tend to the view that pregnant women should postpone or interrupt therapeutic engagement to "resume at a better time" (1999: 29). This is of particular concern given that pregnant women are rarely able to benefit from psychotropic treatment during pregnancy because of the potential adverse effects on the developing foetus (Weissman and Olsen, 1995). The aforementioned epidemiological data evinces the need to consider alternative treatment issues during pregnancy.

The relative absence of published treatment trials and guidelines pertaining to this client group further indicate this lack of intervention. Spinelli (1997) recently claimed to have conducted the first clinical treatment trials of antenatal depression. She reported a progressive and significant decrease in rates of depression amongst a sample of pregnant women engaged in interpersonal psychotherapy, concluding that psychotherapy could be an effective and appropriate alternative to pharmacotherapy during pregnancy. The application of psychological therapies during pregnancy thus has the potential to alleviate antenatal depression. Given the relationship between prenatal emotional disturbances and postnatal psychiatric disorders, the application of psychological therapies may also have the potential to prevent the latter.

Unsurprisingly, infants of depressed mothers have been found to be negatively affected in terms of emotional, intellectual and physiological development (Caplan et al., 1989; Jones et al., 1998; Murray, 1992, Sharp et al., 1995). A child may be adversely affected by maternal mental illness directly through neglect, physical and psychological harm or indirectly through a dis harmonious emotional climate or repeated hospitalisations. Preventative psychological intervention also has the potential to improve the mother-infant relationship, thus significantly and positively impacting upon the life of the child as well as the mother, and, conceivably, her partner if she has one (Sharp, 1996). Looking further afield one also finds evidence that psychological intervention during pregnancy also effectively reduces obstetric complications, such as premature and caesarean deliveries (Mamelle et al., 1997; Sjogren & Tomassen, 1997).
Some contemporary psychoanalysts have highlighted pregnancy as an opportune time for psychotherapy because of the opportunity for change presented in the inherent reappraisal of identity and time-limited need to prepare for and anticipate life with a baby (Langer, 1992; Raphael-Leff, 1990, 1991a, 1993; Rosenthal, 1990; St André, 1993). In general, interest in developing psychological services for pregnant women seems to be growing - but whilst routine psychological screening is not integrated into antenatal care (as it is in Sweden; Verney, 1981) the problem of identifying those women who may be in more need of help remains. Indeed, to date, there is no instrument that has been specifically developed to identify those women experiencing psychological distress or disorder during pregnancy.

Research has collectively identified multiple risk indicators for antenatal depression, for example past psychiatric disorders, lack of social support, crowded housing, partner’s negative response and so on (for a review see Kitamura et al., 1996). However, Bernazzani et al. (1997) have criticised the majority of studies for only assessing a limited number of factors and not testing a specific theoretical model of how these individual factors actually come to affect the individual’s psychological functioning. Along with the fact that few studies have considered individual and sociocultural differences, this limitation may help to explain why the same risk indicators have not been consistently replicated across studies. It may be that concentrating exclusively on the identification of risk indicators does not fully capture the diversity of human existence and experience, or the varying abilities of individuals to overcome negative life experiences and circumstances.

One model, which was proposed to prevent depression, has been adapted for postnatal depression, whereby possible aetiological factors are divided into predisposing, precipitating and maintaining and then each factor is further classified as biological, social or psychological (Jenkins, 1992; Sharp, 1996). However, developing an instrument based on this model may be lengthy and its use may involve considerable time for both women and professionals. In addition to these practical problems, any model which aims to screen for each possible risk indicator implies homogeneity in aetiology and in women. Finally, the model is limited to the detection of depression
and therefore may not do justice to the full range of areas of potential difficulty for pregnant women (including difficulties which may be outside of current diagnostic categories). An approach which is, at the same time, open to a variety of difficulties and ready to accommodate the individual case may be more appropriate.

Such an approach may be identified in Raphael-Leff’s ‘Placental Paradigm’; a model which emphasises the uniqueness of each pregnancy (1993). Her model arises out of extensive clinical experience and has been further supplemented with data from pre- and post-natal interviews and retrospective studies looking at interaction between mothers and their babies (for further details, see Raphael-Leff, 1985a & b; 1986; 1989). This model accounts for the possibility that distress experienced during one pregnancy may not be present during subsequent pregnancies and that, even where there is a pattern of distress across pregnancies, it may not be generated by the same factors each time. Raphael-Leff argues that as social situations and relationships are not static, the experience of pregnancy is likely to change across the childbearing years for the individual and across individuals.

Developing the psychoanalytic theories of Bion (1962, 1970), Deutsch (1944), Pines (1972) and Winnicott (1951, 1956), Raphael-Leff has particularly focussed her model around the fantasy baby held by the pregnant woman. She highlights the paradox of the pregnant relationship whereby the woman and her foetus are physiologically closer than at any other time but the relationship is intensely obscure. In the absence of objective knowledge, the baby within the womb serves as a receptacle for the woman’s subjective hopes, fears and expectations. Developing Bion’s (1962) notion of mothers as emotional ‘containers’, who hold and ‘metabolise’ their babies’ anxieties before safely returning them, Raphael-Leff (1991b) notes that during pregnancy the woman is similarly also a physical ‘container’ for her baby. She nourishes and transforms her unborn child and metabolises his/her waste products within her own body through the two-way placental processes. The placenta, depending on orientation, could be conceptualised as a barrier protecting the woman or the foetus from the harmful toxins produced by the other, or as a permeable medium through which nourishment and antibodies cross. The fantasies and
conceptualisations around this placental activity are depicted as an unconscious prototype for postnatal interaction when the mother comes to act as the emotional ‘container’ for her baby’s complex experiences and feelings.

Physiologically the baby is a foreign body which her immune system initially attempts to reject, and, psychologically, the foetus may also feel foreign (Raphael-Leff, 1996). The woman may experience hugely variable feelings about sharing her body and her internal resources with her foetus. It is however likely that “most women evolve an attitude of mind towards the fetus and themselves, ascribing positive and negative attributes and value judgements to each” (Raphael-Leff, 1993: pp 49-50). Raphael-Leff also argues that the woman’s subjective, intrapsychic experience of herself and of her unborn, unknown child provides insight into how she is coping with pregnancy and vital predictive clues about the postnatal interaction between mother and child.

The theory that the quality of mother-infant interaction can be predicted through the woman’s prevailing conceptualisations during pregnancy finds support in empirical findings that the mother’s representations of the child are stable pre- and post-natally and predict infant attachment (Ammaniti, 1991; Benoit et al., 1997; Bernazzani et al., 1997; Zeanah et al., 1994).

Raphael-Leff has translated the complexity of the imagined placental exchange between mother and foetus into a conceptually simple model which delineates common denominators underpinning a range of possible orientations, focusing on maternal self-esteem and representation of the baby. She presents different kinds of ‘Psychic Interchanges’ (combinations of feelings, representations, judgements and conceptualisations) (see Table 1 below). This depicts “how different positive or negative aspects of the placental exchange of ‘good’ and/or ‘bad’ substances may be emphasised, depending on the woman’s self-confidence in her own internal provisions [ ] and whether her foetus is envisaged as a benign or malevolent force within her” (Raphael-Leff, 1996: 77).
Table 1: Placental Paradigm (Raphael-Leff, 1989: 84; 1993: 53; 1996: 77)
Women’s representations of self and baby: [+] = positive; [-] = negative

<table>
<thead>
<tr>
<th>Mother</th>
<th>Baby</th>
<th>Psychic Interchange</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>ambivalent coexistence</td>
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</tbody>
</table>

This woman (referred to as the *Reciprocator*) experiences herself and her foetus as neither ‘good’ nor ‘bad’ but as mixed. She is aware of their temporary connectedness and the reciprocal give-and-take involved in their interrelated but separate positions. This is associated with realistic assessment of self and the baby as ‘good enough’, and negotiated postnatal interaction with the baby, who is regarded as separate, outgoing, and sociable – whom she will learn to understand.

|        |      | idealized exchange |

The woman (referred to as the *Facilitator*) conceptualises herself as good and bountiful who maintains her baby’s blissful and perfect intrauterine conditions through their mutually enriching, placental fusion. She idealises her own resources and feels vicariously gratified by her own rich provision for her unborn child. Mothering is conceptualised as exclusive and continuous, as if within a postnatal extra-uterine placenta. Postnatally, she may endeavour to maintain this symbiotic merger and deny any imperfections (unless she mourns their lost exclusive intimacy).

|        |      | mother’s barrier against ‘parasitic’ baby |

The woman (referred to as the *Regulator*) may feel anxious if she feels that her previous self-image is threatened by pregnancy. She feels that pregnancy is relentless and that she has no control over the parasitic invader. She may therefore erect a ‘barrier’ of emotional detachment in an attempt to protect herself from the greedy foetus. Postnatally, she may continue to experience the baby as dangerous and persecutory.

|        |      | mother feels dangerous to vulnerable baby |

This woman imagines herself to be empty, or full of ‘badness’, which threatens her vulnerable and good baby. She may strive to keep her baby safe by eating special foods and thinking good thoughts. Postnatally, she may become depressed as obstacles prevent her from maintaining her ‘perfection’ and she feels that she has failed her baby irreversibly. The baby who has been exposed to her internal badness may be alternatively experienced as tolerant/resistant, or accusatory/damning and she may alternate between guilt and acceptance.

|        |      | mutual barrier |

This woman experiences herself and her foetus as mutually harmful and therefore attempts to maintain an impermeable barrier between them by getting on with her normal life and effectively disengaging from the pregnancy and the foetus. Postnatally she may need to create a spatial barrier, via emotional withdrawal or geographical separation, between them and share care-giving to compensate for her own ‘bad’
separation, between them and share care-giving to compensate for her own ‘bad’ forces and to prove their mutual independence.

+/- 0 bipolar conflict: good/bad splitting; baby = non-entity
In this most extreme case, the woman refuses to engage with the foetus. She may consciously disengage or psychotically deny the pregnancy and the baby. She refuses to make any concessions to her pregnancy, such as giving up cigarettes or drugs, in order to demonstrate her resentment at its interference in her life. The postnatal relationship and the baby are at risk because of her indifference, guilt compensation or hostility.

Raphael-Leff’s recognition of fundamentally different orientations to pregnancy and motherhood may also help to explain the inability of research to consistently replicate findings in terms of risk indicators. For example, rather than employment being a protective factor for all women against depression as has been previously suggested (for example, Brown & Harris, 1978; Oakley, 1980), it may be protective for some women and not for others. The woman who regards her baby as parasitic, and needs to create some distance for herself, is likely to benefit from being employed whereas the woman who regards motherhood as her exclusive role is threatened when financial necessity prevents realisation of her ideal. The importance of risk indicators therefore seems to be how they compliment or contradict the individual’s efforts to realise her particular affective orientation to pregnancy and motherhood (see Raphael-Leff, 1985a, for a fuller discussion). Raphael-Leff (1996) also maintains that parenting is significantly affected by the degree of resolution of reactivated conflicts achieved during the transition of pregnancy. Where fixed representations of the self or the baby predict negatively for the future relationship, psychotherapeutic intervention can help the woman to work through some of the underlying issues and resolve internal conflicts by modifying unrealistic ideas, fostering normal ambivalence and mobilising practical resources before the birth. This approach aims to cater to the individual’s specific needs as a mother rather than prescribing a 'right way' for all.

My interest in this model arises out of the hypothesis that the examination of the woman’s prevailing feelings towards, and conceptualisations of, herself and her foetus (“Psychic Interchange”) may aid the early identification of those individuals who are
at risk of ante- and/or post-natal difficulties. The ‘Placental Paradigm’ model may permit preliminary, intrapsychic screening, independently of previously identified risk indicators, which may or may not be related to this particular individual, or to this pregnancy. Those women who are identified may then be appropriately referred to a psychological professional for a more complete assessment of the individual's socioeconomic, relationship, support and cultural circumstances alongside her orientation to motherhood.

Thus, the present study was designed to develop a valid, reliable, brief and simple self-completion questionnaire (Placental Paradigm Questionnaire - PPQ) which could in the future be used to identify women who may be experiencing, or at risk of, future psychological distress. It could also objectively assist in the assessment and referral process for preventative psychological intervention during pregnancy. This scale may be important because of its practical nature in terms of self-administration and economy, and also because it may help to identify women who would not otherwise be recognised as ‘at risk’ in measurements of specific categories of difficulty such as depression.

**Method**

Rust and Golombok's (1999) guidelines on how to develop questionnaires were followed throughout.

**Item Development**

Rating-scale items are the most widely-used item type in person-based questionnaires and are considered to be the most suitable. A five-point scale was used (scoring 1-5) in order to permit participants to express themselves adequately whilst not having to make meaningless discriminations between options. The options strongly disagree (1) and strongly agree (5) anchored the scale. The same options were chosen for each item in order to ensure simplicity in format and administration.
Items were developed based on Raphael-Leff’s ‘Placental Paradigm’ (1989, 1993, 1996). A blueprint specifying content areas was initially constructed and provided a framework for developing the questionnaire. The content areas concerned the woman’s appraisal of herself, her baby and the pregnancy in both negative and positive terms. Weightings of 40% were given to the appraisal of the self and the baby and a weighting of 20% was given to the appraisal of the pregnancy in accordance with the relevant importance of these cells to the theoretical model. Thus the blueprint generated 3 subscales. Within each subscale, the same number of positively-toned and negatively-toned items (to give a positive and a negative subset for each subscale) were developed (see Table 2). In consultation with experts (detailed below), 40 items were selected from a larger initial pool of items, in order to allow for the exclusion of up to 50% of the items (as suggested). Thus approximately 20 items were aimed for in the final questionnaire, to ensure adequate reliability and speed of completion.

Table 2: Blueprint for the PPQ

<table>
<thead>
<tr>
<th>EMOTIONAL TONE</th>
<th>CONTENT AREAS (Subscales)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Self (40%)</td>
</tr>
<tr>
<td>Positive</td>
<td>8</td>
</tr>
<tr>
<td>Negative</td>
<td>8</td>
</tr>
<tr>
<td>No. of items</td>
<td>16</td>
</tr>
</tbody>
</table>

Equal numbers of both positive and negative items were thus designed to be as clear, unambiguous and specific as possible. In the instructions at the beginning of the PPQ, honest and quick responses were requested in an attempt to minimise the risk of acquiescence, social desirability, indecisiveness and extreme response.

Indeed, owing to the sensitive nature of the items and the social desirability issues around expressing negative feelings towards a pregnancy or motherhood, the researcher and the research supervisor monitored the intensity of distribution across
items. In a bid to obtain an even distribution of intensity across subscales, the following procedure was followed. Each item (within the 6 subsets) was jointly rated from 5 to 10 in terms of strength. As statements were deemed to be stronger or more controversial, higher ratings were given, with a rating of 10 denoting the strongest statement. Finally, within each negative and positive subset for the Self and Baby subscales, 8 statements with ratings of 6 (x1), 7 (x2), 8 (x2), 9 (x2) and 10 (x1) were kept. For the more general Pregnancy subscale which consisted of 8 items in total (4 in the negative subset and 4 in the positive subset), the distribution of intensity codes was 7 (x1), 8 (x1), 9 (x1) and 10 (x1). Items were then arranged randomly within the 3 subscales.

After the initial pool of items were developed, content validity for the PPQ was assessed by repeated consultation with Joan Raphael-Leff, who commented upon the relevance of the items to the model. A psychologist (research supervisor) and a midwife were also invited to comment upon the relevance, as they saw it, to the intended population (Lynn, 1986). Two pregnant women were also asked to appraise the PPQ in terms of face validity. Minor changes in wording and format were made to some items based on the comments made by the experts and volunteers. Once the scale was considered to be satisfactory, ethical approval was sought and obtained from the University Advisory Committee on Ethics. The resulting 40 items and their intensity ratings are reported in Appendix 1.

**Supplementary Measures**

In an attempt to address the concurrent type of criterion-related validity (the degree to which scale scores are confirmed by concurrently administering a criterion measure), the GHQ-12 (see Appendix 2) was selected to measure the level of psychological well-being and distress amongst the sample for comparative purposes. The General Health Questionnaire (GHQ) has been found to be reliable, valid (also during pregnancy; Sharp, 1988) and is widely used in the detection of psychological distress. The GHQ-12 has been found to be as reliable as the longer versions of the questionnaire (Goldberg and Williams, 1988) but only takes a couple of minutes to complete. This shorter version was deemed more appropriate than longer versions as
items pertaining to physical discomfort are omitted (obviously responses to such items may have been confounded by the physical discomforts often associated with pregnancy).

The results of the GHQ-12 were correlated with those of the PPQ to see whether women who are particularly distressed as measured by the GHQ-12 would also deviate from the mean score on the various subsets of the PPQ. One would expect negative correlations with positive PPQ subset scores and positive correlations with negative PPQ subset scores. In addition, the results of the GHQ-12 were used to see whether women identified as particularly distressed ('cases') would also deviate from the mean score on the various PPQ subsets.

'Research packs' - consisting of a Demographic Information Sheet (to gather information on the representativeness of the sample; see Appendix 3), Research Information Sheet (see Appendix 4), a Consent Form (see Appendix 5), the PPQ, the GHQ-12 and a stamped addressed envelope (for ease of return and to ensure anonymity) - were then distributed to participants.

Participants
Participants were recruited who fulfilled the criteria of being at least 3 months pregnant and fluent in English. It was decided to sample women from the second trimester onwards because it is during this time that 'quickening' (being able to feel the movements of the foetus) occurs. It is conceivable that the baby's movements facilitate a shift in the woman's attention from the pregnancy to the baby and that the live baby's movements serve as receptacles for the woman's individual fantasies and expectations (Raphael-Leff, 1996).

A snowballing technique was employed which involved friends, associates and colleagues completing 'research packs' and/or helping to distribute packs within their social/professional networks to others who also fulfilled the outlined criteria. A total of one hundred and fifty 'research packs' were distributed in this way. A total of 56 were returned (response rate = 37%). Two packs were returned incomplete and thus a
The final sample size of 54 was obtained (response rate = 36%). The sample size fulfilled guidelines that the minimum number of participants be one more than the number of items on the scale being developed and piloted – in this case 40.

The sample ranged in age from 21 to 42 years (mean = 29). The stage of pregnancy varied from 12 to 40 weeks (mean = 29 weeks). The majority of the women (61%; n = 33) were experiencing a first pregnancy. 37% (n = 20) already had children with the majority having one child (n = 18). In terms of relationship, 38 were married (70%), 8 were cohabiting (15%), 6 were engaged (11%), 1 was separated (2%) and 1 was single (2%). 53 participants stated their sexuality as heterosexual and 1 as lesbian. The sample composition in terms of ethnicity was 87% white/Caucasian/European, 7% Asian, 4% African-Caribbean, and 2% Jewish. In terms of education, 1 (2%) had no qualifications, 14 (26%) had school-leaving qualifications, 22 (41%) had post-compulsory schooling qualifications and 17 (31%) were educated at undergraduate/postgraduate level. Only 2 stated that they were currently on maternity leave and 6 that they were housewives/mothers, 4 were students, 1 was unemployed and the remainder (n = 41, 76%) were employed. The sample thus seemed to reflect variability in the population of pregnant women, which is necessary for scale development in order to ensure variability in terms of how subjects answer items (DeVellis, 1991).

**Data Analysis**

Item Analysis of the PPQ (for each subset): The mean score was calculated as an index of facility for each item (an indication of the extent to which all respondents answer an item in the same way). Items with indexes approaching either extreme score were considered for exclusion as this may indicate limited ability to differentiate amongst respondents. However, items with ‘good’ facility indexes (around 2.5 in this case) were also further examined by looking at the distribution frequencies of responses, in order to identify any items where the majority had chosen the middle option.
The discrimination of each item (the ability to discriminate respondents according to whatever is being measured) was measured by correlating each item with the total score for the questionnaire by using Spearman’s rho (rank order correlation). Items with negative or zero correlations were excluded and a minimum correlation of .2 was required for inclusion. The range of responses produced by each item was also recorded to monitor variability.

In order to assess internal consistency, for each subset of the questionnaire, Cronbach’s alpha was calculated (Kline, 1993). Split-half reliability, using the Spearman-Brown formula, with the Pearson product-moment correlation coefficient, was also calculated. The reliability measures were used to confirm initial choices of items to be excluded (with the criteria that the exclusion of those items improved the correlation coefficients) and also to suggest choices when the superiority of items within a subset was unclear.

Criterion-related Validity: At this stage criterion-related validity is not thoroughly examined but an attempt to measure concurrent validity was made by calculating Pearson’s Product-Moment correlation coefficient between the GHQ-12 scores and each of the 6 totals of the refined subsets of the PPQ. This allowed analysis of the relationship between the PPQ and general psychological distress as measured by the GHQ-12.

Results
Item Analysis
The data from the 54 completed questionnaires were analysed using SPSS (Statistical Package for the Social Sciences) version 9.0. Item analysis was conducted within each subset (as outlined by Rust and Golombok, 1999). The initial stage of item analysis considered the facility index (mean) and the discrimination (item-total correlation and range) for each item (see Table 3). Those items (presented in bold) with poor facility indexes, low correlations and/or poor ranges were provisionally excluded.
Table 3: Item Analysis

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Facility:</th>
<th>Item-Total Correlation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) a</td>
<td>I feel 'more of a woman' now that I'm pregnant.</td>
<td>3.13 (1.27)</td>
<td>.59</td>
</tr>
<tr>
<td>2) b</td>
<td>I have become more superstitious since being pregnant.</td>
<td>2.63 (1.50)</td>
<td>.47</td>
</tr>
<tr>
<td>3) b</td>
<td>I worry in case the baby knows everything about me, including any bad things.</td>
<td>1.60 (1.00)</td>
<td>* .51</td>
</tr>
<tr>
<td>4) b</td>
<td>I am finding pregnancy difficult to cope with.</td>
<td>2.39 (1.27)</td>
<td>.51</td>
</tr>
<tr>
<td>5) a</td>
<td>I feel anxious about labour and giving birth.</td>
<td>3.69 (1.30)</td>
<td>.36</td>
</tr>
<tr>
<td>6) b</td>
<td>During this pregnancy, I feel as though I am blooming.</td>
<td>2.89 (1.22)</td>
<td>.68</td>
</tr>
<tr>
<td>7) a</td>
<td>My baby is in a warm and safe place inside me.</td>
<td>4.24 (1.00)</td>
<td>.25</td>
</tr>
<tr>
<td>8) b</td>
<td>I am not sure I have enough goodness and nutrients inside me for both of us.</td>
<td>2.50 (1.19)</td>
<td>.77</td>
</tr>
<tr>
<td>9) b</td>
<td>I feel better within myself when I’m not pregnant.</td>
<td>2.96 (1.27)</td>
<td>.42</td>
</tr>
<tr>
<td>10) a</td>
<td>As soon as I knew that I was pregnant, I changed my lifestyle considerably (eg eating habits).</td>
<td>3.70 (1.19)</td>
<td>.34</td>
</tr>
<tr>
<td>11) b</td>
<td>I worry that I might damage the baby inside.</td>
<td>3.19 (1.35)</td>
<td>.59</td>
</tr>
<tr>
<td>12) a</td>
<td>I feel more in tune with my emotions than before I became pregnant.</td>
<td>2.48 (1.06)</td>
<td>.56</td>
</tr>
<tr>
<td>13) a</td>
<td>I knew that I was pregnant right from conception.</td>
<td>2.57 (1.49)</td>
<td>.46</td>
</tr>
</tbody>
</table>
14) a  Pregnancy is the peak of my female experience.
   \( 3.22 \text{ (1.41)} \) .61 1-5

15) a  I have become more introspective since being pregnant.
   \( 3.24 \text{ (1.23)} \) .24 1-5

16) b  I do not consider myself to be a 'natural mother'.
   \( 2.70 \text{ (1.21)} \) .60 1-5

17) c  I feel I have a lovely baby inside me.
   \( 4.50 \text{ (.72)} \) .69 3-5

18) c  I feel I'm carrying something special.
   \( 4.69 \text{ (.61)} \) .63 2-5

19) d  The baby seems to live in a world of its own, unaware of me.
   \( 2.22 \text{ (1.06)} \) .53 1-4

20) d  I can't wait to get this baby out of me.
   \( 2.39 \text{ (1.27)} \) .68 1-5

21) d  I experience the baby inside me as hard to satisfy.
   \( 1.80 \text{ (1.00)} \) .59 1-5

22) c  I imagine my baby to be a good person.
   \( 4.22 \text{ (.88)} \) .67 2-5

23) d  The baby does not know what it needs or wants.
   \( 2.56 \text{ (1.21)} \) .50 1-5

24) c  My baby is innocent.
   \( 4.42 \text{ (1.00)} \) .68 1-5

25) c  My baby is vulnerable.
   \( 4.49 \text{ (.91)} \) .50 1-5

26) c  I'm really excited about meeting my baby face-to-face.
   \( 4.67 \text{ (.64)} \) .60 2-5

27) d  I feel polluted or contaminated by the baby.
   \( 1.24 \text{ (.70)} \) .54 1-4

28) d  The baby saps my energy.
   \( 3.36 \text{ (1.27)} \) .40 1-5
29) **d** I feel as though the baby might damage me inside.
   1.52 (.95) .52 1-5

30) **c** My baby tries to communicate with me.
   2.57 (1.49) .44 1-5

31) **d** The baby seems like an intruder.
   1.37 (.81) .56 1-4

32) **e** I experience the baby inside me as friendly.
   4.22 (.90) .68 2-5

33) **f** I feel as though there is a battle going on inside me between what I need for myself and what the baby needs.
   2.04 (1.24) * .79 1-5

34) **e** This pregnancy is perfect.
   3.05 (1.17) .75 1-5

35) **e** I think that the baby and I are closer than now than we ever will be.
   2.22 (1.16) .54 1-5

36) **f** The baby feels like a separate body inside me.
   2.48 (1.26) .54 1-5

37) **e** I feel enriched by pregnancy.
   3.11 (1.16) .82 1-5

38) **f** I do not feel that the baby and I have a relationship yet.
   2.07 (1.11) .74 1-5

39) **e** Both the baby and I are enjoying pregnancy.
   3.37 (1.15) .74 1-5

40) **f** I feel uncomfortable about sharing my body with the baby.
   1.81 (1.29) .69 1-5

Key:
- **a** 'Positive Self' item
- **b** 'Negative Self' item
- **c** 'Positive Baby' item
- **d** 'Negative Baby' item
- **e** 'Positive Pregnancy' item
- **f** 'Negative Baby' item

More information about which items to select or delete was provided by reliability analyses, in particular the internal consistency and split-half reliability coefficients for
each subset (see Table 4). According to these measurements, the exclusion of those provisionally highlighted items (see Table 1 above) was supported and further exclusions were also indicated (items 23, 24, 27, 38, 39) because the value of the reliability coefficients for their subsets improved without them. Taking into account these multiple analyses and considerations, 20 items were excluded in total (see Appendix 6 for a copy of the 'refined' 20 item PPQ). Finally the reliability measures were calculated for each subset before and after the exclusion of items to see if those measures had improved overall (see Table 4 below).

Table 4: Reliability Analysis of Original and Refined Subsets

<table>
<thead>
<tr>
<th>Subset</th>
<th>Crohnbach's alpha</th>
<th>Spearman-Brown split-half</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Positive Self' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.53</td>
<td>.46</td>
</tr>
<tr>
<td>refined</td>
<td>.74</td>
<td>.79</td>
</tr>
<tr>
<td>'Negative Self' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.64</td>
<td>.64</td>
</tr>
<tr>
<td>refined</td>
<td>.67</td>
<td>.75</td>
</tr>
<tr>
<td>'Positive Baby' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.69</td>
<td>.70</td>
</tr>
<tr>
<td>refined</td>
<td>.76</td>
<td>.72</td>
</tr>
<tr>
<td>'Negative Baby' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.74</td>
<td>.62</td>
</tr>
<tr>
<td>refined</td>
<td>.80</td>
<td>.86</td>
</tr>
<tr>
<td>'Positive Pregnancy' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.73</td>
<td>.78</td>
</tr>
<tr>
<td>refined</td>
<td>.79</td>
<td>.79</td>
</tr>
<tr>
<td>'Negative Pregnancy' subset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>.63</td>
<td>.72</td>
</tr>
<tr>
<td>refined</td>
<td>.72</td>
<td>.72</td>
</tr>
</tbody>
</table>
Concurrent Validity

Following the exclusion of the weakest items identified above, the total scores of the GHQ-12 were correlated with the total scores of the 6 refined subsets of the PPQ using the Pearson product-moment correlation co-efficient (see Table 5 below).

Table 5: Correlations of the GHQ-12 and refined PPQ subset scores

<table>
<thead>
<tr>
<th></th>
<th>SELF Positive</th>
<th>NEGATIVE</th>
<th>BABY Positive</th>
<th>NEGATIVE</th>
<th>PREGNANCY Positive</th>
<th>NEGATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHQ-12</td>
<td>-.27*</td>
<td>.32*</td>
<td>-.10</td>
<td>.55**</td>
<td>-.42**</td>
<td>.36**</td>
</tr>
</tbody>
</table>

*. Correlation is significant at the 0.05 level (2-tailed)
**. Correlation is significant at the 0.01 level (2-tailed)

Relation between GHQ-12 ‘Caseness’ amongst the sample and PPQ scores

In any scoring method of the GHQ-12, the higher the score, the more distressed the respondent and the higher the probability of ‘caseness’. The scoring method employed in this study was Likert scoring as recommended with the total score range of 0-36 (Goldberg and Williams, 1988). Milne (1987) found a mean score of 21.2 amongst people attending a clinical psychology service at referral. Within the current sample, 5 individuals scored above 21 (9%). This is a little lower than the reported 12-20% of the normal population at any time (Goldberg and Williams, 1988). In order to allow a closer analysis of the results of the PPQ in those individuals who score highly on the GHQ-12, their scores across measures are presented alongside the means, standard deviations and ranges of the current sample for each refined subscale below (see Table 6).
Table 6: Sample Means, Standard Deviations and Ranges of PPQ Subsets and Scores across measures of Probable ‘Cases’ as detected by the GHQ-12

<table>
<thead>
<tr>
<th>Sample Mean (SD)</th>
<th>GHQ-12 (range 0-36)</th>
<th>SELF (range 4-20) positive/negative</th>
<th>BABY (range 4-20) positive/negative</th>
<th>PREGNANCY (range 2-10) positive/negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Mean (SD)</td>
<td>13 (6)</td>
<td>12 (6) 10 (3)</td>
<td>18 (2) 6 (3)</td>
<td>6 (2) 4 (2)</td>
</tr>
<tr>
<td>Sample Range</td>
<td>4-31</td>
<td>4-20 4-18</td>
<td>12-20 12-14</td>
<td>2-10 2-10</td>
</tr>
<tr>
<td>Case #1</td>
<td>26</td>
<td>11 14</td>
<td>19 4</td>
<td>6 6</td>
</tr>
<tr>
<td>Case #2</td>
<td>26</td>
<td>11 13</td>
<td>20 6</td>
<td>8 2</td>
</tr>
<tr>
<td>Case #3</td>
<td>31</td>
<td>8 15</td>
<td>18 14</td>
<td>2 8</td>
</tr>
<tr>
<td>Case #4</td>
<td>26</td>
<td>12 16</td>
<td>13 12</td>
<td>2 8</td>
</tr>
<tr>
<td>Case #5</td>
<td>24</td>
<td>6 12</td>
<td>13 14</td>
<td>2 10</td>
</tr>
</tbody>
</table>

In order to examine the discriminatory ability of the subsets more closely, the respondents were further divided into three groups according to their scores. Thus the score range was divided into approximate thirds; 4-8 (low), 9-15 (middle) and 16-20 (high) and individuals were grouped accordingly (see Table 7).

Table 7: Frequency of low, middle and high scores on the PPQ

<table>
<thead>
<tr>
<th>Score</th>
<th>SELF</th>
<th>BABY</th>
<th>PREGNANCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive (n=)</td>
<td>Negative (n=)</td>
<td>Positive (n=)</td>
</tr>
<tr>
<td>4-8</td>
<td>10</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>9-15</td>
<td>35</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>16-20</td>
<td>9</td>
<td>3</td>
<td>44</td>
</tr>
</tbody>
</table>
Discussion

The purpose of the research described in the present paper was to develop a practical, psychometrically-sound, self-completion scale for use during pregnancy to identify women who may be experiencing, or at risk of future, psychological distress. The analysis of data focused on the development and the refinement of the PPQ as a measure of the emotional tone of pregnant women’s fantasies, conceptualisations and feelings towards themselves, their babies and their pregnancies in positive and negative terms. Out of a pool of initial items developed from Raphael-Leff’s ‘Placental Paradigm’ model (1989, 1993, 1996), with slight modifications to some items, 40 were judged to be content valid by 3 experts, including Joan Raphael-Leff. Members of the population for whom the scale was intended, that is pregnant women, confirmed face validity. Item analysis yielded the 20-item PPQ (Appendix 6) consisting of 6 subsets: ‘Positive Self’ (4 items), ‘Negative Self’ (4 items), ‘Positive Baby’ (4 items), ‘Negative Baby’ (4 items), ‘Positive Pregnancy’ (2 items) and ‘Negative Pregnancy’ (2 items). Items were initially selected according to their facility index, discrimination and range of responses produced. Their provisional exclusion was subsequently confirmed by reliability analyses of each subset.

The results show good internal consistency for 5 out of 6 of the subsets of the PPQ (varying between .72 and .8) and good split-half reliability for all 6 subsets (varying between .72 and .86). Thus all but the ‘Negative Self’ subset (alpha = .67) were found to be internally consistent and reliable according to the recommended minimum correlation coefficient of .7 for person-based questionnaires (see Table 4). The results of the ‘Negative Self’ subset were retained for further analysis at this stage, despite the slightly lower than recommended alpha, because it has been argued that tests of fewer than 10 items are unlikely to be shown statistically to be highly reliable anyway (Kline, 1993). It should be noted, however, that not all psychometric experts agree that high internal consistency is an absolute pre-requisite for a ‘good’ test as it requires tests to be narrow and specific and may therefore be antithetical to validity (Cattell, 1973). Nevertheless, the PPQ may benefit from the generation and piloting of additional items in the future if the internal consistency of each subset is to be improved.
The selection of items was not entirely clear within the 'Baby' subscale where the distribution of responses to the items of 'Positive' subset was strongly skewed towards agreement, and to the items of the 'Negative' subset towards disagreement (see Table 3). This may indicate a tendency amongst pregnant women to have only positive conceptualisations of, and feelings towards, their unborn child.

One would expect the majority of women to feel positively towards their unborn child and thus the high and low means in this subscale, small Standard Deviations and sometimes-limited ranges of responses are to be expected. However there may be further possible reasons as to why pregnant women should respond to questions about their unborn child in an overwhelmingly positive way. For example, there are strong social dictates governing what constitutes a 'good mother' (for a fuller discussion, see Boulton, 1983; McMahon, 1995; Smart, 1992) which may restrict the expression of any negativity by women towards their children. Thus despite assurances of anonymity, confidentiality and that the data would be used for research purposes only, it may that for many women admitting (to someone else) or acknowledging (to themselves) any such negative emotions, particularly in writing, in response to a psychological 'test', is simply too problematic.

However, this subscale was not abandoned at this stage in order to permit further analysis. Rather it was refined according to reliability analyses, which indicated the items to be excluded based upon the improvement of the reliability coefficients subsequent to the exclusion of each of those items. The future rewriting of some items to render them more discreet and less direct may produce wider variability in responses and clearer discrimination between items. These newly adjusted, or any additional items, would of course need to be piloted as we will not know how such changes will affect the reliability and validity of the PPQ.

As expected, the total scores of the refined positive subsets were negatively correlated, and the total scores of the refined negative subsets were positively correlated, with the total scores of the GHQ-12 (see Table 5). All correlations, except that with the 'Positive Baby' subset, were significant. The strongest positive correlation was found
with the ‘Negative Baby’ subscale scores and the strongest negative correlation with the ‘Positive Pregnancy’ subscale scores. This suggests that within the current sample, those women who experience the baby they are carrying in negative terms are the most susceptible to psychological distress during pregnancy, whereas those women who conceptualise their pregnancy in very positive terms are the least likely to be experiencing psychological distress during this period.

Standardisation of the PPQ on a much larger sample will be required in the future in order to establish population norms and permit interpretation of individual respondent’s scores. As for now, the means and standard deviations (see Table 6) produced by the present sample indicate good variability across items and individuals for the ‘Self’ and ‘Pregnancy’ subscales. The same is not true of the ‘Baby’ subscale but, again, it could be argued that this is to be expected and that future standardisation may well establish norms which reflect this.

Despite the absence of established norms for the PPQ, it was useful to examine individual ‘cases’ (as detected by the GHQ-12) within this sample more closely (see Table 6). Thus it can be seen that all 5 of these individuals scored at or below the average for this sample on the ‘Positive Self’ subset, possibly indicating a tendency to regard the self negatively. All 5 scored above the average on the ‘Negative Self’ subset. This suggests the tendency to negative self-appraisal.

In response to the ‘Positive Baby’ subset, 2 out of these 5 individuals had scores considerably lower than the high mean found for the total sample, and, in terms of the ‘Negative Baby’ subset, 4 individuals had scores equivalent to or well above this. This suggests that some of these individuals, currently experiencing high psychological distress, may tend to appraise the baby within them negatively. It may initially seem surprising therefore that 3 of these women scored at or above the average found for the ‘Positive Baby’ subset amongst this sample. Nevertheless, this is in line with the ‘Placental Paradigm’ model, which suggests that individuals may attempt to defend against negative appraisal by positive thinking. A number of alternative tentative interpretations for this observation are also possible. For example, given that the
cultural mandate for mothers restricts the expression of any ambivalence (Trad, 1990), strongly positive responses may be consistent with social expectations. Or, the participants may have been more honest in response to some items than others. Moreover, it is feasible that women hold both strongly negative and strongly positive feelings towards their unborn babies.

In response to the 'Positive Pregnancy' subset 3 individuals scored considerably lower than the average found for this sample which may suggest an association for some pregnant women between negative experience of pregnancy and psychological distress. This interpretation finds some support within the responses found to the 'Negative Pregnancy' subset where 4 out of 5 of these individuals scored above the average found for this sample.

Inevitably, any interpretations made from such a small sample are questionable and it would not be wise at this stage to attempt to generalise to wider populations. Nevertheless, within the findings of the current study, some inconsistency between the total scores for the PPQ subsets and the GHQ-12 is observable, indicating that, as would be expected, the two questionnaires are not measuring the same thing overall. However, a strong association is suggested for the 'cases' found within the present sample between negative self-image, as measured by the PPQ, and psychological distress, as measured by the GHQ-12. A strength of the PPQ is that it may come to provide more information about the roots of psychological distress for a particular individual in terms of her appraisal of herself, her baby and her pregnancy.

When the individuals were grouped according to their scores (low, middle and high) (see Table 7), it became clearer that neither the positive nor the negative subsets of the 'Baby' subscale seemed to be discriminating well between 'cases' and 'noncases'. It is unlikely that this many women, even though possibly idealising their babies are at risk (81%, n=44, scoring high on positive items, and 89%, n=48, scoring low on negative items). However it may be that the PPQ is picking up women who are not detected by
the GHQ-12, that is there are more than 5 women with scores above the means for the
current sample on 4 out of 6 of the subsets. However, without established norms,
further conclusions are not possible.

**Conclusion**

The present research has focused on developing and selecting items. Future research on
a much larger sample will be required in order to address test-retest reliability during
pregnancy. Standardisation, as mentioned above, will also be required on a
representative sample of several hundred if population norms are to be established
(Rust and Golombok, 1999). Following standardisation, cut-off scores for risk can be
estimated which would permit individual scores to be more closely allied with the
original theoretical model in terms of their ‘Psychic Interchanges’, related dyad and
postnatal experience. Thus each individual could then be assessed in terms of obstacles
or threats to her orientation to motherhood and to her child in order to intervene
appropriately with the hope of minimising the risk of postnatal disorder or disruption.
If data were obtained on a sample of more than 300, the PPQ could be subjected to
Factor Analysis in order to confirm the appropriateness of its theory-driven structure
(Tabachnick and Fidell, 1996).

Predictive validity across the antenatal and postnatal periods could be assessed by
comparison of orientation and risk, as determined by the PPQ, with the administration
of complimentary existing measures during both periods to establish follow-up data.
Such measures might include for example, the Strange Situation (Ainsworth et al.,
1978); the Edinburgh Postnatal Depression Scale (Cox et al., 1987); the Adult
Attachment Interview, (Main et al., 1985); the Dyadic Adjustment Scale (Spanier,
1976); or the Working Model of the Child Interview (Zeanah et al., 1994).

Ideally, a sample of several hundred would have been used for the development and
standardisation of this questionnaire in order to reduce bias (Kline, 1993) but
unfortunately the required large resources were not available at this stage. Additional
research is required in order to establish the PPQ as a reliable and valid scale which
could be used to identify women who are at risk of antenatal or postnatal distress. In
particular, thus far the PPQ has not been able to delineate those women who may be idealising to an extreme degree. The rewording of some items, particularly in the Baby subscale, might be more helpful in reducing the insight the individual has into the item thus deterring them from the socially desirable response. Alternatively, other items could be developed and piloted in the hope of yielding different distributions in this subscale, and higher internal consistencies within all subsets more generally. If future research does not rectify the problems identified with this subscale, it may be that standardisation will produce different norms for the various subsets which cast new meaning on the obtained responses. For example, if the norm for the 'Positive Positive' subscale increases, and for the 'Negative Baby' subscale decrease away from the middle value (as in this study), then what is deemed a high or low score, and cut-off points for risk, will be subject to change.

The results reported here suggest that a further-developed version of the PPQ may provide more information than the GHQ-12 for pregnant women. That is the PPQ seems to correlate with the distress detected by the GHQ-12 but also has the potential to identify where the problem may be in terms of self, baby or pregnancy. While totalling scores has been useful for research purposes, inspection of individual items, used in conjunction with other information about the woman, could serve as a useful assessment tool for clinicians.

This empirical study attempted to translate and begin to test a psychoanalytic theory. Such research activity is acutely needed in this rich theoretical field. However, the question remains about how effectively a complex psychoanalytic theory can be translated into an objective quantitative measure, given the difficulty of items (no matter how well written) to capture the richness and subtlety of human emotions and experience, and to overcome problems around confessing negative feelings. It may be that the assessment of and enquiry into such sensitive issues, as attempted by the PPQ, could be more satisfactorily addressed within a protected, confidential and trusting therapeutic relationship.
References


APPENDICES

Appendix I: The 40-item PPQ (ratings are entered after each item:
+ = positive, - = negative)

Appendix II: GHQ-12

Appendix III: Demographic Information Sheet

Appendix IV: Research Information Sheet

Appendix V: Research Consent Form

Appendix VI: The refined 20-item PPQ (original numbers are entered in parentheses following current item numbers)

Appendix VII: Counselling Psychology Review: Notes for Contributors
APPENDIX I:

The 40-item PPQ (ratings are entered after each item:
  + = positive, - = negative)
Some women experience very strong emotions and reactions during pregnancy, which can sometimes be difficult to cope with. We know all women have both negative and positive feelings about themselves and their pregnancies. I would like to know about your personal experience of this pregnancy. There are no right or wrong answers, just answer as honestly and as quickly as you can. All of your answers are confidential. Please indicate the degree to which you personally agree or disagree with each of the following statements by using the scale below. Please answer every question by writing your answer on the line to the right of the question.

A) This section is about your feelings towards yourself during this pregnancy.

1) I feel ‘more of a woman’ now that I’m pregnant. (8+) ......................................................

2) I have become more superstitious since being pregnant. (7-) ...........................................................

3) I worry in case the baby knows everything about me, including any bad things. (8-) ..........................................................

4) I am finding pregnancy difficult to cope with. (10-) ............................................................................

5) I feel anxious about labour and giving birth. (7-) ............................................................................

6) During this pregnancy, I feel as though I am blooming. (10+) ..........................................................

7) My baby is in a warm and safe place inside me. (7+) ........................................................................

8) I am not sure that I have enough goodness and nutrients inside me for both of us. (8-) ..........................................................

9) I feel better within myself when I’m not pregnant. (6-) ..........................................................

10) As soon as I knew that I was pregnant, I changed my lifestyle considerably (eg eating habits). (8+) ..........................................................

11) I worry that I might damage the baby inside. (9-) ........................................................................

12) I feel more in tune with my emotions than before I became pregnant. (7+) ..........................................................

13) I knew that I was pregnant right from conception. (9+) ..........................................................

14) Pregnancy is the peak of my female experience. (9+) ..........................................................

15) I have become more introspective since being pregnant. (6+) ..........................................................

16) I do not consider myself to be a ‘natural mother’. (9-) ..........................................................
B) This section is about your feelings towards the baby that you are carrying.
17) I feel I have a lovely baby inside me. (9+)
18) I feel I’m carrying something special. (10+)
19) The baby seems to live in a world of its own, unaware of me. (6-)
20) I can’t wait to get this baby out of me. (8-)
21) I experience the baby inside me as being hard to satisfy. (8-)
22) I imagine my baby to be a good person. (9+)
23) The baby does not know what it needs or wants. (7-)
24) My baby is innocent. (7+)
25) My baby is vulnerable. (7+)
26) I’m really excited about meeting my baby face-to-face. (6+)
27) I feel polluted or contaminated by the baby. (10-)
28) The baby saps my energy. (7-)
29) I feel as though the baby might damage me inside. (9-)
30) My baby tries to communicate with me. (8+)
31) The baby seems like an intruder. (9-)
32) I experience the baby inside me as friendly. (8+)

C) This section concerns your more general feelings about this pregnancy.
33) I feel as though there is a battle going on inside me between what I need for myself and what the baby wants from me. (10-)
34) This pregnancy is perfect. (10+)
35) I think that my baby and I are closer now than we ever will be. (8+)
36) The baby feels like a separate body inside me. (7-)
37) I feel enriched by pregnancy. (7+)
38) I do not feel that my baby and I have a relationship yet. (8-)
39) Both the baby and I are enjoying pregnancy. (9+)
40) I feel uncomfortable about sharing my body with the baby. (9-)
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
APPENDIX III: DEMOGRAPHIC QUESTIONNAIRE

To begin with, I would like to get some basic background information about you and your pregnancy. The information that you give will never be used to identify you in any way. Please answer every question.

1. How old are you? ..................... years

2. How many weeks pregnant are you? ................. weeks

3. Is this your first pregnancy? YES / NO

4. If no, how many other times have you been pregnant? .................

5. How many children do you have? ...................

6. Please circle your relationship status:

   Married, Engaged, Divorced, Separated, Single, Cohabiting, Other?

7. Please circle your sexual orientation:

   Heterosexual, Homosexual, Bisexual, Other.

8. What is your ethnic origin? ..................................................

9. What is your highest educational qualification, if any? ...................
   .............................................................................................

10. What is your current occupation and job title? ....................................
    .............................................................................................
APPENDIX IV: RESEARCH INFORMATION SHEET

Research Title: Developing a scale to identify the possible need for preventative psychotherapeutic intervention during pregnancy

This research is being carried out as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology by Linda Charles, under the supervision of Riccardo Draghi-Lorenz, Chartered Counselling Psychologist, at the University of Surrey.

For all women pregnancy is a challenging time and it may be that some women could benefit from some psychological support and intervention during this time. Currently, there is no formalised psychological screening procedure incorporated into antenatal care. Therefore, it is likely that those women, who may be in distress and in need of help are not noticed. The aim of this research is to develop a questionnaire which could, in the future, be used to help to identify those women so that, if they wish, they could be referred onto the appropriate professionals for the help that they need.

You are requested to complete a basic personal information sheet and two short questionnaires about how you are feeling. This should take no longer than 15 minutes in total. The questionnaires concern negative, as well as positive, feelings that you may have about yourself and your pregnancy and some of the questions therefore may appear offensive. If you have any worries or concerns arising from either questionnaire you are encouraged to discuss this with your midwife, or another professional. Your help would be greatly appreciated but of course you have the right to withdraw from the study at any time without having to justify your decision.

If you decide that you are willing to participate, please sign the Research Consent Form. Your name will not appear on anything else that you complete and it will be given a code number in order to ensure anonymity. The information that you give is for research purposes only and will not be shared with your GP or any other professionals who may be involved in your care. In any write-up of this research, or any submission for journal publication, these anonymity and confidentiality proceedings will be maintained.

If you have any questions or feel you would like further information about this research, please do not hesitate to contact me, or my supervisor (details below). If you are happy to proceed, please complete the Research Consent Form, the Demographic Questionnaire, the PPQ and the GHQ-12 and forward them to me in the Stamped Addressed Envelope as soon as you can.

Thank you for your time and interest.

Linda Charles
Counselling Psychologist in training
APPENDIX V: RESEARCH CONSENT FORM

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

I the undersigned voluntarily agree to take part in the study 'Developing a scale to identify the possible need for preventative psychotherapeutic intervention during pregnancy'.

I have read and understand the information sheet provided. I have been given a full explanation by the researcher of the nature and purpose of the study and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood any advice and information given as a result.

I understand that all documentation held on a volunteer is in the strictest confidence and complies with the Data Protection Act (1984). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved. I understand that this form is the only document to contain my name.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to take part in the study.

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

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

On behalf of those involved in this research, I understand that anonymity will be protected and confidentiality will be maintained throughout. Any information obtained will be used for purposes of research only.

Name of Researcher LINDA CHARLES
Signed ..........................................................................
Date .............................................................

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

On behalf of those involved in this research, I understand that anonymity will be protected and confidentiality will be maintained throughout. Any information obtained will be used for purposes of research only.

Name of Researcher LINDA CHARLES
Signed ..........................................................................
Date .............................................................
APPENDIX VI:

REFINED 20-ITEM PPQ
(original numbers are entered in parentheses following current item numbers)
Some women experience very strong emotions and reactions during pregnancy, which can sometimes be difficult to cope with. We know all women have both negative and positive feelings about themselves and their pregnancies. I would like to know about your personal experience of this pregnancy. There are no right or wrong answers, just answer as honestly and as quickly as you can. All of your answers are confidential.

### Please indicate the degree to which you personally agree or disagree with each of the following statements by using the scale below. Please answer every question by writing your answer on the line to the right of the question.

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A) This section is about your feelings towards yourself during this pregnancy.

1. (1) I feel 'more of a woman' now that I'm pregnant.

2. (3) I worry in case the baby knows everything about me, including any bad things.

3. (6) During this pregnancy, I feel as though I am blooming.

4. (8) I am not sure that I have enough goodness and nutrients inside me for both of us.

5. (11) I worry that I might damage the baby inside.

6. (12) I feel more in tune with my emotions than before I became pregnant.

7. (16) I do not consider myself to be a 'natural mother'.

8. (14) Pregnancy is the peak of my female experience.

B) This section is about your feelings towards the baby that you are carrying.

9. (17) I feel I have a lovely baby inside me.

10. (18) I feel I'm carrying something special.

11. (21) I experience the baby inside me as being hard to satisfy.

12. (22) I imagine my baby to be a good person.

13. (27) I feel polluted or contaminated by the baby.

14. (29) I feel as though the baby might damage me inside.

15. (31) The baby seems like an intruder.
16. (32) I experience the baby inside me as friendly.

C) This section concerns your more general feelings about this pregnancy.

17. (33) I feel as though there is a battle going on inside me between what
    I need for myself and what the baby wants from me.

18. (34) This pregnancy is perfect.

19. (39) Both the baby and I are enjoying pregnancy.

20. (40) I feel uncomfortable about sharing my body with the baby.

Linda Charles, 2000
Developed from the 'Placental Paradigm' model of Professor Joan Raphael-Leff.
APPENDIX VII:

Counselling Psychology Review
Notes for Contributors

N.B. The requirement for a word count on each page was not adhered to due to technical difficulties.
Notes for Contributors to
Counselling Psychology Review

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author’s name and the date of publication thus: Davidson (1999). All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

Academic submissions only
All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society’s Style Guide provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author's name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

Other submissions
Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

For publication in Copy must be received by
February 5 November
May 5 February
August 5 May
November 5 August

All submissions should be sent to: Counselling Psychology Review, The Editor, Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.