A Portfolio of academic, therapeutic practice and research including an investigation of a process-based study of the HIV testing experiences of heterosexual women and the role of a counselling psychologist. Submitted by Lynne Harrison in part fulfilment of the requirements of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology, University of Surrey, Guildford, England on September 1st 1997.
Portfolio of academic, therapeutic practice and research work for submission for the Practitioner Doctorate in Psychotherapeutic & Counselling Psychology.

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INTRODUCTION

This portfolio contains three Dossiers of selected work conducted over the period of three years of a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology.

• The Academic Dossier contains examples of essays and reports drawn from classes and workshops under the following titles: 'Normal Lifespan Development', 'Context of Counselling Psychology', 'Issues in Counselling Psychology', 'Advanced Theory & Therapy' and 'Child Abuse: Models of Clinical Interventions'

• The Therapeutic Practice Dossier contains a description of all training placements, and a personal overview of these experiences. A summary of four client studies is included, and a discussion of process issues, derived from two audio-taped therapy sessions is presented.

• The Research Dossier contains the three research submissions presented in specified formats of either a standard essay, research report or in the form of a journal article.
I would like to acknowledge the following people for their input over the last three years: In particular my fellow trainees for their support and encouragement in times of sense-of-humour-failure. To Dr. Adrian Coyle, my research supervisor, for his patience and provision of a paddle on the occasions when I was stuck up the proverbial creek. To Dr. Jill Wilkinson and the rest of the course team for their hard work in getting the course up and running, as well as marking our work! To Kay Hambleton, who put up with our moans, groans and constant requests.
I would like to dedicate this Portfolio to my mother, and to the memory of my father.
The following dossier contains examples of essays and reports drawn from classes and workshops attended throughout the course, including the following titles: 'Normal Lifespan Development', 'Context of Counselling Psychology', 'Issues in Counselling Psychology', 'Advanced Theory & Therapy' and 'Child Abuse: Models of Clinical Interventions'
NORMAL LIFESPAN DEVELOPMENT ESSAY

CRITICALLY EVALUATE HALL'S (1904) CONTENTION THAT

ADOLESCENCE IS A TIME OF "STORM AND STRESS"
"To be normal during the adolescent period is by itself abnormal."
(A. Freud, 1958 in Powers et. al., p200)

The implications of the above quote are far reaching, and have been debated for many years. G. Stanley Hall has often been considered to be the father of adolescent psychology, although many of his ideas about the universal 'storm and stress' of adolescence, based on evolutionary theory, have become rather out-dated. It is commonly assumed in Western cultures that adolescence involves a number of stereotypical behaviours including mood swings, fluctuating energy levels, unpredictable behaviour, anxiety, self-consciousness and increased family conflict. It is over the global nature of such behaviours that there seems to be some contention and difficulty.

There have been a number of different definitions as to when adolescence occurs, e.g., Hall's (1916) definition covered ages 12-25; Erikson's (1959) psychosocial stage (of identity versus role diffusion) spans ages 14-20; Petersen (1988) focuses on ages 10-20. So there is a certain amount of flexibility, although a general definition might consider the onset of puberty as an indication (a very practical biological approach). However the general consensus over the last 20 years or so is that there is not a universal time of storm and stress, although there may be (and often are) a number of transitional stresses. This discussion will follow this latter line of argument in consideration of various areas of contextual, psychological and biological research.

In the past there have been a number of researchers who have asserted that adolescence is more of a stressful time in a person's life than other transitions (and this seems to mainly stem from the work of Hall, 1916). Specific factors associated with this have been identified and include motivational constructs, intrinsic motivation, factors related to Self (Self-concept, perception and efficacy), puberty, drop-out rates in school and increased family conflict (Eccles et al., 1993). The common factor which may be identified is that of a number of concurrent changes (psychological, physiological and contextual/social) which seem to bombard the young person in a relatively short space of time. However, accepting this view implies that the occurrence of disruption is not only universal, but consistent among
all adolescents. This may cause problems in that it is known that certain events at
the time of adolescence, e.g., puberty, can be a source of stress, because, for
example, of the social norms concerning physiological changes and what is 'normal'
or acceptable; differences in timing and extent of pubertal status can be
uncomfortable and embarrassing for some adolescents (Noam et. al., 1984). Much
weight has been given to the influence of hormones on mood swings and erratic
behaviour of adolescents. It is apparent that internal physiology is somewhat 'hectic'
around the age of 10 onwards (Apter, 1980). However it seems that although
hormonal factors do appear to have an influence on behaviour, the adolescent's
perception of their environment may also be influenced. Consequently their
behaviour may be influenced as well, although it is not clear how strong this
influence might be (Buchanan, Eccles & Becker, 1992). So, over and above
everything else, puberty is unique to adolescence, and thus the behaviours which
are consistent (though not necessarily 'stressful') in this time may have become
intrinsically perceived as 'stormy' by society.

The psychoanalytic view of adolescence has it's roots in biological theories,
specifically the internal physiological drives and desires of the person. Essentially it
was believed that hormonal changes in puberty triggered latent desires e.g., Electra
and Oedipal desires, which, being socially unacceptable and anxiety-provoking for
the adolescent, resulted in the different erratic behaviours of the adolescent.
However, although it was acknowledged that the stress experienced in this time was
not apparent for all adolescents, the implication was that some turmoil was
universally present:

"most adolescents bring to bear with them a system of defence and coping
skills that enable them to successfully negotiate these stresses."

There has been a significant amount of research about the possible influence of
increased family conflict around the time of adolescence, especially in relation to
control and autonomy e.g., Smetana (1988a). Adolescence has generally been
seen as the time when a search for 'self-identity' is taking place and as such the
'generation gap' between child and parent is highlighted in areas such as values,
attitudes and beliefs, which may or may not clash. If a Piagetian view is taken; that the adolescent may have entered the beginning of formal operational thought, then he / she might:

"take the role of others [ ] think in terms of possibilities, alternatives and principles, and they may have the cognitive equipment to think about family issues and situations independent of their own immersion in them."


Taking this into account it may be understandable that some negotiation and re-evaluation would be required within the family to accommodate the new status, although it would not necessarily lead to conflict. Indeed Eccles et. al., (1993) concluded that the closer the fit between the social environment (which included positive and supportive family interactions) and the needs of the individual adolescent, the smoother the transition would be perceived. Other important factors related to the umbrella term of 'family interactions' have been considered e.g., the life-stage of the parents may be important (many child-adult transitions may coincide with parental life-stage transition which may increase tension within a family). Also of interest (and indirectly related to 'stormy and stressful adolescence') is the finding that an authoritative parenting style appears to be related to a higher degree of autonomy in the adolescent as:

"the authoritative parent combines limit-setting with negotiation, thus encouraging the child's contribution to the discipline process."


However it may also be argued that if such a process did occur, one of the implications would be that the adolescent may not be experience stress over issues such as their control and autonomy, thus a clash with parents would be less likely to occur (this is not to say that other events in the young person's life may not be difficult).

Although the majority of recent research rejects the idea of universal adolescent 'storm and stress', it may be seen that in the West there is generally negative
associations attributed to the transition (Larson & Lampman-Petraitis, 1989). It would seem reasonable to assume that a greater number of negative events occurring in this transition might lead to higher stress in an individual (although this is only an assumption and far from conclusive; there are clearly many individual differences, and factors, such as coping strategies, which affect the situation). Indeed Larson and Ham (1993) found that adolescents reported more daily negative events than pre-adolescents, and also that the effect was perceived as stronger in adolescence than pre-adolescence. Although some of these events appeared to be 'scheduled', there appeared to be a number of 'unscheduled' events which were significant in the transition because of their multiple nature. It seems that the negative events were frequently associated with areas which were in the external environment, such as transition to school. However there were also a number of other factors related to this that were not necessarily perceived as negative, e.g., more responsibility in a number of environments, new peer interactions and extracurricular activities. With respect to these occurrences, Coleman's (1987) focal model of adolescent transition seems to have some relevance. There is recognition that there are a number of different events occurring during this period, but also that, as much of the research indicates, it is only a minority of the adolescent population who experience serious disturbances (between 10 and 20 per cent). Petersen and Ebata (1987) found that 57 per cent of young adolescents had 'basically' positive and healthy development; Siddique and D'Arcy (1984) reported 33.5 per cent of the adolescents in their study reported no adverse psychological symptoms. Coleman hypothesised that the adolescent's way of working with the many issues in this period was to deal with one predominant issue at any given time, rather than attempt to work through all of them at once. This idea acknowledges that there may be issues (important to the individual) which are stressful and unique to adolescence, but that do not necessarily mean some kind of psychological problem will result.

It is noticeable that the research outlined has been based on traditional Western cultures, although there has been research on other cultures. One of the most well known pieces of research was carried out with adolescents in Western Samoa, by Margaret Mead. She concluded that there was not the normal "disruptive concomitants" apparent in the Samoan adolescent passage and adolescence was:
"particularly free of all those characteristics which make it a period dreaded by adults and perilous for young people in more complex-and often also, in more primitive societies."

(Mead, 1929. In Freeman, p255)

Unfortunately her results have been discredited by a number of researchers e.g., Freeman (1983), although there still appears to be a fairly strong consensus that some distraught behaviour will accompany the average adolescent. It is possible that the idea of storm and stress is a result of the fact that a significant number of the societies studied are 'continuous'; there are no clear boundaries defining the transition to adulthood, as there may be in a culture which has definite rites of passage. It has also been found that a societies' recognition of physiological changes may have an effect on the amount of apprehension an adolescent may experience. Worthman (1986) found that in parts of Kenya there was an integrated and well managed structure to the manner puberty was handled, and consequently any anxiety was lessened due to the 'normal' cultural practices.

So, although the notion of a universal time of storm and stress is no longer accepted by the majority, there continues to be acknowledgement of potential difficulties in the transition. It seems that physiological changes and anxiety about related aspects of Self-image and ideal Self play a large role in this period of life, although this is not always the case for all adolescents. With regards to the above and the number of other life changes in a typical Western teenagers life, I feel that theories such as that of Coleman (1983), which consider the coping strategies of individuals are particularly useful. They recognise that there are many different types of events which may be occurring and that each individual will handle the issue in their own manner. There will be different perceptions and interpretations of 'an event' by different people, thus what is perceived as stressful by one person may not be by another, and as such strategies and outcomes will vary tremendously.
REFERENCES


CONTEXT OF COUNSELLING PSYCHOLOGY REPORT

CONSIDERATIONS IN THE USE OF TOUCH IN PSYCHOTHERAPEUTIC &
COUNSELLING PSYCHOLOGY
INTRODUCTION

Even though touch is one of the main forms of Non-Verbal Communication (NVC), it is an area which has not been researched as much as other modalities of NVC. The impact and implications of appropriate physical touch has been recognised as far back as Hippocrates, although its usage in relation to psychologically-based therapies has always been controversial, especially since it's use in the early psychoanalytical era.

The research which has been carried out on touch has not been extensive and the results gained have not been conclusive. In this report, literature relating to sexualised touching in therapy has been deliberately excluded, and the focus has been to cover only the possible use of what has been termed nonerotic touch.

The significance of touch

The physiological importance of skin and the role it plays in homeostatic mechanisms has been known about for a number of years; it provides information to the Central Nervous System about the external environment, as well as acting as a physical container. Harlowe's (1959) experiments with young monkeys gave much insight into the importance of touch in development. Research into the effects of touch deprivation on human infants found how important it was in development of constructs such as a unified Self.

If the nature of touch is examined it may be seen that it is paradoxical; physical touch brings people into closer contact and although this contact may be intimate it does not necessarily mean that the feelings being conveyed are positive or friendly. Touch can be of an aggressive nature, involving anger, frustration or hurt or it may be comforting, friendly and a sign of trust. Whatever the message there is usually a shared cultural, social or common understanding of the variety of possible meanings. Although this also can mean that there is greater scope for misinterpretation.
The intended meaning of touching is crucial if it is be considered of use in therapy and Autton (1988) has outlined three different functions of touch and the meaning that it might convey:

i/ Passive touch: occurs when a person is touched in response to their pain with the conveying messages indicating feelings such as care and tenderness.

ii/ Self-touching: is often used in exploration, as a method of self-control and also in stimulation.

iii/ Active touch: which is also used in exploration, although it may accentuate the message or messages that are being communicated.

It may be that at least one or more of these types of touch might be used in some kind of therapy, although clearly it would vary tremendously, taking in many different factors relating the specific dynamics of the psychotherapeutic relationship.

If used, touch in therapy can be very significant, and as Jourad (1968) found there can be a kind of 'bridging' not only between the own Self and other but also between Self and own body, providing distinctions of me and not me. By implication physical touch involves reducing the distance between one of more people and thus increasing the intimacy in an interaction. Hall (1966) suggested that humans segment their social environment into quite distinct regions, surrounding their bodies as if they were invisible bubbles as illustrated in Figure 1. This has relevance in therapy, as touch would involve entering a person's 'intimate zone'. For the most part, in psychological therapies, the proximity might usually be within the personal zone (which is about a 60cm-1.20m) or the social-consultative zone (1.20m-3.30m). This would vary not only between and within cultures, societies, social classes and families, but also according to the individual differences.
FIGURE 1.

SUMMARY OF HALL'S (1966) PERSONAL SPATIAL ZONES

- **INTIMATE ZONE**: (Circ.) 0-60cm
- **PERSONAL ZONE**: (Circ.) 60cm-1.20m
- **SOCIAL-CONSULTATIVE ZONE**: (Circ.) 1.20-3.30m
- **PUBLIC ZONE**: (Circ.) 3.30+m


Cultural aspects and differences in therapy are an important consideration for the therapist, and touch is no different. Attitudes and practices vary greatly, not only between cultures but also within them and, as with other aspects of NVC, there are rules about touch. For example, in peoples of Anglo-Saxon origin such as the English or German, it has been found that they are generally non-tactual with a reputation of being 'stiff and cold'. Whereas, in other cultures, such as Russia and France, there is a large amount of touching and embracing. In the Hindu caste system the lowest caste, the 'untouchables', would hazard a perceived risk of contamination if they came into physical contact with a person from a higher caste. In some Buddhist societies the top of the head is considered to be the 'seat of the soul' and thus touching it would not be acceptable.

The rules of who can touch who, and where on the body are very important, although there does not seem to be much research into 'accessible zones'
specifically in relation to psychological therapy. Jourard (1966) carried out some research into the Western rules of touching by mothers, fathers, same-sex and opposite sex friend for males and females; the results are summarised in Figure 2.

**Figure 2. Rules of touching (After Jourad, 1966).**

It may be seen that there are noticeable differences and a number of comparisons that can be made between males and females, some of which may seem surprising. For example, if one looks at the differences between the females and males in relation to where it is considered acceptable for an opposite sex friend to touch (as according to this model only), the highly and second highest touchable areas for females appear to include just about all areas of the male body! However this type of body-mapping technique would appear to have a number of limitations and would obviously be used with caution and as a very general guide. The applicability and usefulness of this type of model in psychological therapy is be debatable, although it may be of great use when considering transference / countertransference issues where projections of all kinds may be operating. The possible interpretation of a touch by the client and the repercussions of this interpretation are therefore crucial to consider.

**Definitions of the therapeutic touch in the literature and research carried out in America and Britain**

There has been research carried out which has examined specific effects of touch in therapy, e.g., in working with depressed clients, although much of the research has been carried out in America. Related to this is the importance of the different qualities of touching, which have been outlined by Weiss (1986). Consideration has been given to location (the part of the body which is being touched); the intensity (weak, medium or strong depending on the indentation of the skin); the action (quality of either stroking, rubbing, holding or squeezing) and the duration (temporal length of touch from initiation to cessation). This gives some idea of the complexities and different manners of touching that are possible and thus the variety of meanings and interpretations that might be made.

Pattison (1973) was one of the first to examine the effect of touch on self-exploration and the therapeutic relationship; the areas of touch included in the study were the hands, lower and upper arm, upper back and shoulder region, middle back and front shoulder areas. The length of time of contact, amount of eye-contact and other variables were also controlled and it was found that clients who were touched engaged in more self-exploration [as measured by the Depth of Self-exploration
Scale (cited in Pattison, 1973, p172), Relationship Inventory (Barratt-Lennard, 1962) and Relationship Questionnaire (cited in Pattison, 1973, p172)].

Stockwell and Dye (1980) investigated not only client self-exploration but the evaluation the client gave to therapeutic outcome. The areas of the body touched by the therapist included the hands, wrists, arms, shoulders and the upper back.

In a slightly later study conducted by Hubble, Noble and Robinson (1981), several other factors were explored, including the therapist's perceived expertness. The use of touch was again strictly regulated and included the same areas of contact as in previous studies.

Bacorn and Dixon's (1984) study emphasised the effects of using touch on ratings of three core conditions and their presence in the therapy, and whether a request for a second session was made, in depressed and vocationally undecided clients. The only difference in the areas touched was in the inclusion of the leg.

Suiter and Goodyear's (1985) study found that the therapist was perceived as least trustworthy when a semi-embrace was used and interestingly, the clients perceived the therapists in the interview as more expert, attractive and trustworthy than did therapists.

The kinds of touch which have been used in these investigations have been termed by the researchers as nonerotic and may be summarised as in Figure 3.
FIGURE 3. SUMMARY OF THE DEFINITIONS AND RANGE OF NONEROTIC TOUCH USED IN RESEARCH OF PSYCHOTHERAPEUTIC THERAPIES

(WILLISON & MASSON, 1986, p497)

• THE HANDS OF THE THERAPIST

• THE HANDS, ARMS, SHOULDERS, LEGS, LOWER AND UPPER BACK (AS IN A SEMI-EMBRACE) OF A CLIENT
THE USE OF TOUCH IN PSYCHOTHERAPEUTIC AND COUNSELLING PSYCHOLOGY

The following section will briefly outline some of the considerations surrounding the use of touch in the psychological therapies, including some of the guidelines which have been suggested by various researchers and professional bodies.

It may been argued that there is a kind of 'all or nothing' attitude towards to use of touch which may have contributed to the taboo against its usage. However it would appear that it is not that simple; in the area of touch there does not appear to be anything specific in the B.P.S. Code of Conduct Ethical Principles and Guidelines (1991), although as in Part 5.2 concerning Personal Conduct:

"Psychologists shall not exploit the special relationship of trust and confidence that can exist in professional practice to further the gratification of their personal desires."

In the Division of Counselling Psychology 'Guidelines for the Professional Practice of Counselling Psychology' (1995) which are supplementary to the above Codes, part 1.3.3. concerning 'Respect for client's autonomy' states:

"In view of the personal and often intense nature of the therapeutic relationship practitioners will take particular care to avoid exploiting their clients financially, sexually, emotionally or in any other way"

And goes on in Part 1.3.4. that:

"The practitioner will normally work with approaches and procedures that can be made understandable to the client and to which client's can be asked to give their informed consent."

This may be a source of ambiguity as prohibition is not stipulated and there is no direct reference to touch; possibly because it may be considered to be a very
subjective and situational aspect of therapy which might be included in a category such as 'Boundary Issues.'

**Taboo against touch in psychological therapies**

Other factors that might affect the possibility of using touch, apart from ethical factors, include the theoretical orientation of the therapist. Holroyd and Brodsky (1977) found that humanistic therapists used touch the most often with psychodynamic, behaviour modification and rational-cognitive therapist touching the least often.

In the psychoanalytic tradition there is a clear 'rule of abstinence' with regard to physical contact with clients. The view seems to be related to the idea that touching would be a source of gratification and tension reduction and that it would also be introducing a kind of reality into the therapy. In turn this would interfere with the transferential material and reduce the motivation to understand and work through the therapy. Hedges (1983: 68) stated that by using touch:

"one runs the danger of moving away from the essentially noninfluencing study of the introspection and interaction toward a variety of manipulations and justifications which have seldom served well and which, in the long term, tend to maintain the arrest rather than to release forces which permit a continuance of growth."

These views have been echoed more recently by Kupfermann and Smaldino (1987), who suggested that gratification of a patient's desires would lessen the patient's energy and stagnate the therapy. It has been argued that touching might run the risk of arousing feelings of a sexual nature and / or anger in the patient. Robert Berne, founder of the Transactional Analysis technique, was extremely wary about the use of touch and seemed to be concerned not only about the interpretation the client might make of a touch, but the possible sexual misconduct which might result.
Alyn (1988) recommended that until it has been shown more conclusively that touch is not harmful it should not be used. Her belief is that the definitions of touch are confusing and to use a physical definition does not account for the many different perceptions which are made about, for example, a touch to the upper arm. She also argued that there is a confusion as to the dividing line between nonerotic and erotic touch, which again may be seen to reflect the many variations of interpretation. There is also the consideration of the power dynamics within therapy, which ties in to the intimacy that often occurs in therapy. Henley (1977) found a relationship between gender, status and who may touch whom and where. For example, it was suggested that females are touched more than males, reflecting the Western culture's social structure and attitude towards females. Alyn warned that even use of so-called nonerotic touch might reinforce the already-present higher power status of the therapist, and disturb boundaries with the risk of abuse in therapy. It was also suggested that using touch might also affect the client's development in areas such as autonomy, self-esteem, and possibly even prevent successful therapy in the sense that conflict resolution would not be satisfactory.

**Arguments against the touch taboo**

There has been a growing trend in therapy of a relaxation of the touch taboo which has been especially apparent in the Humanistic movement and even more recently, as argued by Kertay and Reviere (1993), in the psychodynamic writings. One of the main conclusions that has emerged from the Humanistic stance has been that if touch is to be used it should be genuine. In direct opposition to the psychoanalytic position it is suggested that if the relationship is to be real, a dissipation of the illusion of a transference projection through touch would help therapy. There seems to be some consensus, cautiously advocating the use of touch if the therapist is real and if touch is part of a therapist's 'realness'. Although this would only be acceptable if, in the analysis of the transference, touch would further therapy and that in touching, the motives were genuine and not for gratification reasons. This seems to be an increasingly acceptable stance among many therapists and cuts across a number of orientations.
As noted previously, a few studies have found that more specific aspects, such as client self-disclosure and exploration, seemed to increase when touch was used, and these have been related to research such as that carried out by Jourard (1966). Lomraz and Shapiro (1974) found a significant relationship between body accessibility and self-disclosure, as did Pedersen (1973). There has been some prominent psychoanalysts, including Balint, Winnicott and Little who have advocated the use of touch in some patients and specific populations such as with delusional patients or as Winnicott (1965: 85) stated:

"There are times when you carry around your child who has an earache. Soothing words are no use. Probably there are times times when a psychotic patient needs holding, but eventually it will be understanding and empathy that will be necessary"

It has been suggested by a number of different researchers that in some areas well considered use of touch may be appropriate. There areas include working with adults who have been victims of childhood abuse, in crisis intervention and in hypnosis, and again the emphasis was placed on the genuineness of the intervention. Goodman and Teicher (1988) believed that touching, what they described as, 'non-developed patients' might help communicate a message which the patient is having difficulty in expressing verbally. They also suggested that it might increase ego strength and give the patient a positive parenting experience.

Some therapies explicitly include physical contact between therapist and client, for example, when the therapist aims for a concreting of the containing and holding experience. It has often be used in anxiety and tension management therapies where pressure or massage might be applied. Johnson (1987) aimed to find a method of integrating psychodynamic principles with body work, where direct physical manipulation of the shoulders, neck and jaw was used in order to reduce 'blockages' in these areas. It would seem that this approach was able to move between a directive, instructional mode and exploration through use of the transference and countertransference into the familial roots of the client. Indeed Heron (1993), in part of a six category interventions as a cathartic intervention, discussed the possibility and usefulness of the application of physical pressure to
specific parts of the body in order that blocked energy might be discharged. He also suggested the use of physical holding or embracing which might be of help in facilitating the release of tears in grief work, for example.

Thus it can be seen just from the short review that there are a number of complex issues that would need to be considered before touch was used by a therapist.

**GUIDELINES FOR THE USE OF TOUCH IN THERAPY**

There are number of guidelines proposed by various researchers about the kinds of issues a therapist would need to stay mindful of in the consideration of the possible impact and usefulness of physical contact in therapy. Kertay and Reviere (1993) outlined a three level approach which takes into account ethical, therapeutic and theoretical and considerations:

Firstly there are ethical considerations which focus on the possible exploitation of clients; this may be sexual in nature although it may be based in a power issue and again judgement of this, needs to be made. It is recognised by the majority of therapists that sexual contact with clients is unethical, thus if there are sexual feelings occurring in the transference (or countertransference), touch should be avoided. Holroyd and Brodsky (1980) proposed that therapists who consistently touched opposite sex clients almost exclusively, were at greater risk of sexual contact; if this pattern is recognised then ideally, use of touch should be discontinued. Exploitation and gratification of needs does not have to be sexual, as discussed earlier, and the male therapist in particular may need to be mindful of the possible interpretations a female client may draw from a touch.

The second level consideration involves examining the nature of the therapeutic relationship with a the client; generally it is considered that touch should be used only if and when the relationship is well established. This is consistent with other research and guidelines such as that proposed by Gelb (1982), and which have been echoed by Tudor and Worrall (1994) who specifically discussed levels of congruence in the therapy. It was noted previously, that there should be a level of 'realness' or genuineness about the relationship before touch might be considered;
if a therapist is not comfortable in themself with touching, then the client is likely to sense this and the interaction will not be perceived as a genuine expression. Both therapist and client need to be aware of the boundaries and definitions which exist in the relationship, that is, a knowledge of the level of intimacy that is appropriate to the relationship. At all times when touch might be a possibility, the use should be appropriate to the client's current needs, that is, that touch will enhance and help develop the therapy. This would also include the possibility of discussing the use of touch with the client although it has been argued that this is not always practical; a rule of thumb might be to discuss with the client the appropriateness and how it may affect the process.

Thirdly, in contemplating theoretical considerations, Kertay and Reviere contended that these are obviously very relevant and have ethical implications, however they believe that the issue is so complex that only very general recommendations may be made. From reviewing some of the literature it is clear that the number of different opinions on the use of touch and theoretical considerations span an enormous range, and that each argument can be justified and supported in theoretical terms. Thus it might seem sensible to maintain the view which posits that there are some circumstances and issues where the use of touch might be useful, although again the picture is not clear. The therapist needs to explore their own theoretical standpoint in a decision about using touch, whilst remaining loyal to their client's needs.

In conclusion decisions might be taken on the basis of the summary given in Figure 4. and the advice given by Willison and Masson (1986: 499):

"Therapist's must be clear about their own attitudes towards touch and sensitive to the patient's receptivity to touch and the impact of the intended touch on the therapeutic process. In other words, the use of touch must not be made blindly but must be a carefully considered process. Touch should not generate discomfort in the therapist or client and the physical contact must be consistent with the needs of the client at that moment"
And also as highly recommended by many, if touch is used, discussion in supervision and with experienced colleagues for support, advice should be used as a safety net.

FIGURE 4.

A SUMMARY OF SUGGESTED GUIDELINES AND CONSIDERATIONS OF USING TOUCH IN THERAPY

• LEVEL 1: THAT THE USE OF TOUCH DOES NOT COMPRISE A CLEARLY HARMFUL PRACTICE

• LEVEL 2: NECESSARY RELATIONSHIP PARAMETERS ARE ESTABLISHED

• LEVEL 3: THEORETICAL CONSIDERATIONS

REFERENCES


ISSUES IN COUNSELLING PSYCHOLOGY ESSAY

SIMILARITIES AND DIFFERENCES BETWEEN THERAPIST AND CLIENT:

ISSUES OF MATCHING IN THERAPY
It has been recognised in the literature over the last forty years that the inevitable similarities and differences between clients and therapists are a complex and extremely important consideration to be mindful of. This in turn has maintained the debate over the desirability, practicality and usefulness of attempts and effectiveness of client-therapist matching. The kind of variables examined in the literature are numerous, and one of the major problems with much of the research has been with the variations in methodologies used, and thus the difficulty in generalising between findings.

In the infancy of therapy (in psychoanalysis), part of the analyst's role was that he or she should remain as a 'blank screen' for the client's projections, transference's and so on. Thus, the 'real person' behind the analyst was apparently not available to the client, rather the thoughts, fantasies and ideas the client had about the analyst were the relevant aspects of therapy. It would seem that issues such as matching may not have been considered overtly, although attention was paid to aspects such as gender where distinctions were clear. Development in the topic as a whole has encompassed a number of areas, and studies have attempted to explore the effects of client and therapist variables on areas such as therapeutic outcome, drop-out rates and continuation in therapy. In this review I shall consider some of the research on gender and ethnicity in relation to therapies in general rather than to a specific aspect, e.g., therapy outcomes. The variables selected for review were chosen from a simplistic (in the sense that the issue of matching is complex), but effective representation constructed by Beutler, Crago & Arizmendi (1986), which provides a concise view into the number of areas which have been researched. This is shown in Figure 1.
Figure 1. Factors influencing therapist-client interactions

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<td>Attitudes &amp; values</td>
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<td>Social Influence attributes</td>
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**Gender**

The research on gender matching in therapy has proved inconclusive; there do seem to be some consistencies in results, although suggestions of 'better combinations' appear to be tentative (the operational definitions of what variations on 'better' and/or more 'successful' might entail has differed between studies, contributing to the inconsistency in research). There has also been some confusion
between the use of the terms 'gender' and 'sex' as they are separate but related concepts, but often used synonymously. Beutler, Crago & Arizzmendi (1986) in their review of research into therapist variables in psychotherapy process and outcome, made the following distinction: "Gender refers to one's biological identification while one's sex includes the more subjective attribute of sexual attitudes and adopted sex roles." (p263). These distinctions have often been neglected in the research, though in this brief essay, I have tried to focus on gender as defined above.

Dancey, Dryden and Cook (1992) found no significant client preferences for a male or female therapist, although the female therapists were rated higher than male therapists by female clients, in terms of being able to potentially provide certain conditions (given on a standard questionnaire). Thus there was a preference by female clients for the same sex therapist, though this was not a significant preference and does not imply a need for gender matching. Indeed in an earlier study, Giles and Dryden (1991) found only a slight client preference for female therapists, although there were interactions with other variables. These included aspects such as the title of the therapist (and the beliefs held about that), as well as the nature of the problem and the types of fears clients might have about how different professionals might respond to the client and their problem. One of the explanations offered for the weak client preference for females was client assumptions about gender characteristics, i.e., that females have feminine qualities more appropriately suited to being in the helping profession. This has indirectly received some support through research suggesting that male therapists were preferred by male and female clients when the problem was related to vocational concerns, whereas there was a general preference for a female therapist when the problem was of an intimate or personal nature (Bernstein, 1987).

Jones and Zappel, (1982) found a sex difference in the way that male and female therapist viewed their client's and the nature of their problems; female therapists apparently saw both sexes as having more relationship and sexual concerns than did male therapists, as well as the belief that all their clients had improved on nearly half of the outcome measures used. In contrast male therapists seemed to feel that their female clients improved less than their male clients at outcome; overall this
piece of research gave some weight to the idea that clients tend to 'do better' with a therapist of the same gender, although this was from the therapist's point of view! It might have been interesting to gain a perspective on these kinds of issues from the client's point of view. There may be other instances when a female therapist might be preferred because of the nature of the problem, such as after rape, although later work with a male therapist may be extremely therapeutic. Indeed, if the results that Jones and Zappel (ibid.) obtained indicating that female therapists seemed to develop more effective working alliances with both male and female clients, are accurate, then the implications are very important to consider. This might apply particularly in the initial stages of the relationship when the working alliance was developing. However, as with much of the other research, the results should be treated with caution as there appear to be a number of interactions with other variables which affect potential influences of gender.

It should also be noted that changes have been noticed over time, and it seem that the influence of stereotyped attitudes has played a major role in this process. In her comment on women counselling women, Chaplin (1993) found that in society clear importance was given to the role that women were viewed in (and perceived themselves in), which might then be reinforced in a male therapist / female client situation. Caution is advised, although it seems that the main area in which Chaplin anticipated potential problems was that of sexuality (gender) issues, especially in light of recent attention to abuse in therapeutic relationships (e.g., Rutter, 1991). Thus, it is apparent that there are some advantages of seeing a therapist of the same gender, though in general the literature seems to support the conclusion that Mogul (1982) came to in his review of the issues of gender matching:

[there have been] "no clear, replicable results salient to decision-making."
(Ibid., p10).

Ethnicity

As with the issue of gender, the research on client-therapist ethnicity matching has shown inconsistencies and differences of opinion. The possibility of generalising findings has been made all the more difficult as many of the methodologies used have been marred by the influence of confounding variables and the large amount
of variance that ethnicity appears to have accounted for. One of the major problems is of researcher effects; Abramowitz & Murray (1983) suggested the ethnicity of the researcher might influence the conclusion drawn in a particular piece of research so comparisons are difficult. There have been many studies which have explored different aspects of matching (and mixing) and which have been criticised on methodological grounds, however, a few themes have emerged. It has been suggested that if there is an ethnic match between therapist and client the likelihood of early dropout is reduced, as it may well be when matching occurs with regard to language (Flaskerud & Liu, 1991). This has been supported by other studies, e.g., Turrell & Turrell (1984), and it seems that one of main problems identified when mismatches have occurred, and the therapeutic relationship has been disrupted, is the apparent insensitivity of both therapist and client to sense and / or acknowledge the differences between them. It may be that on some occasions, influences may not be observable and immediately apparent and, as with some of the views relating to gender of the therapist, some of a societies' beliefs and values may impinge on the process at an unconscious level.

However, to assume that because a client shares the same ethnic background as a therapist will necessarily mean the relationship will be more effective than a dyad in which client and therapist are not matched, is in itself an insensitive assumption. Indeed, in my own experience of working with clients where some of their concerns revolved around cultural issues (different from my own), sometimes it seems to have been a relief to explore their concerns in an environment in which the client may have felt they were not at as much risk of being judged in some way. Often there seemed to be a certain amount of shame at somehow betraying one's own culture. In these situations space and acceptance from the therapist was important in order that the client might gain a clearer perspective in a safe environment. Presumably this would not always be the case, and it would seem that an ethnic match where certain aspects of the relationship are appreciated through common experience could be a distinct advantage. Ideally, there would be enough therapists to be matched if required, however it would seem that if this is not desirable or available, Dupont-Joshua's (1994) stress on understanding and awareness of the variety there is between (and within) cultures, is essential. Not only can there be differences in the terms and meanings used in different cultures (Laungani, 1994), acceptability of
'being helped' can itself be an anxiety-provoking experience as it may be viewed in a certain way by different cultures, e.g., as a taboo and sign of weakness.

Alladin (1993) suggested that matching could facilitate empathic understanding and higher levels of disclosure, however, careful consideration was implied in his answer to the question as to how important it was to match clients and therapist on the basis of ethnicity: "It depends" (In Dryden, p50). This was a brief, but significant answer to the question, and also serves to suggest that matching in this area may present several problems and dilemmas; a rather frustrating state of affairs, though a reflection of wider issues relating to other aspects of the client-therapist relationship.

There has only been brief opportunity to brush the surface of the debate into matching in therapy; as seen in Figure 1, there are many variables that interact with each other and which make research into specific variables difficult. As with many areas in the study of psychology, and as discussed by Kantrowitz (1993), the therapeutic encounter and the client-therapist match is unique and replication is impossible. Thus, in matching client and therapist, there will almost certainly be aspects that are effective, and those which are not. Similarities between a client and therapist, whether it be of their own problems, certain personality characteristics, ethnicity and so on, can exert different effects. For example, the therapist may not realise their blindspots, there may be collusion, or the match may encourage some particularly rich therapeutic work (Kantrowitz, 1995). In terms that seem realistic, I feel that the following quote by Arnold Lazarus, although not directly linked to matching in therapy, has some relevance:

"'Relationships of choice' are no less important than 'techniques of choice' for effective psychotherapy. A flexible repertoire of relationship styles, plus a wide range of pertinent techniques seem to enhance therapeutic outcomes. Decisions regarding different relationship stances include when and how to be directive, supportive, reflective, cold, warm, tepid, formal, or informal. If the therapist's style differs markedly (my italics) from the patient's expectations, positive results are unlikely."

(Lazarus, 1993. P404)
It seems that there is a place for matching client and therapist in therapy, although the wealth of research indicates that this is certainly not a must, rather as the above quote advocates, a flexible approach would appear to be more useful. Awareness of the issues involved is a must, although a somewhat mind-boggling proposition to consider when one sees the quantity of individual differences in clients and therapists! As much as matching sounds a desirable and useful state of affairs to achieve, so that optimal therapeutic outcome might be possible Berzins (1977) makes a valuable point:

"there is at present no organised body of knowledge that could serve as an effective guide for implementing matching strategies."

(In Garfield, p245)
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ADVANCED THEORY & THERAPY REPORT

THE POSSIBILITY OF MAINTAINING A SECURE FRAME IN AN N.H.S. PSYCHIATRIC OUT-PATIENTS DEPARTMENT
In this brief essay, I shall outline some of the issues which may arise in attempts to maintain a "secure frame" (defined below) in a Mental Health Resource Centre and the effects this can have on clinical work. The aim of ensuring safety in the therapeutic environment was striven for by Sigmund Freud (1915) so as to foster a context in which the development and analysis of concepts such as transference might be possible. Milner (1952) first applied the term 'frame' to the analytical situation comparing it to the marking of boundaries of a picture frame, between that contained within it and the reality outside it. Specifically, Langs (1979) has defined the frame as:

"A metaphor for the implicit and explicit ground rules of psychotherapy or psychoanalysis. The image implies that the ground rules create a basic hold for the therapeutic interaction, and for both patient and therapist, and that they create a distinctive set of conditions within the frame that differentiate it in actuality and functionally from the conditions outside the frame."

(ibid.: 540).

I aim to give some illustration of the deviations in the frame which may be apparent in a hospital setting. Specifically, in relation to confidentiality and aspects of location and physical setting

It has been postulated by Langs (1979) that for some kind of safe environment to be provided, whereby provision of 'effective' therapy can take place, certain conditions should be evident:

- Confidentiality (total)
- Anonymity (of the therapist)
- Specific aspects of the location and physical setting to be controlled: neutral location in a professional building, private (un-shared office) and consistency of therapeutic conversations to that office.
- Set and consistent frequency and continuity of sessions.
- Set fees, times and lengths of sessions.
- Exclusiveness of therapist to therapeutic material (not 3rd & 4th parties).
- Therapist neutrality: truth (with tact and concern).
Langs differentiated between 'fixed' and 'variable' frame; respectively this accounts for aspects of the frame that he considered to be constant, such as length of sessions and those which are open to variation or subjective preferences, e.g., therapist neutrality.

Here it may be worthwhile briefly noting some of the history to these ground rules in the context of how they developed. It was evident that Freud was well aware of the importance of establishing some consistent type of code by which therapeutic work could be carried out. However, it seems that he considered these 'rules' as generally serving to provide a situation where therapy and transference's could evolve. It is also apparent, but perhaps not surprising given the relative infancy of therapy, that some of these were developed through trial and error. Langs was very focused on the significance of creating clear boundaries between patient and therapist; he recognised the contribution Freud's insights and practices made to this area, as did others therapist's who modified some of Freud's assertions. The modification and tightening of these ground rules can be seen in other writings, such as Winnicott (1954); although in his accounts, the importance of some of what Langs refers to as the frame, is much more implicit. Essentially Winnicott saw the therapeutic environment as a representation of the relationship the patient had with its mother; the holding, containment and provision of a good-enough environment has within it an indication of the importance the therapist has in creating and maintaining (managing) an environment safe enough for growth and development. Eissler (1953), clearly outlined times in therapy when deviations from the basic ground rules could provide useful information and he named these deviations 'parameters'. Basically this gave some leeway to the rules, and were applied when certain conditions were present: when a basic psychoanalytical working model was not working or when the use of the parameter would ultimately lead to elimination of the need to use it, so treatment could proceed in line with the basic ground rules.

There was, therefore, a recognition that at some point in classical psychoanalysis, a command of some kind might be needed in order to facilitate fuller exploration and confrontation with the underlying psychopathology in order to move towards
resolution. Bleger (1967) also saw the use of the frame as extremely important in shaping the effects of therapy. He saw the frame as an institution, in that its base consisted of a set of norms and attitudes within the boundaries of which therapy took place. However, in a similar vein to Winnicott, Bleger considered the therapeutic environment as a portrayal of the early mother-child relationship, and with correct management, ego development could take place. In terms of the frame, the client would be seen to attempt avoidance of intrapsychic anxiety-provoking instances (representative of the early maternal relationship), and it is the deviations which were attempted (in order to avoid anxiety) that Bleger saw as requiring close analysis.

The Secure frame in a Community Mental Health Resource Centre

In the following section discussion of specific components of the secure frame as outlined by Langs (1979: 3-42) and David Livingston Smith (1991:174-191), will be reviewed: namely confidentiality and aspects of the location and physical setting.

The context consisted of a Mental Health Resource Centre (within Hospital grounds) which accommodated a Day Hospital, a psychiatric out-patient department with psychiatrists, psychologists, social workers, community psychiatric nurse’s (CPN’s) and occupational therapists. Together, these professionals represented the Community Mental Health Team (C.M.H.T.). Referral was mainly from GP’s and all referrals were discussed and allocated in a weekly team meeting, as were re-referrals (internal or tertiary), reviews, feedback from assessments and in-patient admissions to the ward.

With regard to therapy in settings such as counselling centres, GP’s practices and N.H.S. hospitals, Milton (1993) suggested that:

"To work with a secure frame in institutions, is difficult at best and impossible at worst."

(ibid.: 284).
It can be seen in Milton's observations that there are a number of deviations to the secure frame, as defined by Langs (1979), that may well be sources of deviation common to a number of N.H.S. settings some of which are discussed below.

Confidentiality (total)

In the C.M.H.T. new referrals were discussed in the team and allocated 'appropriately'. Even before a client had seen any of the professionals available, a certain amount of their personal history had been discussed by at least ten people. On seeing the client for an initial assessment it was often unclear as to whether the client was aware that their details may have been discussed in the team. It seems to have been the norm, rather than the rule that clients' were informed that confidentiality was not absolute and that their situation had been discussed or may have been discussed in a team. Certainly there were guidelines that emphasised the early disclosure of instances where confidentiality would be broken, preferably after prior discussion with the client (e.g., if they were considered in danger of harming themselves and/or others; or in the context of supervision). In my own experience, clients do not appear to have had difficulty with the possibility that confidence might be broken. However, in practice, when I discussed with a client, who had described suicidal intent, that I might be discussing the situation with his key worker, he became noticeably defensive, minimising the extent of the problem. In this instance, after discussing the situation further with the client and in supervision, confidence was not broken to the key worker, but had never been absolute as I had every intention to discuss it with my supervisor, and the client was already aware that this was a possibility. As seen overleaf, involving third parties would mean that a secure frame has not been maintained, although supervision seems to be seen as essential in therapy, and seems to be more of a necessary modification of the frame than a total deviation. Phillips (1991) expressed curiosity about the possible effects informing a client of third party supervision might have on premature drop-out rates, although felt that it might be a contributing factor that is not generally voiced by clients. The view that Langs (1989) held about third party involvement is quite clear:
"Introduction of a third party on any level into the patient-therapist relationship is a deviation in the ground rules that has major consequences for the patient and the therapy."
(ibid.: 185).

The situation on my clinical placement not only included the other members of the team, but included the administrative staff. Clients would 'report' to reception before the required person was phoned and informed that their client had arrived, thus, the administrative staff often had details of clients and their attendance rates. This was partly redeemed by the fact that the psychologist's made their own appointments directly with the clients and not through a secretary, by-passing a certain amount of the problem.

As a trainee, one of the requirements of the course involved the use of audio-taped session process reports; signed consent was given by the client allowing a transcription of sessions to be produced, and the tape heard by a member of staff at the University. Livingston Smith (1991: 183), considers the use of tape-recording as damaging to the client and potentially detrimental to the therapeutic process. On enquiring as to whether I might tape a client, after discussing the details of what and who would be involved I gave her time to come to a decision between sessions (even though she had given permission to be taped). However, my hunch had been that she would have given consent as it was consistent with a 'conformity' theme running through her life story. On her return to the next session she was able to say that she no longer felt comfortable with the idea, for a number of reasons including the fact that someone else would have access to the material discussed in her sessions. This in itself was particularly valuable therapeutically, as she later divulged that had I accepted her permission immediately on first request, she felt that she would not have been able to object to the presence of the tape recorder in the next session.

**Location details and the consulting room**

The Resource centre was a single building within the grounds of the Hospital with the therapy rooms located on the second floor above the day hospital. Often day
hospital clients would attend individual therapy sessions or appointments upstairs, though would also be involved in groups in the day hospital. Although no difficulties seem to have been expressed over this arrangement, confusion had arisen between the different functions of the two facilities and how they are portrayed to the client. I have had to be very clear when giving information about my role and how it differed from, for example, the client's keyworker, who might have been a nurse. This seems to be an aspect of this kind of setting which would be virtually impossible to modify, and is something which is 'coped with'.

The office I used was private / un-shared, although at one point there were three of us (two trainees + supervisor) attempting to negotiate available times to see our clients! The office was not soundproofed and the location was certainly not ideal; it was next to the reception, where the voices of the secretaries could be heard, as could discussions in the corridor outside the room. It would seem highly probable that this could have affected development of trust, is connected with the issue of confidentiality and has implications in the client's experience of feeling safe to explore their concerns.

The door to the office was perpendicular to a door leading to the rest of that floor (which consists of the duty office, psychiatrist's, social workers, CPN's offices and the toilets). The effect I had occasionally experienced when in the room itself, was that anyone going to another part of the building sounded as though they might be just about to enter the room (there was no 'engaged' sign on the door). In most cases this does not occur, although when it did happen, obviously it was extremely intrusive.

Although I have outlined some of the so-called deviations which have occurred in my clinical placement, it should be noted that Langs was aware of these kinds of difficulties in certain settings. As such, it was hoped that the therapist would strive to maintain as ideal frame as could be secured in the given context. The therapist, in maintaining the given frame (that is, a deviant frame), should be aware that some clients might manifestly ask for alterations to the frame whilst also non-verbally communicate that they would like the rules to be adhered to. The adherence by the therapist to the rules constitutes "secure frame moments" and seems to be
something that may be beneficial to aim for when in a settings such as psychiatric out-patient departments or GP's practices (Hoag, 1991). It also seems that it would be more realistic than aiming for the components of a secure frame that Langs saw as ideal. In terms of practicalities as well, within a setting such as the one I was placed in, provision of an ideal secure frame would not be accommodated well by the nature of the multidisciplinary system (or by finances). And as Milton (1993) points out, this could jeopardise a therapist's professional relations within the settings if secure frame environments were set up. As such modifications might be useful to a certain extent and are important to stay mindful of, though do not appear to be pragmatic in settings such as N.H.S. out-patients departments. The importance of these ideas lies in alerting therapists to the meaning of unavoidable frame deviations, and the need to interpret this non-defensively.
References


CHILD ABUSE: MODELS OF CLINICAL INTERVENTION ESSAY

A SELECTIVE REVIEW OF THE LITERATURE ON WORK WITH ADULT SURVIVORS OF CHILD SEXUAL ABUSE AND PSYCHOTHERAPEUTIC ISSUES IN THERAPY WITH SURVIVORS SEXUALLY ABUSED BY FEMALES.
Childhood sexual abuse (CSA) has almost certainly existed for years, yet it seems the acknowledgement that it takes place is still difficult for society to accept (Herman, 1981). And whilst people do understandably become outraged and disgusted at abuse of children, such as the recent reports on paedophile rings in Belgium, the problem may often be seen as 'someone else's'. In reviewing the literature it can be seen there is currently greater recognition of the possible effects CSA can have on all who are involved than there has been in the past. The first part of the discussion will include a selective review of some of the literature on adult survivors of CSA, present some statistical data, summarise initial and longer term effects and discuss some psychotherapeutic treatment issues relevant to other mental health professionals, including counselling psychologists. In the second part an aspect of CSA which has only just begun to receive attention will be explored; CSA by female perpetrators and some of the therapeutic issues which may arise when working with these survivors.

Reference made to CSA will include incest, unless specifically stated. It is also noticeable that more research has been carried out on effects of CSA on female survivors than male survivors. Much of the material presented in this discussion relates to the material on female survivors, and it is clear that more research is needed into the possible impact CSA on males (e.g., Etherington, 1995).

Selective review of the literature on CSA

Historical considerations
It can be seen that although there was not a total denial of the existence of CSA, the belief that such behaviour might be occurring was not an easy pill to swallow. Indeed Freud (1893) interpreted reports of CSA in his female patients as unconscious desires about incestuous relationships with their fathers. In Hamilton's (1929) study, although there were methodological problems, the prevalence of what would currently be classed as CSA was high. It is also apparent that often the significance of the harm to the person who had been abused was down-played and often blame apportioned to the them (e.g., Abraham, 1927; Kinsey et. al., 1953; Weiss et. al., 1955; Mohr, Turner & Jerry, 1964; Henderson, 1975; Virkkunen, 1981). This view appears to be changing, although there is still much controversy.
**Definition of CSA**
Sanderson (1995) noted that there have been a number of problems in the variety and scope of definitions suggested, e.g., limiting factors involving confusion about how to integrate legal, social and anthropological definitions. This seems to relate to a commonly held assumption that CSA involves incest, excluding the possibility that acquaintances might abuse, not just family. There have also been debates about the nature and extent of sexual acts; on the whole it seems there is a strong belief that CSA would have occurred if sexual intercourse had taken place. This latter point is very important and is a major limiting factors in the definitions. Sanderson employed the following definition of CSA:

"The involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, in which the child is used as a sexual object for the gratification of the older person's needs or desires, and to which the child is unable to give consent due to the unequal power relationship."
(Ibid., p15).

**Incidence**
Problems with gathering reliable and valid data have come about mainly because of the lack of consensus on many aspects of CSA and other methodological issues, such as differences in data collection (e.g., individual versus group interview or a survey technique). There seems to be a rule of thumb that one person in ten will have been sexually abused in childhood; Baker & Duncan's (1985) study on the prevalence of CSA in Britain suggested figures of 12% of girls and 8% for boys. This finding would seem to support the view that the most common abuse scenario is father to daughter. However, recently there has been increased interest into the prevalence and impact of CSA on males. Researchers such as Finkelhor (1984) have proposed that the apparent lower figure for males has occurred because it is more difficult for males to disclose; possibly due to factors such as society's emphasis on masculine traits, e.g., being seen as strong and able to cope. On the whole it has been found that perpetrators are male; Finklhor suggested between 91-97% tend to be male, although a report from Childline (1992) indicated that 9% of abusers were female. This latter issue will be explored later in the discussion.
Initial (Short term) effects of CSA

The scope of these issues alone is very large and an overview will be presented in this discussion.

In their review of the impact of CSA, Browne & Finklehor (1986) defined initial (or short term) effects as reactions being exhibited within two years of the last abuse act. They suggested that many of the results obtained from studies were flawed as most had not used standardised assessment measures. However, in a study by the Tufts Medical centre in America (1984) it was found, that amongst other things, of the children who had been sexually abused, within six months after the last incident 40% of 7-13 year olds were scored in the 'seriously disturbed' range. This research also found that levels of fear were high, as were levels of aggression, antisocial behaviour and other behavioural disturbances such as disruptive behaviour at home and in school. Various physical symptoms have been noted (Anderson, et. al., 1981), including change in eating habits and sleep disruptions, although it is possible that these problems are part of a wider picture of depressive symptomatology. There has been a number of studies that have discussed inappropriate sexual behaviours in children (e.g., the Tufts study, 1984; Salter, 1988) with comparisons having been made against control groups of non-abused children. Observation of the types of activity they engaged in was carried out. These included noting the following: the level of force they might use in their play with other children, objects or animals and the age differences between themselves and others they interact with in relation to sexualised play. The extent and nature of these kinds of behaviours has been noted as indicators, though not as concrete markers, of a child having been sexually abused.

Longer term effects of CSA

A number of inconsistencies are apparent in the research literature in this aspect of CSA, e.g., methodological differences which have shown wide variations in the operational definitions of what constitutes CSA; and sampling variations, such as differences in sample populations have been identified. There are also other problems, in particular the difficulty of showing that the difficulties a person may be exhibiting are directly related to the CSA. However, as above an attempt will be
made to be present an overview of some of effects that seem to be common in people who have been sexually abuse as children.

Sanderson (1995) noted that often extremely painful aspects of CSA may be repressed and / or dissociated; the person may be seen to function well until some trigger reactivates the trauma. These triggers might be anything from a smell to various developmental milestones, such as marriage or birth of a child and the death of an abuser. Although some researchers have suggested that up to a third of survivors report no negative long term effects (e.g., Kendall-Tacket et. at., 1993) there have been consistencies found (e.g., Browne & Finkelhor, 1986; Draucker, 1993; Mullen et. al., 1993). Sanderson (1995) has categorised long term effects as follows:

- Emotional effects (e.g., depression, anger).
- Interpersonal effects (e.g., isolation, relationship problems, fear of intimacy).
- Behavioural effects (e.g., self-harm behaviours, eating disorders, substance misuse).
- Cognitive-perceptual effects (e.g., denial, cognitive distortions, dissociation)
- Physical effects (e.g., psychosomatic pain, sleep disruptions).
- Sexual effects (e.g., various impairments in sexual functioning, promiscuity, problems in distinguishing sex from affection).

A full outline may be found in appendix A

Impact of CSA
As has been mentioned previously, although earlier research tended to down-play the negative effects of CSA (e.g., Lukianowicz, 1972), it seems that more recent research has acknowledged that there can be serious mental health problems in people who have been sexually abused (e.g., Bagley & Ramsey, 1985; Courtois, 1988). Indeed the attempts at using the diagnostic criteria of Post Traumatic Stress Disorder (P.T.S.D.) indicate the seriousness of the impact CSA can have. Finklehor (1988) argued that there were still aspects of CSA which were not adequately covered by the P.T.S.D. diagnostic criteria, such as guilt, fear and self-harm gestures. Finklehor & Browne (1985) proposed a 'traumagenic' model which they
felt clarified a fuller understanding of the dynamics relating to the impact of CSA. It includes the following dimensions:

- traumatic sexualisation
- betrayal
- stigmatisation
- powerlessness

These have within each of them divisions considering various dynamics, the psychological impact and the behavioural manifestations relating to the main dimension (A full outline of the model is presented in appendix B). This model seems to have several advantages over using the P.T.S.D criteria, mainly in its flexibility in accounting and allowing for the presence or absence of inter-relationships between the dimensions; and in helping to manage possible treatment strategies which are tailored towards the individual's experience. It also moves away from pathologising a person's reaction to CSA, which may occur in the event of a DSM diagnosis being given.

Effects by type of abuse
The issue of the possible effects of different types or kinds of abuse has also been considered and, as might be expected, includes a number of factors which seem to make consistent agreement rare, among both researchers and therapists. For instance Sanderson (1995) pointed out that attempting to compare the differences, for example, between 'children who have been consistently raped by their step-fathers, to the daughters who have regularly been orally masturbated by their fathers' (p16) is extraordinarily difficult.

Research has been carried out in the following areas and their possible relationship to long term effects of CSA: duration & frequency of abuse (e.g., Russell, 1986; Langmade, 1983); the relationship to the offender (Bagley & Ramsey, 1985; Tufts, 1984); the type of sexual act (Russell, 1986); the influence of force & aggression (Finkelhor, 1979); age at onset (Meiselman, 1979); sex of the offender (Russell, 1986; Elliot, 1993); age of the offender (Russell, 1986); disclosure versus no disclosure (Bagley & Ramsey, 1985); parental reaction to disclosure (Bagley & King,
1991; Ainscough & Toon, 1993; Gomes-Schwatz et. al., 1990); and institutional response (Bagley & King, 1991). Attempts to draw these studies together has caused problems as outlined above (Browne & Finkelhor, 1986; Sanderson, 1995; Draucker, 1993), although the following themes have emerged as possibly resulting in greater trauma: when the perpetrator was either father or step-father; when the type of sexual act involved contact with the genitals, when the nature of the act or behaviour is particularly invasive, long-lasting and aggressive; and when the relative power disparity between victim and perpetrator was strong. It is stressed by most authors that these are tentative themes and require further investigation.

**Therapeutic issues in working with survivors who have been sexually abused by females**

**Issues related to prevalence**

As noted previously, few studies have actually specifically explored CSA by females and if mentioned, women have been seen as aiding male partners or engaging in behaviours that were not really considered 'serious' abuses e.g., sexualising a goodnight hug (Draucker, 1993). Some texts have made no mention or implication of women perpetrating sexual abuse (e.g., Bagley & King, 1991). Researchers such as Finkelhor & Russell (1984), suggested that up to 13% of perpetrators were female, and Krugman (1986) reported that 40% boys seen at their clinic were abused by females. O'connor (1987) found that of the women committed to Holloway prison between 1974-1985, 81 were classed as sex offenders, of which 62 had committed one or more of the following offences against children: indecent assault, indecency with children or had unlawful sexual intercourse (most often in aiding and abetting a male).

On the whole it appears to be much less socially acceptable that a female could commit sexual acts, in many cases, similar to that of male perpetrators (e.g., vaginal and anal penetration with fingers and inanimate objects). Kirsta (1994) believes that the apparent denial of CSA by females may relate to societies' distorted beliefs about females as feminine, as mothers, as care-takers, as nurturers and as less powerful than males.
Long term consequence of female CSA

Elliott et. al., (1993) conducted a study of female CSA, in which data was collected from a sample of 127, consisting of 95 females and 32 males. Female survivors reported a variety of problems including suicidal ideation, eating disorders, gender identity problems, unresolved anger, relationship problems, depression and fears about touching their own children. The male survivors reported similar problems, although notably gender identity concerns and extreme ambivalence in their attitudes towards women.

Clinical observations and therapeutic issues in working with survivors of female CSA

(Much of this discussion is based the work Elliott et. al., carried out with 10 survivors, and therefore any generalisations should be made with extreme caution).

Clinical observations

It was virtually impossible to differentiate the impact of the gender of perpetrator when a person had been sexually abused by both a female and a male. However some of the female survivors reported that they felt that their abuse by a female first degree relative was the abuse that they felt most ashamed about and affected by. One women reported:

"There's something about a mother. When you're small, she should be the first person you go to if you're hurt; the first person to cuddle, who gives you love and care. So when she abuses you, it leads to an even greater sense of despair than when your father does it. In my dreams I castrate my father and suffocate him. But I can't attack my mother. I'm torn between love and hate."

(In Elliott et. al., 1993. p10).

It has been seen previously that the reality of females being involved in sexually abusing a child is difficult for many people to grasp, including therapists. Elliott reported one man's anguish at not being believed by his therapist:

"I tried to tell my therapist when I was 35. She told me that I was having fantasies about my mother and that I needed more therapy to deal with it. In reality my mother had physically and sexually abused me for as long as I
could remember. The abuse was horrific, including beatings and sado-masochistic sex. It took quite a lot of courage for me to tell. When she [the therapist] didn't respond, I quit therapy and spent the next 15 years in hell."
(In Elliott et. al., 1993. p8).

The cognitive dissonance that may well result from the knowledge that one has been a part of behaviours that are socially unacceptable, with ones own mother for example, might be 'dealt with' in various ways. In extreme cases dissociation might occur, although many women in Elliott's sample used coping strategies such as denial, repression and acting out. These kinds of strategies serve to protect the Self and Elliott noted that in the female survivors, differentiation of the Self was often an issue. It seems that having difficulty developing autonomy in the sense of knowing the boundaries between Self and other (mother), raised great concern that survivors would turn out the same as their mothers. It also seems that issues of maternal power, perception of female identity and what that entails are particularly relevant for the therapist to be aware of.

In looking at relationship issues in areas of the survivor's lives, such as long term commitment, marriage and sexual relationships, clear problems were identified. Emotional and physical intimacy appeared to be frightening and difficult to tolerate, and impairment in sexual functioning was reported by most of the sample. However Elliott has stressed that it is extremely difficult to make causal links between these relationship impairments and the CSA, mainly because of other factors in the backgrounds of the sample population.

Therapeutic issues in working with survivors of female CSA.
Elliott et. al., posit that the therapist's views on females in all the roles they might have, as well as their own experiences of females in their lives are important to stay mindful of (as with any therapy). In particular the importance of monitoring ones own reactions to a disclosure of CSA by a female; if the therapist finds it difficult to believe that women can give and receive 'good enough' parenting (Winnicott, 1965), this could be quite destructive in working with someone who has been sexually abused by a female. It is possible that a therapist's anger and disgust at the abuser,
for example, would inhibit adequate exploration of the client's relationship with their mother. It is likely that strong transference's will develop, and as a therapist, as in any therapeutic encounters, an awareness of the influence of mechanisms such as projective identification is a must. Dolan (1991) noted that female therapists of a clients abused by a females can be in a powerful position in providing some kind of reparative therapeutic experience for the client. And whilst this would make sense, caution should be taken that in providing a 'corrective emotional experience' other dynamics are not being ignored, being replayed or colluded with in the transference / countertransference relationship.

It does not seem surprising that the capacity of the therapist to present a non-judgemental and accepting stance is crucial, as is helping to provide the client with a positive, appropriately nurturing model of what a trusting relationship can be like. Elliott et. al., found that people who had been sexually abused by females tended to disclose this information later on into the therapeutic relationship than if abused by a male. This seemed to be related to the perceived stigma of being sexually abused by a female. Thus developing a strong working alliance with high levels of trust may be particularly difficult for some clients. Elliott et. al., suggested that female survivors would be more likely to present with a wider range of concerns including relationship difficulties, self-hate and fears about involvement with children. On the other hand it appeared that males who had been sexually abused by females might be more likely to present with concerns about sexual dysfunction and intimate relationship difficulties. Sinason (1996) noted that in the referral letters of adolescent boys there was pattern in the lives of those who had been sexually abused by their mothers: high levels of acting out / violence; an either totally absent or psychologically detached father and the frequent use of aggressive language degrading women. And whilst these kinds of presenting problems certainly are not indicative of female CSA, having some knowledge about these issues will hopefully facilitate positive movement in the therapy, rather than taking the therapist by surprise if they occur.

Although there has not been much research carried out into survivors of female CSA, there has been even less conducted into possible differences between male and female survivors. Elliott et. al., have run some peer group therapy, although
acknowledged that it may be difficult for such facilities to be provided for survivors of female CSA (because of the lower numbers of clients who have experienced female CSA). However in their experience the issue of the stigma attached to female CSA was an important consideration in a client's participation in a group where they might be the only one who has been abused in that way. In this event, it is recommended that initially guided focus might involve discussion of some of the similarities in issues presented rather than drawing attentions to possible differences. Elliott et. al., also caution therapists on the dynamics and issues that might arise in a female client's participation in an all-female survivors group which may illustrated by a quote from one of their group members:

"There are an awful lot of breasts in this room! I'm not sure I'm going to be safe"

(In Elliot et. al., 1993. p33).

And whilst there does not appear to be literature regarding male survivor groups of female CSA, presumably the possible dynamics which might occur if the facilitator was a female would require some scrutiny. In female survivors groups key issues were identified by Elliott et. al., which might be included in the therapy:

- The demonstration of supportive and nurturing relationships between adult females without ulterior motives, i.e., boundary issues.
- Appropriate challenges to distortions of reality.
- Opportunity to mutually interact with other women in ways which communicate and provide for personal needs and desires.
- Role-play: to work through and express feelings, thoughts and behaviours related to their abuse and relationships in a safe environment.
- Use of metaphor: this can often help clarify internal processes occurring in clients in a relatively non-threatening or overpowering manner.

Clearly these are group guidelines although Elliot et. al., have also found that this kind of group appears to be complimented by individual therapy as well. One could imagine that it might be difficult for a person to disclose extremely sensitive and possibly shameful aspects of their experience in a group setting; individual therapy
might seem safer for the person who may feel very vulnerable and exposed anyway. This could also be a place where any issue which may have arisen from the group might be explored further and in greater depth if desired.

In conclusion then, recognition of the occurrence and possible effects and impact CSA can have on adult survivors is increasing. And even though the extent of its prevalence is disturbing it may be that people would begin to feel it is easier for them to seek help, whether abused, abuser or both. However, the issues which need to be taken into consideration in the therapeutic encounter are complex and require that the therapist is aware of their the impact their own backgrounds, beliefs and attitudes could have in the therapy process. It seems obvious, but regular supervision, and if necessary personal therapy, will help in the dilemmas which might become apparent in work of this kind. And while I am not down-playing the significance of female survivors who have been abused by males, the therapist would benefit from having some preparation for a disclosure of something like CSA by a female as there are some unique issues in this area. This would also apply to male survivors, although there seems to be slightly more research carried out in this area.
References


**APPENDIX A.** List of long term effects of childhood sexual abuse on adult survivors by category

<table>
<thead>
<tr>
<th>Emotional effects</th>
<th>Cognitive/Perceptual effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Denial</td>
</tr>
<tr>
<td>Low Self Esteem</td>
<td>Cognitive distortions</td>
</tr>
<tr>
<td>Guilt</td>
<td>Dissociation</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Amnesia</td>
</tr>
<tr>
<td>Obsessive/Compulsive</td>
<td>Multiple personality</td>
</tr>
<tr>
<td>Anger</td>
<td>Nightmares</td>
</tr>
<tr>
<td></td>
<td>Hallucinations</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal effects</td>
<td></td>
</tr>
<tr>
<td>Isolation/Alienation</td>
<td></td>
</tr>
<tr>
<td>General Social Relationships</td>
<td></td>
</tr>
<tr>
<td>Relationships with Men</td>
<td></td>
</tr>
<tr>
<td>Relationships with Women</td>
<td></td>
</tr>
<tr>
<td>Relationships with Parents</td>
<td></td>
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<tr>
<td>Effects on Parenting</td>
<td></td>
</tr>
<tr>
<td>Fear of Intimacy</td>
<td></td>
</tr>
<tr>
<td>Revictimisation</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral effects</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Destructive Behaviours</td>
<td></td>
</tr>
<tr>
<td>Self Mutilation</td>
<td>Impaired arousal</td>
</tr>
<tr>
<td>Suicide</td>
<td>Impaired orgasm</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Sexual dissatisfaction</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>Vaginism</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>Dyspareunia</td>
</tr>
<tr>
<td></td>
<td>Impairment to separate sex from affection</td>
</tr>
<tr>
<td></td>
<td>Oversexualisation</td>
</tr>
<tr>
<td></td>
<td>Sexual Orientation</td>
</tr>
<tr>
<td></td>
<td>Promiscuity</td>
</tr>
<tr>
<td></td>
<td>Prostitution</td>
</tr>
</tbody>
</table>

APPENDIX B.

The Traumagenic Dynamics Model of child sexual abuse
(Finkelhor and Browne, 1985)

1: Traumatic Sexualisation

**Dynamics**
(a) Child rewarded for sexual behaviour inappropriate to developmental level
(b) Abuser exchanges attention and affection for sex
(c) Sexual parts of child fetishized
(d) Abuser transmits misperceptions about sexual behaviour and sexual morality
(e) Conditioning of sexual activity with negative emotion and memories

**Psychological impact**
(a) Increased salience of sexual issues
(b) Confusion about sexual identity
(c) Confusion about sexual norms
(d) Confusion of sex with love, care getting, and sexual sensations
(e) Aversion to sexual intimacy

**Behavioural manifestations**
(a) Sexual preoccupations and compulsive sexual behaviours
(b) Preoccupation with sexual activity
(c) Aggressive sexual behaviours
(d) Hyperactivity
(e) Prostitution
(f) Sexual dysfunctions, flashbacks, difficulty in sexual organs
(g) Avoidance of, or phobic reactions to, sexual intimacy

2. Stigmatisation

**Dynamics**
(a) Abuser blames, designates victim
(b) Abuser and others pressure child to secrecy
(c) Child infers attitudes of shame about activities
(d) Others have shocked reaction to disclosure
(e) Others blame child for events
(f) Victim is stigmatised as damaged goods

**Psychological impact**
(a) Guilt, shame
(b) Lowered self-esteem
(c) Sense of difference from others

**Behavioural manifestations**
(a) Isolation
(b) Drug or alcohol abuse
(c) Criminal involvement
(d) Self-mutilation
(e) Suicide

3. Betrayal

**Dynamics**
(a) Trust and vulnerability manipulated
(b) Violation of expectation that others will provide care and protection
(c) Child’s well-being disregarded
(d) Lack of support and protection from parent(s)

THERAPEUTIC PRACTICE DOSSIER

The following dossier contains a description of all three training placements and a personal overview of these experiences. A summary of four client studies is included, and a discussion of process issues, derived from two audio-taped therapy sessions is presented.
N.B. Statement of anonymity and confidentiality regarding clients and personal details.

It should be noted that this Portfolio is a public document. In order to preserve the anonymity and confidentiality of clients, personal information and details have been altered. Only summaries or discussions of full reports are presented in the Portfolio.
SECTION 1

DESCRIPTION OF TRAINING PLACEMENTS YEARS 1-3
Summary of training placement from November 1994 - July 1995: Year 1

• Placement: A University Student Counselling Service.

• Type: Mostly psychodynamic, although other models were integrated, e.g., Humanistic.

• Duration: One day per week during University terms from November 1994 - July 1995.

• Client population: Students and staff (adult mental health).

• Type of supervision: Weekly psychodynamic sessions with the senior counsellor (a chartered counselling psychologist and psychoanalytic psychotherapist).

Context of the psychological therapy

The service was part of the Student Services at the University although was available to members of staff as well.

The referral system involved a reception interview with one of the established counsellors with the intention of gathering general information about the presenting problem (duration of difficulty, other/previous sources of support, reason for current referral) and possibly other more specific areas, e.g. severe disruption(s) in childhood.

There were no specific guidelines about the number of sessions offered although a review was recommended after six sessions. The honorary counsellors were often given the opportunity to have slightly longer term clients, e.g. six months.
Summary of training placement from October 1995 - July 1996: Year 2

• Placement: Within a Community Mental Health Team in the psychiatric out-patients department and day hospital of a teaching hospital.

• Type: Mostly psychodynamic, although other models were regularly used, e.g., cognitive-behavioural.

• Duration: Two - two and a half days per week from September 1995 - July 1996.

• Client population: Secondary or tertiary adult mental health referrals.

• Type of supervision: Weekly sessions in mainly psychodynamic or cognitive-behavioural models with a principle psychologist (chartered clinical psychologist).

Context of the psychological therapy

The Day Care Service based at the Hospital was part of a Healthcare Trust incorporating three districts. Within this service there were Community Mental Health Teams (C.M.H.T.) divided into two with different catchment areas. The main emphasis of the C.M.H.T. was on maintenance of the individual in the community and the care of clients with either short, long term and acute serious mental health problems. The teams consisted of psychologists, psychiatrists, social workers, community psychiatric nurses, community intensive care workers, mental health support workers and occupational therapists. Referrals were received from various sources, primarily GP's, out-patient consultants and in-patient staff.

The types of services on offer included individual and group therapies, detoxification programme, depot clinic and drop-in facility, emergency duty rota, liaison with GP's and other agencies, regular reviews and C.P.A. meetings.
Summary of training placement from October 1996 - October 1997: Year 3

• Placement: Community Mental Health Team.

• Type: Cognitive-behavioural.

• Duration: Two - two and a half days per week from October 1996 - July 1997. Available full time from August 1997 - October 1997 (inclusive).

• Client population: Primary and secondary adult mental health referrals.

• Type of supervision: Weekly sessions, mainly cognitive-behavioural although sometimes eclectic (from a chartered clinical psychologist).

Context of the psychological therapy

The Community Mental Health Team (C.M.H.T), was part of a Mental Health N.H.S. Trust and one of their eight C.M.H.T.'s. The main emphasis of the C.M.H.T.'s was on maintenance of the individual in the community and the care of clients with either short, long term and acute mental health problems. The team consisted of a consultant psychiatrist, clinical medical officer, C.M.H.T. co-ordinator, occupational therapist, community psychiatric nurses, psychologists, social workers (mental health & approved) and community support workers.

The types of services offered by the team included individual and group input, emergency duty rota, liaison with GPs and other agencies, regular reviews and C.P.A. meetings. Team referral and allocation meetings were held every Tuesday morning.
SECTION 2

A PERSONAL OVERVIEW OF PLACEMENT EXPERIENCES OVER THE DURATION OF THE COURSE
My clinical practice experience at the beginning of the course was limited and the prospect of working therapeutically with 'real' clients was a little daunting. My knowledge of various psychological theories and models of working was somewhat more sophisticated, although contemplating how I might improve in both these areas to a proficient level of integration presented a challenge at that time.

In aiming towards integration of theory and practice, the first year placement (psychodynamic) proved to be one which required application in both areas and certainly background reading. The initial skills training provided by the university was based around a problem-solving approach; the emphasis of the placement was on applying a fairly strict psychoanalytic model (Kleinian theory). Initially there were some struggle in my attempts to balance the two approaches of psychodynamic and humanistic, however, the situation encouraged me to think about several issues. In particular, the strengths and shortcomings of only using one specific theoretical model in therapeutic work, as compared to tailoring the therapeutic input to client need. My views and knowledge of the efficacy and usefulness of other models and approaches increased, although trusting in my own judgement about these was still at a preliminary stage. As my self confidence grew, a process of enquiry and questioning strengthened, as did my desire to learn about and integrate more skills into my practice.

The first training placement setting was one which demanded high amounts of independence and limited contact with other members of the student counselling services (the university has several sites, each with their own counselling facility). Although I enjoyed working with the client group, after being in a relatively isolated setting, my ideas about the future context in which I might like to work became clearer; a team setting held great appeal.

It was not until I began the second year training placement that I really appreciated some of the benefits which had come out of some of my struggles in the first year. Aspects of integrating theory and practice began to unite and I felt increasingly comfortable with a psychodynamic approach. My thoughts about the usefulness of other major approaches, in particular cognitive-behavioural therapy, developed within the setting of a psychiatric out-patients department. The opportunity to apply
what seemed the most appropriate approach for individual clients became greater, not only as a result of the client group and context, but with my skills and own self confidence in applying them. The second year of the course, as a whole, was demanding. On several occasions there were times when, professionally, I felt a strong sense of knowing where I wanted to get to and found myself somewhat overwhelmed by a sense of how I might ever achieve this. I was beginning to realise the amount that I did not know. These feelings applied to both my knowledge of theory, and my clinical practice at various stages throughout the second year. I also realised the value, as well as some of the difficulties, of working within a team setting and the importance of feeling comfortable in this. I found the multidisciplinary team both supportive and challenging and the development of my identity as a counselling psychologist grew stronger, as did my appreciation and understanding of the role other mental health professionals held. It was most certainly a time of working towards greater consolidation and confidence within myself as a professional psychologist. At the end of the second training placement I felt comfortable with the level of professional competence I perceived myself to be functioning at, particularly in terms of integrating psychodynamic theory and practice.

The final training placement provided an opportunity to practice at a level which seemed the most consistent with my thoughts about how I thought post-qualification practice might be. Working in another team context reinforced my views about the strengths of a multidisciplinary approach. I valued the support and the opportunity to familiarise myself with, and draw on, the skills of other mental health professionals. This was a two-way process and my sense of professional identity and role was enhanced by the respect other team members gave me.

A major focus was the integration of knowledge and skills acquired over the previous two years. My sense of feeling somewhat daunted by the amount that I didn’t know lessened, and I viewed the situation more as a way to focus my career interests for the near future, and to move towards closing some of the gaps in my experience. A second major focus of this training year was in strengthening the link between cognitive behavioural theory and practice. Whilst there had been many opportunities to work within this model during my second training placement, the supervision and
practice had centred on psychodynamic work whenever possible. In many ways I felt comfortable and familiar with a psychodynamic framework, and the final year’s emphasis on a cognitive-behavioural approach was a little unsettling at first. It was almost like using a second language that already held a certain amount of familiarity; at first I would catch myself formulating from a psychodynamic perspective, and then translating it into a cognitive-behavioural formulation and language. On some occasions it would be a mixture of both! Clarity and greater understanding of the cognitive-behavioural model has come from applying a similar kind of focus as occurred in the second training placement. Some careful selection of client problems and cognitive behavioural supervision provided me with the opportunity to build on my application in that model. Of the two main theoretical approaches taken throughout the course psychodynamic theory and practice has been the most influential in my clinical practice. It is acknowledged that in attempting to fill some of the gaps in my knowledge of theory and clinical practice, building on my existing experiences of working in a cognitive behavioural framework would be desirable.

I have found the three years of academic work and clinical practice extremely valuable, although there have been some models and approaches that inevitably I have only had a ‘taster’ of. This partly explains my views about the amount that I feel I do not know, or have not experienced fully. The prospect of building on my existing knowledge of theory and practice, in conjunction with learning about other ways of working, is exciting and challenging; I look forward to it.
SECTION 3

SUMMARY OF FOUR CLIENT STUDIES
CLIENT SUMMARY 1:
The client and her reasons for seeking help

Mrs A., a 35 year old shop assistant, had described her presenting problem as "not feeling happy", and that she felt guilty about her inability to cope adequately. She had reported symptoms consistent with depression, such as frequent weepiness, hopelessness about the future, low motivation, sleep disturbances, low self-esteem and self-worth, depressed appetite and apathy as well as some past suicidal ideation. She scored 27 on the Beck Depression Inventory, indicating the lower end of the moderate to severe rating for depression.

Theoretical perspective taken and the rationale behind taking this approach

A cognitive-behavioural approach was taken with Mrs A. It was thought that she might respond well to a cognitive approach, which had been evidenced by the following: willingness to take responsibility for change; quickly making sense of the relationship between thoughts, feelings and behaviours (she was able to identify a number of cognitive distortions in her thinking); ability to maintain the problem focus (she drew up a problem list and identified the areas she wished to address).

Family and personal history

Mrs A. was the youngest of three siblings (two females, one male) with an age range of ten years. Her father, who she was close to, died in a road traffic accident in the early 1980's. Her mother, aged 64, was still alive and lives in north Wales. Mrs A. married her husband, an accountant, in 1982; they had two children, aged 14 and 10.

Formulation

From an early age Mrs A. had developed a number of dysfunctional assumptions based on her need to conform to other's expectations of her. She had low self-esteem and had a fear that other people would view her as incompetent or reject her if she refused their requests. Mrs A. found it difficult to negotiate compromise, engaging in polarised thinking, which probably served to lower her self-esteem further.
Mrs A. saw her life as having "gone down hill" since the death of her father and getting married. She had been unsure about staying in the marriage, having felt a failure as a good wife and mother, and automatically personalising and blaming herself for any marital problems.

Mrs A. possessed the motivation, insight and ability to work within a cognitive-behavioural model. She was able to identify, challenge and rephrase her negative thoughts. Her sense of hopelessness about the future of her family relationships lessened and she reported feeling greater confidence about her ability to create more control over aspects of her life.

Development of the therapeutic relationship
Mrs A. had not sought help for her difficulties before and seemed to adapt to the therapeutic situation quickly. This may partly have been relief that her problems were taken seriously. Although adherence to the cognitive model was encouraged, early sessions served a significant containing function as well as educating her in the cognitive approach.

The working alliance appeared to be healthy; Mrs A. quickly became more forthcoming about various aspects of the therapy and its progress. She had become more willing to explore painful issues in-session, allowing herself the opportunity to do so in a safe environment. This had helped to challenge some of her cognitive distortions about 'what might happen' to her, and had enhanced her capacity to make changes in other parts of her life.

Outcome of the therapy
Mrs A. was able to assimilate the skills she had learnt, which gave her a clearer understanding of possible triggers and indicators that might lead to negative thinking and depressive symptoms. She described feeling confident that she would be able to take preventative action in times of increased stress and anxiety and use her skills to monitor and shift her perceptions and reactions to events. She reported continued progress at follow-up and did not re-present during the time I was on placement.
CLIENT SUMMARY 2:
The client and his reasons for seeking help
Mr D., a 52 year old ex-labourer, had presented with problems managing his anger, which he felt had primarily been as a result of an indecent assault on him in April 1996. He had wished to explore some of his feelings about the assault and look at ways to channel his anger constructively.

Theoretical perspective taken and the rationale behind taking this approach
Mainly psychodynamic, although some cognitive-behavioural input had been used in the initial stages. The latter approach had been chosen in an attempt to help Mr D. manage his anger more effectively; this included monitoring of cognitions, somatic-affective influences and behavioural patterns. The psychodynamic approach allowed him to explore some of his concerns in terms of lifespan experiences, in particular, at looking at the pattern and dynamics of relating to others.

Family and personal history
Mr D. was the second of five siblings although had not had any contact with them for twelve years. His parents were no longer alive and his relationship with both of them had been strained. He had been 'kicked out' and isolated from the family home at 17 after throwing a knife at his then pregnant mother. He married at 23 to a woman 26 years his senior; they divorced 9 years later. He has been in variety of short term jobs throughout his life.

Formulation
For a number of years Mr D. had thought of himself as weak and insignificant. In attempting to change this 'weakness', gain attention and cope with his anger he had engaged in self-destructive and distancing behaviours, such as self-harm or projecting his anger outwards onto others. His marriage to a woman 26 years his senior may partly have reflected his desire for the type of relationship that he did not feel he had been in with his own mother. His reluctance to allowing a divorce might have given some indication to possible fears about separation and rejection.
Mr D.'s experience of being sexually assaulted had been extremely painful, intrusive and had reinforced his feelings of lack of control over his life. The event had given him a clear and legitimate reason for expressing feelings such as anger, guilt and shame that would not be belittled by others. Therapeutic input encouraged him to convert the energy of these feelings into constructive avenues, rather than fearing that they might destroy him.

Development of the therapeutic relationship
Mr D. had been familiar with the N.H.S. system and had not wholly been satisfied with some of the professionals he had encountered previously. From the beginning of the therapy, I had felt a strong sense of challenge and resistance, which had been evidenced in his testing strategies.

It was important that I was not perceived in the same light as other people in Mr D.'s life who he had felt had not accepted or valued him; trust had been a significant issue. He had initially been quite resistant to disclosure; in the transference I felt that I had been kept at a distance through his tendency to externalise and protect himself from potential damage to his self-esteem.

In the later sessions I felt Mr D.'s trust in me and the therapeutic process had grown. It had been anticipated that change might take a while, although he had been able to engage in some of the immediate input offered to him during the time we met.

Outcome of therapy
Mr D.'s tendency to externalise his emotions and focus on his financial situation turned out to be quite an engrained pattern. He did progress a little in learning to manage his anger, although therapy was terminated prematurely. There may have been a number of explanations for this, though it is likely that a significant factor in this was the compensation money he received for the assault (£7000). He went abroad for several months, although asked for re-referral to continue with anger management when he came back (I was due to leave, and he saw another member of the team).
CLIENT SUMMARY 3:
The client and her reasons for seeking help
Ms L., a 48 year old unemployed lady had presented with a history of chronic depressive symptoms and low self-esteem. She had felt that her problems stemmed from suppressed emotions from her early childhood and felt psychodynamic (preferably psychoanalytic) exploration would have been of help her.

Theoretical perspective taken and the rationale behind taking this approach
Much of the work was psychodynamic, although at some points it had been appropriate to draw on other approaches such as working with cognitions and looking at problem-solving strategies.

Family and personal history
Ms L. was the youngest of two other siblings who were 20 and 25 years her senior; both had died in the last 15 years. Her father was alcohol dependent and most of her memories of him incorporated his alcohol-induced behaviours. She had seen more of her mother than father, and it seems that their relationship had been volatile and confusing for her. Both parents were deceased.

There had been a number of disruptions in Ms L.'s life: a suicide attempt when she was 20; an eating disorder in her mid 20's; a 3 year unsuccessful marriage at 23, in which both of them had drunk heavily and she had been physically abused. She had been admitted to a psychiatric hospital after her mother had died and it seems this bereavement was complicated by heavy drinking. She was admitted again 3 years later, after further alcohol and substance misuse. She was diagnosed with cirrhosis of the liver 7 years ago and had been abstinent ever since.

Formulation
Ms L.'s distanced and somewhat isolated family relationships gave insight into possible mechanisms which she had developed to 'cope' with her life. Notably, these defences included projection (onto herself or externally) and avoidance strategies such as denial. On some occasions these defences had been inadequate, resulting in self-destructive behaviours. She had developed a strong sense of independence, although at times she had given the impression of being
very needy; this manifested in periods of alternating between passive and aggressive demands.

Given Ms L.'s upbringing, it was possible that these fluctuations had some roots in conflicts about dependency; with confusion about the level she felt able to invest her energies in others whilst looking after her own needs. She had acknowledged her difficulties about which 'direction' she would have liked her life to go, and this seemed to relate to other issues, such as her life-stage, past regrets and fears about the future.

Development of the therapeutic relationship

I became acutely aware very early on of my own reactions towards Ms L., which for the most part consisted of frustration (of her circumlocutory manner of answering questions and, initially, an air of being challenged to some kind of intellectual competition). It may have been that this feeling of challenge was part of a testing process: requests for information, telling a secret, asking a favour, putting herself down, and inconveniencing me; all of which Ms L. had engaged in throughout the early sessions. The frustration I felt was interesting and I suspect had been a strong projection of the way Ms L. had been feeling, along with a sense of not really knowing where to go in that current situation. The feeling of challenge shifted once explanations about the nature of therapy, boundary issues and a focus for therapy had been firmly established, i.e., that she felt more contained and secure.

Outcome of therapy

Ms L. did progress in her ability to use the therapy in a constructive manner once she felt more at ease with the situation and saw she could gain something in a shorter period of time than she had initially expected. She had become more able to plan and prioritise, and to look at aspects of her life in manageable 'chunks' as well as exploring strategies she could use to achieve her aims. She continued to expressed keenness about having some kind of longer term therapy, which helped us both prioritise and work on some of more immediate concerns, such as strategies to lift her low mood and maintain positive change.
CLIENT SUMMARY 4:
The client and his reasons for seeking help

Mr G., a 36 year old factory worker, had presented with symptoms of depression and anxiety. He felt the reason behind these symptoms had been related to his experiences over an eight year period with his ex-wife, Ms K. He claimed she had sexually abused their son, now 5 years old, and physically abused his daughter (by another marriage). The reason for Mr G. seeking help at this time had appeared in part to have been precipitated by an impending court case over his ex-wife's attempt to gain unsupervised access to their son.

Theoretical perspective taken and the rationale behind taking this approach

A cognitive-behavioural approach was taken. The focus of the therapeutic work had been in exploring strategies to relieve Mr G.'s depressive symptoms and in managing his feelings of anxiety and frustration at the current situation.

Family and personal history

Mr G. was the oldest of two other siblings and described having had a generally close and supportive relationship with them. Both his parents were alive, although had divorced when he was 16. He had stayed with his mother (now aged 56) and had some contact with his father (now aged 58), although their relationship had 'always' been conflictual. He met his partner in 1984; they had not married but had two children from this relationship; they separated amicably in 1989 and Mr G. had gained custody of the children. He had not experienced any significant or enduring childhood illnesses, but reported being a short-tempered person, and on occasions had been physically aggressive towards partners.

Formulation

Mr G.'s upbringing had been generally supportive, with disruptions and troubles being openly discussed within the family. He had begun to experience various symptoms of depression from the age of fourteen, which had coincided with the start of being bullied at school. However, he felt he had managed these feelings adequately until his relationship with Ms K. began. He felt he was a good, caring father and was devastated on hearing the allegations of Ms K.'s behaviours towards the children.
His relationship with Ms K. had been one which seemed to worsen with time, with increasing instances where both were physically violent towards each other. Mr G. maintained that he still loved Ms K., although felt somewhat trapped and frightened of her. This conflict and ultimate fear of her seemed to be a significant factor in his decision to stay in this difficult relationship for the length of time that he did.

Mr G. had expressed significant feelings of guilt and anger at not having realised what might have been going on between Ms K. and the children and therefore had felt responsible in not having prevented it continuing. These factors may well have contributed to the increase in the number of his symptoms of depression and it was apparent that he felt a significant amount of self-blame, lowered self-esteem and a dent to his sense of being a good parent. It was also clear that his feelings of being able to trust in his own judgements about women and in trusting women per se had altered which has affected his perception about his own future happiness.

**Development of the therapeutic relationship**
Mr G. engaged in the working alliance quickly, possibly feeling relief at being able to discuss his experiences without being judged negatively or as weak, as he had been by others. Initially I had been aware of my own feelings of anger, which was interesting as Mr G. had not expressed anger in early sessions; he had harboured significant feelings of guilt about not deducing the cause of the changes in his children's behaviour. It was through challenge of some of his dysfunctional assumptions and cognitive distortions that feelings of anger became easier for Mr G. to express. It seemed that from that point in our relationship, where he had felt he had a legitimate reason to experience some of the feeling he had done, his levels of self esteem rose and trust in his own judgement and self efficacy increased.

**Outcome of therapy**
The intention from early in the therapy had been a referral for Mr G. and the children to a child and family service which had been deemed more appropriate. By the time the referral came through, Mr G.'s low mood had lifted significantly and he had felt more confident in his ability to cope with the court hearing and in managing his feelings of anxiety and anger.
SECTION 4

DISCUSSION OF PROCESS ISSUES DRAWN FROM CLINICAL WORK OVER YEARS 1-3
The main themes identified in this discussion of process issues were derived from two selected audio-taped, hour long therapy sessions conducted throughout the three years of the course. These reports consist of the transcription (which was verbatim) with personal commentary, evaluation and analysis of therapeutic processes.

There have been various views and models offered on aspects of student's experiences of going through their trainings in areas of applied psychology and / or psychotherapy. I will draw on some of these below in conjunction with some of the issues arising from the selected process reports. Extracts of the process analysis (presented in italics) are given to illustrate salient points (due to reasons of confidentiality and anonymity the extracts will refer only to my own dialogue or commentary on it).

**Awareness of client issues**

In the first training placement an issue which was identified as particularly important by my psychoanalytic supervisor was in allowing time and space for underlying client issues to surface. Possibly one of my tendencies in this part of my clinical training was in feeling that 'I should' be doing something. In the early stages my desire to be a good and effective therapist and attempts to take notice of as much as I possibly could was very strong. There were a few instances were I did not feel my attention was always geared towards noticing some of the more subtle client issues which might have been communicated; I was slightly distracted by trying to 'do the right thing'. I began to learn about looking at what was not being said by clients as well as the philosophy of client issues: 'if it looks like a duck, and quacks like a duck, then it probably is a duck'. So there was a constant refining process occurring in the way I viewed clients and the issues that arose. I felt a greater desire to explain my awareness of the need for balance in the earlier stages of the course, possibly as a way to quell my concerns about whether I was actually working with the client's agenda rather than my own.

'I attempted to keep my information-gathering technique subtle and carried out in such a way that it would not be seen as interrogative. I had to consider this balance carefully due to [name of client]'s sensitivity to
perceived or actual criticism of him, although I felt a need to listen for
indications of manipulation possibly because of my reluctance to be seen
as too 'pushy.'

My awareness of issues such as the possible influences of gender, age, ethnicity
and sexuality has grown, although this has been part of a larger appreciation of how
various factors may affect the therapeutic process as a whole.

Self awareness
This is an area which had been a fairly prominent issue throughout the three years,
and something which I have commented on in both the selected reports. My levels
of self awareness were probably one of my strengths; the most noticeable change
was in how I tended to use the awareness and the level of confidence I had in using
it constructively rather than worrying about it. In my first training placement I was
very aware of my perceived short-comings as a therapist:

'I had moved out of [client name]'s frame of reference and made a
misinterpretation [ ]. I was apprehensive about 'getting it wrong' and being
judged.'

In retrospect these kinds of worries were 'normal' and my concerns seemed to be
consistent with Hawkins and Shohet (1989) who proposed a four stage model of the
development of professional competence ranging from novice, apprentice,
consolidation and mastery. At each stage various needs, skills and levels of
confidence have been suggested as representative of student's experiences. As
illustrated above I certainly experienced a number of initial insecurities, which
equate to the 'novice' stage. Moving through the stages to reach the level of mastery
is something I feel I have been able to attain, which in part has been evidenced in
the use of my self awareness in sessions:

'It did not worry me that I was slightly confused because [name of client]
was showing that he did have the capacity to view his concerns from a
different perspective.'
The learning process involved moving forwards and backwards between the stages outlined by Hawkins and Shohet (1989). It also encouraged me to think about issues such as boundaries and appropriate levels of self-disclosure as well as developing greater awareness of my own strengths and limitations.

Awareness of relationship issues
The theme which has run consistently across a number of aspects of the training (not only through the process reports) had been the level of confidence that I had about my abilities. As with my awareness of client issues, in the initial stages of my training, some of my thoughts about what was going on in a therapeutic relationship may well have been slightly clouded by my need to be 'doing it right'. The training included a major focus on relationship issues, and to this end, my tendency to analyse had been something that was evident from the beginning of my clinical practice:

I felt that [my response - "so how would you like to go about that?"] would not only convey a sense of being listened to but also an indication that I was not about to become a 'critical parent' or punitive superego by directing the course of therapy ( - there was room for compromise).

Shifts in my understanding of the therapeutic relationships I have with clients, and the ways in which this knowledge can be applied constructively within the therapy process, occurred throughout the three year period:

It may well have been useful to have used immediacy and given some feedback to [client] about my levels of frustration and seen what he might have made of it. It certainly seemed possible that the three people who apparently understood him may have been the three people who tolerated his pain, anxiety and depression better than others.

My confidence grew in acknowledging some of the less 'positive' aspects of the relationships I had with clients developed, along with finding a balance about how I might give feedback about these feelings to the client. Sometimes it was clearly not
appropriate and something which required a certain amount of internal supervision (Casement 1985, 1990) and external supervision from colleagues and peers:

I felt a little angry at this point, teetering on the brink of wondering what the point was of [client] being in therapy at all, and why it was me who was the one to have to listen to the ins and outs of his car trouble!

Theory-practice links
Thinking about these links was easier than actually having the confidence to put them into practice. My knowledge of psychodynamic theory in my first training placement grew quickly, although the practice link was more tentative, and sometimes interspersed with theory from other approaches:

It is possible that by using language more commonly associated with transactional analysis, I was colluding with R. in his tendency to use jargon [ ]. The terms used were intentional, as the analogy to parts of his current situation was a useful one to work with, and I felt that using the 'Ego states' type language was both relevant and accessible to R. (rather than speaking of, for example, conflicts between Id and Super-ego). Although it may also be understood as a representation in a triangle of insight, where the Other/Parent link may be made (Malan, 1995)

One of the major shifts throughout the three years was my ability to apply the 'model of most appropriate fit' to my client work, with an increased knowledge and confidence about the skills that I have to draw on. Although I was able to make use of the theory from other models, as illustrated in the above quote, applying both theory and practice not surprisingly took a little longer and involved what I perceived as some risk-taking:

Using a strategy based in Gestalt (Korb et. al., 1989) [ ] held some [possible] risks; further externalising of his problems or the substitution of one focus object to another following an obsessive-type pattern that seemed to have been part of his life for many years.
Decisions about what might be the most appropriate approach to use were discussed in supervision. The reasons for using specific approaches began to be based on the 'appropriateness', and my ability to 'deliver', rather than by limitations of my knowledge and experience of applying theory and practice from and across approaches.

**Critical thought**

In drawing on another model of learning which I was able to identify with, Clarkson (1994) outlined a cycle of 'eternal return' between unconscious competence, conscious competence, conscious incompetence and unconscious incompetence. My thoughts about my levels of competence were based on my levels of self-confidence; much of the time I expected myself to be achieving at a higher level than I perceived myself to be, and my evaluations of myself were quite critical.

Although my initial process reports contained high levels of perceived conscious incompetence there was almost certainly a fair amount of what may be seen as unconscious incompetence. My level of conscious incompetence may have peaked during the middle phase of my training; the point where I reached a realisation of the amount that I did not know, and where my clinical inexperience seemed to me to be glaringly obvious. However it was in the same training year (2) that I began to allow myself to the possibility of conscious competence, especially in exercising confidence to apply skills such as challenging and being directive. The second half of year two, and throughout my final year, a process of consolidation occurred. I was able to view my level of input using constructive criticism and comment, rather than erring on the side of self-criticism:

> Although this was a blatant interruption I do think it was quite relevant. [client] had entered into talking about an area which clearly held significance; he had become more animated and less stilted.

**Summary**

A tuning process has taken place over the three years, and changed along with my growing sense of self-confidence. This involved not only learning about new aspects
of working therapeutically, but in realising my limitations and areas which need looking at. Gaining experience in issues such as setting clear boundaries, working with sensitive issues, maintaining client confidentiality in difficult circumstances and working with people who have more enduring mental health problems, has been acquired through greater client work. My ability to take more responsibility developed through increased confidence in all the areas mentioned in this discussion, and it is anticipated that this process will continue and broaden in the future.
References


RESEARCH DOSSIER

The following dossier contains the research submissions carried out in each of the three years. They are presented in specified formats of either a standard essay, research report or in the form of a journal article.
YEAR 1 LITERATURE REVIEW

ASSAULTATIVE TRAUMA AND THE DISSOCIATIVE DISORDERS: A BRIEF OVERVIEW
Abstract

Although there are varying levels of severity of 'trauma' that a person might experience, it has been shown that often there may be a marked and unexpected change in psychological state during or after the event. Sometimes this 'discontinuity' in experience and the damage in basic assumptions about human nature can involve, and result, in some type of dissociative symptomatology. In this brief overview and discussion of some definitions of 'trauma' and 'dissociation' will be presented. In an attempt to illustrate that dissociation may often occur during and / or after traumatic events, examples have been drawn from the research carried out in the areas of assaultative trauma (physical assault, rape and torture). Criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, will be examined in the light of changes made to DSM-III-R. Finally, aspects of therapy in working with victims of traumatic events will be considered, with a focus on countertransference issues.
Introduction

- History

Interest in this area has been found as far back as 1734 with the work of Franz Anton Mesmer, much of which would now be rejected by many, but which gave some insight into a recognition of the occurrence of dissociative-type symptoms. However, it has been noted that Briquet first used the concept of dissociation in 1859 when he made a connection between hysterical symptoms and trauma. The idea that dissociative-type symptoms were often attributed to changes in brain physiology after a traumatic event or events, seems to have been predominant. The concept of 'psychic trauma' was established in a more concrete fashion by Pierre Janet (1859-1947) who conducted more valid and reliable research into dissociative disorders, and introduced a set of principles that laid the foundations for more recent investigations into this area. This included work into the relationship between trauma, dissociative responses, altered states of consciousness, and treatment involving reintegration of dissociated material, as well as hypnotherapy. One of the major differences in the assumptions of Janet and later researchers is that of the psychological state of the person experiencing some kind of dissociative disorder. More recent research has indicated that dissociative symptoms are generally found in 'normal' populations as opposed to people with psychopathology, as maintained by Janet; it may be that the definition used by later researchers has not been quite as specific in its features, especially in relation to amnesia:

'Things happen as if an idea, a partial system of thoughts, emancipated itself, came independent and developed itself on its own account. The result is, on the one hand, that it develops far too much, and on the other hand, that consciousness appears no longer to have control of it.' (Janet, 1926. In Putnam, p415).

There were a number of disruptions to the research including two world wars and the strong influence of Freudian theory, where mechanisms such as repression were often cited instead of dissociation, although there was a recognition of dissociative phenomena:
'We found that the perceptual content of the pathogenic existing experiences and the ideational content of pathogenic structure of thought were forgotten and debarred from being reproduced in memory, and we therefore concluded that the keeping away from consciousness was the main characteristic of hysterical repression ... the patient can not remember the whole what is repressed in him and what he cannot remember is precisely the essential part of it ... he is obliged to REPEAT the repressed material as a contemporary experience, instead of remembering it as something belonging to the past.'

With later work focusing on psychopathologies such as schizophrenia, dissociation was not such a topic of interest and research. The recent resurgence of investigations involving dissociative disorders has been evident, notably in areas such as diagnostic systems (e.g., the Diagnostic and Statistical Manual of Mental Disorders). This has reflected the growing recognition, acceptance of the scope, and variety of the symptoms as well as the occurrence.
DSM-IV and Dissociation

'The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient of chronic.'
(American Psychiatric Association, 1994)

There are several sections included in the classification:-

- **Dissociative Amnesia** (formerly Psychogenic Amnesia)
Characterised by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

- **Dissociative Fugue** (formerly Psychogenic fugue)
Characterised by sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.

- **Dissociative Identity Disorder** (formerly Multiple Personality Disorder)
Characterised by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behaviour accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

- **Depersonalisation Disorder**
Characterised by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

- **Dissociative Disorder Not Otherwise Specified**
Included for the coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder.
There are overlaps of the Dissociative symptoms into the other criteria sets of Acute Stress Disorder (ASD), Post Traumatic Stress Disorder (PTSD) and Somatisation Disorder, although if a diagnosis is made of a dissociative episode within the criteria of, for example, PTSD, then an additional diagnosis of a dissociative disorder would not be made. There is emphasis on the notion of taking a cross-cultural perspective as there are many variations about the prevalence and acceptance of dissociation in different societies.

N.B. For the full criteria see Appendix A.

• Describing The Concept Of Dissociation

Recent research has shown that dissociation is not only confined to those with psychological problems, and seem to occur along a continuum of awareness and severity (Spiegal, 1963; Berstein & Putnam, 1986). It has been represented diagrammatically in Figure 1.

**Figure 1.**

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"FULL"

AWARENESS SUPPRESSION DENIAL REPRESSION DISSOCIATION
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That most of us, in daily life, have mild dissociative periods has found explanation in accounting for our abilities to carry out such actions as driving a car whilst simultaneously having a conversation, and when we daydream. Much of the work which has been carried out has involved the study of hypnotic processes in normal and psychiatric subjects, most commonly using the Dissociative Experiences Scale (DES); a reliable and valid measure of types of dissociative experiences such as depersonalisation, derealisation and amnesia (see Appendix A for fuller descriptions of these terms). It has been shown that in the general population the distribution of DES scores may appear similar to that shown in Appendix B, with a score of 7 out of 100 proposed as a general score for a normal population. It has also been
suggested that there is an certain amount of susceptibility to the development of the dissociative disorders is predicted by a DES score of 30 or above (Bernstein and Putnam, 1989a).

There does not appear to be a clear relationship between gender and susceptibility to dissociative phenomena or dissociativity, although it is often found that in cases of dissociative identity disorder (formerly multiple personality disorder), females can out number males by as much as 9 to 1 (Ross et. al., 1989c). Whether these differences are an indication of gender differences is not clear, and almost certainly involves other considerations such as social and sampling factors, e.g., a greater number of females may be likely to present with mental health concerns compared to males, as the latter might be less likely to consider help-seeking as some kind of weakness, thus possibly skewing findings.

There seems to be confusion in several areas relating to definitions of dissociation; not only regarding the extent of the 'compartmentalisation' of processes that takes place but with the level of influence which the separated processes may have upon each other (if any) at any one time. Although it is apparent that even though there may be no conscious memory of the trauma, behaviours and responses of a person may reflect directly on the trauma. With this in mind, recent research has shown that the apparent influences of the dissociated and unconscious material on behaviour may have an interfering or priming effect. That is, performance on a given task performance may either be enhanced because of the dissociated material interfering in the ongoing task, or the dissociated material may serve to impose on the processing in the ongoing task and result in poorer performance. (Kihlstrom & Hoyt, 1990).

There had been some debate over the possible differences (or not) between dissociation and repression since the definitions have often been vague (Frankel 1990). A proposed distinction has been that dissociation is more of a 'severing of connections between various ideas and emotions' (Singer & Sincoff, 1990), rather than a process where material is pushed or pulled into an inaccessible depth of unconsciousness. This then gives greater specificity to the use and meaning of the word, and possibly more scope for understanding the influence of the different
mechanisms on mental processes. A two-principled distinction concerning the 'pathology or not' of dissociation has been proposed by Nemiah (1981); this involves a clear change in identity (e.g., possibly Dissociative Identity Disorder), and disruption to memory of occurrences in the dissociative state (often amnesia). This latter disturbance may not involve total memory loss, but a distortion of the reality (as in depersonalisation) and more of an 'as if' experience.

Thus, it may be argued that dissociation acts as some kind of protection mechanism, which one might assume occurs in proportion with the trauma. This protective function of dissociation has been likened to that employed by other species; it has been hypothesised that something similar to the 'sham-death', which animals have been known to use in response to the presence of predators, may occur. In these terms a dissociative episode would be seen as an adaptive measure serving a number of functions: a) the automatisation of behaviours, b) the resolution of irreconcilable conflicts, c) the isolation of catastrophic experiences, d) the cathartic discharge of feelings and e) escape from the restraints of reality (Ludwig, 1983). It seems that this initially adaptive and natural response may develop into something that is maladaptive and possibly chronic. Interference may occur in many aspects of a persons life, because of the many different 'requirements' and pressures of society to behave in an appropriate manner (this will be elaborated on later in the paper)

Describing Trauma

'Trauma constitutes an abrupt physical disruption in ordinary daily experience, often with loss of control over the body'
(In Classon et. al., 1993. P.197)

The DSM-IV definition of a traumatic event has been amended since DSM-III-R from a definition which was quite restrictive:

'an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone...'
(American Psychiatric Association, 1987)
To the DSM-IV definition which endeavours to account for inconsistencies in the previous definition. It states that a person experiences a traumatic event when:

(1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganised or agitated behaviour

(American Psychiatric Association, 1994)

From this one could infer that the sense of control over oneself is an important factor, and the defences of denial and dissociation are central to the maintenance of this feeling. And even though they do not actually change the traumatic event, it is the perception of the event that is altered in such a manner that the victim can cope with it in a way that makes sense for them at the time.

From the literature reviewed it may be seen that feelings of helplessness and lack of control during and after the trauma appear to be common. This seems to be related to a number of factors, in particular the discontinuities in psychological and physical experience. There may be a feeling that one has been treated as an object and not as a whole person, leading to intense fear about the environment and what may be included in it (Classen, et al., 1993). Spiegel et al., (1993) noted that the sense of Self may be so undermined and unable to make sense of what is or has occurred, that the only way the body and mind can cope with the experience is to use distortion of reality or total 'blocks' from the consciousness. This implies that the dissociative reaction to trauma allows the person to 'place' the fragmented and damaged parts of the Self, i.e., memories and perceptions, into hypothetical compartments. The function suggested by researchers in this area (e.g., Putnam, 1989), is a separation of the Self and the impact of the experience and trauma; this may be apparent during a traumatic experience or may serve to delay working through the painful event.
There is much variation in the type of trauma a person might experience; this includes any warning of symptoms likely to occur, duration of the event and whether or not there has been a history of prolonged and repeated trauma such as childhood sexual abuse. The severity of the trauma may well depend on the individual perception of the event, i.e., not everyone will be psychologically affected by the event to the same extent. It seems that the meaning attributed to the event has a significant role on the impact of the trauma (Herman, 1992). The types of influences which have been suggested to affect the extent of 'damage' include the level of integration that is achieved between the Self and the world, and the perceived level of threat to the Self. In very basic terms the literature indicates that the less integration there is, the more psychological damage is likely to occur.

A hierarchy of events which are considered as traumatic has been suggested and includes events which would be perceived as a threat to one's life, and those which are not e.g., divorce. Often this has been considered a problematic and restrictive distinction which does not allow for the complexities of situations, e.g., Solomon & Canino (1990). Other definitions have imposed limitations on the scope of a 'traumatic event', although are still wide enough to encompass an accessible set of events. Norris (1990) provided an example of this in her definition: 'violent encounters with nature, technology, or humankind.' Whilst also stating that characteristically a traumatic event includes 'sudden or extreme force and involves an external agent.'

Terr (1991) constructed a typology of trauma based on work with childhood trauma which considers the duration and number of times the trauma occurred. Two types of trauma are outlined:

Type I traumas are described as 'single-blow events, isolated traumatic experiences that are sudden, unexpected and devastating.' These would include experiences such as rape and car accidents, where suddenly life may be threatened. Attention is sharply focused and there is a requirement to draw on all the resources of the body in order to find a coping mechanism. Although there might have been an elaborate processing of the experiences, complete integration into consciousness may not have occurred, distorting the internal representations of the event. Thus, as
mentioned above, a distancing of the Self from the experience can take place in the form of a dissociative disorder:

'A young woman, accidentally pushed off a balcony, fell 60 feet and suffered a broken pelvis. She recalled "standing on another balcony watching a pink cloud float down to the ground. I felt no pain and tried to get up and walk back upstairs."'  
(In Classon et. al. 1993, p.180)

Type II traumas, as described in Terr's model, include 'variable, multiple or long-standing traumas, including ongoing physical and sexual abuse and combat.' The initial trauma would be experienced as a Type I, although the process of the integration would be such that the person would fear a reoccurrence of the traumatic event and a renewed sense of helplessness that control over future occurrence would not be possible. Often the trauma is so immense that some kind of change in the Self-view occurs; one that is prolonged and resistant to change. Feelings of shame, guilt and worthlessness are common, thus denying feelings of helplessness to consciousness, and providing a defence against the reality of the trauma.

• **Dissociative Experiences And Other Responses In Relation To Assaultative Or Physical Trauma**

The psychological impact of an experience, created by nature or humans, that undermines many of our everyday assumptions about ourselves and our environment can be enormous. Janoff-Bulman (1992) suggested that there might be a tendency for humans to have a schema of our immunity to traumatic events and an illusion that 'it always happens to someone else'. If this is suddenly shattered one of the most common outcomes seems to be that the sense of control over ones life is destroyed. Or as Erikson (1968) described it, there may be a 'distinct loss of ego identity. The sense of sameness and continuity and the belief in one's social role were gone.' Thus some part of the self may be so damaged that it [the Self] will never be the same again, other aspects may be displaced or separated in some way so they are not immediately available to consciousness and are not processed or accessed in a continuous and integrated manner.
In this section I shall very briefly outline some of the research which has been conducted on some forms of human-induced trauma (physical assault, rape and torture), and the possible occurrences of dissociative phenomena in relation to such events.

Some researchers have hypothesised some commonalities among the psychological responses that may occur after a traumatic event, e.g., McCann et. al., (1988). Specific categories in which various responses may be identified are presented in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Psychological Response Patterns Among Victims</th>
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<tr>
<td><strong>Emotional</strong></td>
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<tr>
<td>- fear, anxiety &amp; intrusion</td>
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<tr>
<td>- depression</td>
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<td>- self-esteem disturbances</td>
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<td>- anger</td>
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<td>- guilt &amp; shame</td>
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<td><strong>Cognitive</strong></td>
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<td>- perceptual disturbances</td>
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<td><strong>Biological</strong></td>
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<td>- physiological hyperarousal</td>
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<td>- somatic disturbances</td>
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Physical Assault and Rape

Focus in the following section includes an examination of the psychological impact (specifically dissociative disorders) that can occur during and after a traumatic event or events. In the examples relating to physical assault, reference may be to males or females, references to rape are limited to male-female rape.

Different people may have different responses to sudden physical violence; there may be some kind of dissociation, although there may also be reactions such as anger and retaliation by the person who has been assaulted. However an immediate response might be that of shock and disbelief, accompanied by 'a temporary paralysis of action and a denial of sensory impressions':

"When I listened to my own screaming, it was freaky..."

"I was just being beaten and then my mind just... I just felt it really wasn't happening. I continued to scream, but at some point, I guess, it just became so horrible that I felt it was just a bad dream and that at some point someone had come to the door and he [the assailant] took off."

(Nana. In Neiderbach, 1986. P. 104)

The above quotes are examples of depersonalisation. Davidson & Foa (1993) suggest that, on an (arbitrary) scale of the importance of a traumatic event, representing a necessary component of a subsequent disorder, depersonalisation rates 3 out of 5. It has been found that depersonalisation seems to be especially common in rape victims and may act as a protection mechanism for an overwhelmed ego during the assault. Victims have reported this phenomenon as involving a detachment from their body, and a floating sensation, observing themselves being raped. It may be noted that some researchers have identified a transient form of depersonalisation (e.g., Noyes et. al., 1977) which might occur in response to a life-threatening situation, although 'vanishes just as quickly when the threat to life is past.' (ibid.: 415). In line with this, some of the proposals for the new DSM-IV included consideration of a new set of criteria to be introduced, for a 'Transient Dissociative Disturbance' or 'Brief Reactive Dissociative Disorder' This
proposal does not seem to have been implemented in the criterion for dissociative disorders, although a new category in anxiety disorders has been introduced, Acute Stress Disorder (ASD), which includes dissociative symptoms as part of the criteria (see Appendix C).

There may be a compartmentalisation of the experience, which helps the victim believe that, for that time anyway, the traumatic event may not have actually occurred. An example of this is given in Spiegal et. al., (1993) where a rape victim reported that "No one was raped." She had created a dissociated personality called 'no one' during the attack, and so it was this latter state that was salient during recall of the rape experience. She had felt like 'a nobody', resulting in the development of an 'unreal' psychological structure which represented her physical feelings during the rape. Other reactions in this type of assault may involve memory disturbance and amnesia of the event:

Aspects of her memory of the traumatic experience were fragmented, particularly those parts that occurred while she dissociated. Although many of the memories were within conscious awareness, she was unable to verbalise the imagery portion of memory because it was so overwhelming emotionally.

(Rape victim: Case study. In McCann & Pearlman, 1990. P311)

There have been a number of proposals which have aimed to systematically outline common reactions to victimisation occurring immediately after the event (which implies there is a determined response pattern). For example Bard & Sangrey (1986) described this phase as the 'impact-disorganisation' stage that included some of the following symptoms: numbness, disorientation, denial, disbelief and helplessness. Other symptoms have been included in this stage, such as temporary paralysis (Symonds, 1976). Symonds also identified a second stage in which the victim might exhibit 'frozen fright' and 'feels a pseudo-calm detachment from others and shows regressive behaviours' (which might also be classified as ASD). This phenomena has been noted by other researchers, and has been linked to an adaptive mechanism which assists in a greater chance, at the time, of integrating appraisals of the event. It may be afterwards that the victim questions
their behaviour, often resulting in feelings of guilt and self-blame (Neiderbach, 1986).

Fischer & Wertz (1979) state:

'Being criminally victimised is a disruption of a daily routine. It is a disruption that compels one, despite personal resistance, to face one's fellow predator and oneself as prey, even though all the while anticipating the consequences, planning, acting and looking to others for assistance. These efforts to little avail, one experiences vulnerability, separateness, and helplessness in the face of the callous, insensitive often anonymous enemy. Shock and disbelief give way to puzzlement, strangeness and then to a sense of the as crime as perverse, unfair, undeserved...'

It could be argued that a paradox might be presented in human-induced crimes: that on one level the assault is impersonal, in the sense that it may have been perpetrated by a stranger, but the actual attack is often perceived, understandably, as personal (at the time, at least). However, as mentioned earlier, Janoff-Bulman (1992) suggested it is the damage to the assumptive world of the individual that is significant. If this was the case, therapeutic input would need not only to acknowledge the paradox but facilitate a process of reconciling it.

In an effort to identify specific reactions to specific events the term 'rape trauma,' a clinical term, has been outlined; the symptoms include a 'clustering of sensory, perceptual, cognitive, behavioural, and interpersonal symptoms exhibited in varying degrees by a victim following non-consenting sexual activity' (Hartman & Burgess, 1993). It has been noted that in a number of victims there may have been an acute pattern of symptoms (in what has been termed as rape trauma syndrome), which varied in severity from mild to severe (Burgess & Holstrom, 1974), and were a reaction to the forced external event. There appears to be two types of emotional coping style immediately after the event: i) an expressed style involving obvious reactions, e.g. nervousness, crying, and distress when questioned about the event and ii) controlled style where the victim seems to be calm, have little or no affect and is not obviously distressed by questioning about the assault. It may be that this
latter type of style has some relationship with dissociative symptoms, such as derealisation, as impaired processing of the reality of the event might be apparent either during or in the course of the event. Rose (1986) identified dissociation, depersonalisation, reinactment and regression as the major defences that seem to be apparent, which is also consistent with other findings (e.g., van de Kolk, 1987). More recent research (e.g., Weaver & Clum, 1995) has highlighted the idea that the universality of psychological symptoms after interpersonal violence is not a realistic proposal; there are often a number of response patterns which are based in stress-related factors that need to be considered.

**Torture**

With changing definitions, torture has been a part of human life for centuries and has been defined as follows:

'deliberate, systematic or wanton infliction of mental or physical suffering by one or more persons acting alone or on the orders of any authority to force another person to yield information, to make a confession or for any other purpose.'


Or as in the main elements of the United Nations (1984) convention:

It is an act by which severe pain or suffering (physical or psychological) in intentionally inflicted on a person for such purposes as: (a) obtaining information; (b) obtaining a confession; (c) punishment; (d) intimidation or coercion; (e) any reason based on discrimination.

(In Turner & Gorst-Unsworth, p475).

Thus, because the usual methods of criminal inquiry and discipline do not have to apply, and it is a purposeful act by a state against an individual, using unorthodox methods (of which torture may only be one), the term 'organised state violence', has been introduced.
For the victim, the experience of torture often carries with it not only psychological, but social and physiological consequences. If one considers that the aim of torture is to gain an explicit psychological change in a person, then it is probably realistic to assume that the methods employed to achieve this will be, in some form, very powerful and destructive. The reactions which have been seen in victims vary greatly, and seem to depend on a number of characteristics of the whole situation, e.g., individual differences and aims of the perpetrator. However, documented responses have included emotional numbing, memory disturbances, depression, helplessness and anxiety, giving an indication of the variety and extent of damage.

In the vein of this review, I shall be considering reactions that include dissociative symptoms, such as altered states of consciousness as a result of hyperventilation during torture, that may have initially served an adaptive purpose but have persisted beyond the event, becoming maladaptive.

Attempts have been made to outline a 'torture syndrome' (e.g., Allodi & Cowgill, 1982; Basoglu & Marks, 1988) although there are mixed responses. Turner & Gorst-Unsworth (1993) believe that the descriptive value and symptom range may be gauged from models, but whilst this may be useful, it does not provide a theoretical base. Goldfeld et. al., (1988) proposed a model which organised the common symptoms into smaller distinct groupings; cognitive, psychological and neuro-vegetative, although this also suffered from similar restrictions as other models.

As has often been found in / during physical trauma (i.e., not exclusive to torture), a notable response is that of psychological detachment or depersonalisation from the external environment or aversive stimuli. This may vary in severity, and can include being in a state of shock, physical numbing from physical attack, and other distortions such as in temporal judgements (Hillman, 1981). Indeed as reported in Hillman's study:

One hostage was kicked on the head, back, ribs and testicles. Eventually he "saw" all these things happening to him, but he did not feel anything. Or he felt it but it did not hurt. Another hostage said "I could see my body moving and I knew that I had been kicked ... but I didn't feel anything. (Ibid.:p1195).
The account does not appear to be an isolated incident, especially among hostages who have undergone traumatic physical assault. Seigal (1984) found 25.8% of the hostages in his sample reported feelings of depersonalisation and, in some, out-of-body experiences were also described (12.9%). Other ways in which the pain of torture might be endured included hyperventilation and head-banging (Turner & Gorst-Unsworth), which can induce the adaptive response of light-headedness and decreased pain thresholds. There may be memory impairment (i.e., amnesia) for some or, all of the event, which often will have been extremely painful (psychologically as well as physiologically). One method employed at the time as a protection mechanism, is to dissociate the memory. This not only assists in the immediate situation, but also as way of avoiding having to re-experience the trauma and affect if, for some reason other than in therapy, memories could be triggered.

There are many other responses to the traumata outlined in this section; some dissociative symptoms are often seen as at, or near, the end of a continuum as described earlier, and are thought of as basically pathological if they persist in a chronic manner. Other aspects, also mentioned previously, suggest that there are some symptoms that do occur, possibly at a universal level, and frequently in 'everyday' life, e.g., detachment feelings which are not considered pathological and do not necessarily 'require' a traumatic event to trigger them. There is not scope in the present discussion to explore these 'non-pathological' occurrences, although it would seem very probable that there would be a number of influences on what may or may not be considered within a range of 'normal', e.g., cultural and social factors. Much of the research that has been carried out has focused in PTSD, and indeed there are some overlaps with Dissociative Disorders, especially since the introduction of ASD which also provides linkage between the disorders.

Classification and Nosology

The introduction of DSM-IV has seen a number of changes, including the classification of the Dissociative Disorders where there has been a recognition of a relationship between trauma and dissociative symptoms. A brief review of some of the changes that have been made from DSM-III-R will be presented.
There have been changes in the definition of a 'traumatic event' as outlined previously; these have taken account of the previous definitions that seemed to have made assumptions about the occurrences of traumatic events. Recent research has suggested otherwise, proposing that prevalence rates of 'traumatic events' are more common than implied by the classification criteria, e.g., rates of as high as 89% of people in some community samples have reported experiencing at least one highly stressful event, such as physical assault, rape and natural disaster (Kilpatrick et. al., 1992). Thus the amount of times a 'traumatic' event occurs is not so much of a defining characteristic, rather, that there is a recognition that such events do occur, and it is the meaning a person attaches to the events that is an important feature. This also links to the acceptance that there are some contexts where events seem to occur frequently, and so may not be unusual (and by implication of the DSM-III-R criteria, not necessarily traumatic), but are traumatic for those involved whether directly or indirectly. The refinement of the response criteria is also made clearer in DSM-IV, with the recognition that the level of fear experienced is an important characteristic of traumata in general (and as a guidance tool, has practical use for predictions in symptom course and possible overlaps into other disorders).

There is a wealth of research in the area of Post Traumatic Stress Disorder (PTSD), and in this short review there has not been scope enough to do credit to the amount of research in Dissociative Disorders. However, there does not appear to have been nearly as much investigation conducted on the relationship between the Dissociative Disorders and PTSD (Davidson & Foa, 1993).

- Dissociative Amnesia (formerly Psychogenic Amnesia)

There needs to be some consideration in regard to dissociation and amnesia: memory processes may be affected in a number of ways, such as how much, and from when there may have been memory loss, as well as the type of memories that have been lost. The main criteria in dissociation involves disruption in memory for 'important personal information' (a term use in the current DSM-IV that may have present number of problems in itself). It has also been found that selective amnesia may not be as uncommon with respect to dissociation as implied in DSM-III-R.
Coons & Milstein, 1988), and that often, material lost is of an affective nature rather than a temporal nature (Kopelman, 1987).

There is now a recognition that memory disturbances do not necessarily require a sudden traumatic event to trigger them, i.e., it may be seen that sudden amnesia is fairly common after a traumatic event, however it has been decided that previous criteria were too limited in the requirements. This would apply especially to victims of long term repeated abuse or other traumatic events, where there are a number of 'memory gaps' which may only have become apparent in adulthood, or where any gap was not noticed. Possibly as a result of the research that has been carried out, there is the inclusion of a 'traumatic or stressful event' having occurred and playing an important role in the disorder. Although, even in the current DSM-IV, the wording of the criteria (A) does not immediately appear to be clear in its definition of the 'important personal information' and the traumatic event.

- **Dissociative Fugue (formerly Psychogenic Fugue)**

There has been a recognition of fugue states for years, especially in relation to the 'escape value' of the disorder in events such as war. The new criterion has acknowledged recent findings which suggest that frequently, there is a confusion of identity rather than the assumption of a new identity. This has allowed a more inclusive definition for this disorder.

- **Dissociative Identity Disorder (formerly Multiple Personality Disorder)**

There is much support for the association between severe traumata (especially in early life) and the later development of Dissociative Identity Disorder or DID (Putnam, 1986). The main changes in the DSM-IV criterion consider the research by Hilgard (1986) on the extent to which an alter personality can influence the conscious behaviour of a person. Thus there has been the omission of the criterion that a full alter personality emerges, so recognition has occurred that there may still be an influence of another personality, regardless of whether the person has a conscious knowledge of this potential influence. There is also the addition of criterion which was omitted in DSM-III-R; the acknowledgement, based on extensive
research (e.g., Ross et al, 1989), that in many cases of DID there appears to be a significant amount of amnesia. It is argued that this being the case there is greater accuracy in making a diagnosis, and not mistaking other conditions, such as different ego states, that are not generally accompanied by amnesia, for DID.

- **Depersonalisation Disorder (no name change)**

This has been defined as 'an alteration in the perception or experience of the Self, so that one feels detached from, and as if one is an outside observer of one's mental processes or body (e.g., feeling like one is in a dream).' (American Psychiatric Association, 1994. P766). However it seems that the term has often been used in a general sense, in that it has many variations according to the severity of the detachment. Kubin et. al., (1989), in their review of the literature, identified a number of common features to the definitions: (a) an altered state of relatedness to emotions, thoughts, or body senses; (b) a precipitating event (e.g., marijuana use); (c) a sense of unreality or a dreamlike state; and (d) sensory alterations (e.g., colours are less vibrant). However it seems that the existence of this type of symptomatology occurs in a number of other psychiatric disorders, and in approximately 50% of non clinical populations under certain circumstances (Noyes et al, 1977), giving rise to potential errors in diagnosis. There has been some attempt to remedy some of these problems in the recent changes to DSM-III-R: evidence is required of some dysfunction in the person's behaviour as opposed to a brief non-pathological episode. An indication that the depersonalisation is not a symptom of another disorder (DID in particular) is also required.

- **Dissociative Disorder Not Otherwise Specified (see Table 2)**

There have been a number of changes in this category, incorporating some of the changes to other criteria. In relation to the symptoms outlined in example 1. phrase changes have occurred that integrate the new criterion for DID. There is the addition of the words 'in adults', possibly due to the amount of research into fantasy proneness and the chance of subsequently developing a dissociative disorder (e.g., Rauschenberger & Lynn, 1995). In example 3. the only change has been the omission of the coercive practices by 'terrorists and cultists'. It may have been
considered that using such terms was too specific, and that greater scope and variety would be more preferable. There may also have been other reasons, such as slightly undesirable political connotations associated to those particular terms. There is a significant addition concerning the cultural aspects of dissociative disorders, and a number of examples of the kinds of terms used by other cultures relating to dissociative-type symptomatology. This reflects the emphasis in DSM-IV on the multicultural considerations to be taken by therapists when working with any client. It also gives an opportunity to explore the specific reference group of a client and to learn more about the context in which the therapy is taking place (i.e., both culture and ethnic). This may also include gaining an understanding of the different ways in which client's express a symptom or need for help. It also has implications to the types of meanings that may be attributed to an event, the social supports that might be available to the person, and the effect of cultural aspects on the therapeutic relationship.

The inclusion of the example referring to 'loss of consciousness, stupor, or coma not attributable to a general medical condition' is new and was not in DSM-III-R. This may be a result of recent research, in attempts at linking dissociative symptoms and other medical conditions, such as temporal lobe epilepsy (e.g., Sivec & Lynn, 1995).

With respect to Ganser syndrome there has been integration of the revised criteria for dissociative amnesia and dissociative fugue. There has been deletion of the phrase 'commonly associated with symptoms such as [amnesia] disorientation, perceptual disturbances, [fugue] and conversion symptoms', thus there appears to be greater specificity in the example.
### Table 2. Dissociative Disorder Not Otherwise Specified

Disorders in which the predominant feature is a dissociative symptom (i.e., a disturbance or alteration in which the normally integrated functions of identity, memory, or consciousness) that does not meet the criteria for a specific Dissociative Disorder. Examples include:

1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which (a) there are not two or more distinct personality states, or (b) amnesia for important personal information does not occur.

2. Derealisation unaccompanied by depersonalisation in adults.

3. States of dissociation that occur in individuals who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).

4. Dissociative trance disorder; single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviours or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity or other person, and associated with stereotyped "involuntary" movements or amnesia. Example include **amok** (Indonesia), **bebainan** (Indonesia), **latah** (Malaysia), **piboktoq** (Arctic), **ataque de nervios** (Latin American), and possession (India). The dissociative or trance disorder is not a normal part of a broadly accepted cultural or religious practice.

5. Loss of consciousness, stupor, or coma not attributable to a general medical condition.

6. Ganser syndrome: the giving of approximate answers to question (e.g., "2 plus 2 equals 5") when not associated with Dissociative Amnesia or Dissociative Fugue.
Therapeutic Considerations In The Treatment Of Trauma

'The traumatised individual seeks a safe environment, a therapeutic sanctuary, in which to engage in an interpersonal relationship that facilitates recovery and movement toward integrating the stressful experience within the ego-structure in ways that are no longer distressing or disruptive of adaptive functioning.'


There appear to be a number of trauma-specific considerations seen in trauma therapy; the individual differences in trauma type, the duration since the trauma and the specific symptoms that have been experienced post trauma. Herman (1992) suggests there are also two aspects common to client work that span across different trauma types: The first is an intellectual element which encourages the client to rebuild the meaning he or she had attributed to the trauma and to consider the ramifications of the event. The second element involves consideration of relationships and the potential positive growth aspects (especially related to self and healing some of the damage) that the client might gain from others around him/her. However, unlike some other therapies, the aim is to decrease the amount of responsibility that the client takes for the trauma, and to use insight in achieving this. Spiegel (1993) found that whilst there were a number of positive aspects to therapy such as pain and fear management, there were also disadvantages (for the client), such as working through control issues that once were (or currently still were) protecting the client. Using Bower's (1981) model of 'state-dependent learning' (where a connection between affect and content is hypothesised), the implications in therapy are very important as the person may well re-experience the memories with the same affect as would have been apparent at the time of the traumatic event. The potential impact of the psychological pain would almost certainly be an important part of the therapeutic process, and the repercussions of re-experiencing the trauma make it essential that defences are not increased further.

Horowitz (1986) outlined one of the major goals of therapy as aiming for integration of the fragmented self-schemas that may well have developed during / after the
event. This would allow the conflict between compartmentalised aspects of the experience to be repaired (to a certain extent). However there are many issues that are important for the therapist to consider, especially relating to transference / countertransference issues. It is slightly problematic in an overview such as this to consider all the treatment options, as there are such a range of issues and individual differences in and between the reaction to trauma. For instance, in working with torture victims the client's experience may have been so horrific, and the defence mechanisms developed so strong, that 'penetration' is a formidable task in itself, let alone judging the pacing of such interventions, or considering the dynamics of the therapeutic relationship (Mollica & Caspi-Yavin, 1992).

Classen et al., (1993) described how therapists should be aware of 'trauma transference' When this occurs the client may attribute characteristics of the perpetrator(s) to others (including a therapist) in a generalising manner, if they perceive there to be some external similarity. This may be detrimental in two ways: that the client is unable to begin to form safe relationships with others due to their fears, or that they neglect to notice a similar threat (to the traumatic event) in the future. Although the use of the transference is a often a useful therapeutic tool, a certain amount of caution is advised especially with respect to the strength of the therapeutic alliance. In attempting to work through past events there may be a certain amount of 'testing', distrust and contempt of the therapist. The client's experience of the therapy is important in that it is an opportunity, in a safe, holding environment, where 'lost' trust may require significant time to be rebuilt. Therapy would also be a forum where self worth may be strengthened, and where it is acceptable to experience and show pain. The therapist will need to use empathy and build trust before other work may be done, and the term 'sustained empathic inquiry' used by Wilson & Lindy (1994) has been seen as essential to trauma work.

Slatker (1987) identified 'the factors that cause empathic strain in the therapeutic relationship are potential determinants of affective reactions (ARs) in the therapist.' Trauma specific transference (TST) is a term Wilson & Lindy used to describe the client's unconscious material that might influence the interactions with the therapist, and affect the therapy (similar to trauma transference used above). It has been seen to have the effect of the client placing the therapist in a specific role or roles, thus
influencing the process. How this is perceived and worked with by the therapist may vary, although it may be positive and supportive, or negative and sometimes very extreme (e.g., the therapist becomes the perpetrator in the reality of the client). These responses are important and need to be monitored. Indeed the therapist needs to be aware of the potential for shock reactions to client’s reports, and the effects of their countertransference reactions (CTR’s) not only on their clients, but on their own personal beliefs and attitudes.

Wilson & Lindy (1994) outline two types of CTR’s which may be activated in therapy: Type 1: which entails the therapist withdrawing from the client through mechanisms such as denial or distancing manoeuvres. Type II CTRs are characterised by therapist overidentification with the client, including enmeshment and overidealisation. This can be detrimental to the therapeutic process as the trauma story may be disrupted, although they may also be a useful indicator to the phenomenological world of the client and thus the nature of the transference. These CTRs can affect empathy, such as in ‘empathic withdrawal’ where the therapist’s responses (including personalised reactions) are in line with Type 1 CTRs and the distancing mechanisms may serve to hinder integration processes in the client. In ‘empathic repression’ the therapist’s reaction would also be subjective, as it is based on their own issues, and may result in a misguided focus. In relation to Type II CTRs, ‘empathic enmeshment’ would involve a subjective response that may be seen to be outside the usual therapeutic role, e.g., breaching boundary issues. A therapist may become overwhelmed and unsure of how to work with the clients. This dilemma is based on objective reactions which may be quite natural and not necessarily detrimental to the process. Figure 2 gives a summary of the above.
**Figure 2.** Modes of empathic strain in countertransference reactions (CTRs).

**Reactive style of Therapist**

**Type of reaction**

(UNIVERSAL, OBJECTIVE, INDIGENOUS REACTIONS)

<table>
<thead>
<tr>
<th>Normative</th>
<th>Empathic Withdrawal</th>
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<tr>
<td>Empathic Disequilibrium</td>
<td>Blank Screen Facade</td>
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<tr>
<td>Uncertainty</td>
<td>Intellectualisation</td>
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<tr>
<td>Vulnerability</td>
<td>Misrepresentation of dynamics</td>
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<td>Unmodulated affect</td>
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<tr>
<th>Type II CTR (Over-identification)</th>
<th>Type I CTR (Avoidance)</th>
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<tr>
<td>Empathic Enmeshment</td>
<td>Empathic Repression</td>
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<tr>
<td>Loss of boundaries</td>
<td>Withdrawal</td>
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<tr>
<td>Over-involvement</td>
<td>Denial</td>
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<tr>
<td>Reciprocal Dependency</td>
<td>Distancing</td>
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**Personalised**

(PARTICULAR, SUBJECTIVE, IDIOSYNCRATIC REACTIONS)


The above reference gives an extensive and detailed account of how, through much research and practice, a conceptual model was produced, and in the process highlighting the variety within the field of trauma. The authors emphasise the feedback loops and the dynamic qualities of therapeutic process and the relationship; This overview has only very briefly covered some aspects of the role that countertransference issues may play in that process. As the authors also
conclude 'transference and countertransference are the "lock and key" phenomena; two halves of a complementary process in post-traumatic work.'

Conclusion

From such a short overview there has not been scope to expand on many aspects of these two areas, dissociation and trauma. Although there has been a significant amount of investigation, there are still areas that are ripe for future study, such as dissociation in children; possible links between the dissociative disorders and PTSD (such as depersonalisation in PTSD). From reviewing some of the literature, there does not appear to be much British research on occurrences of dissociative disorders in relation to physical assault or others traumas such as rape. Recently there has been increased interest in the relationship of dissociative symptomatology and cognitive and neurological factors, giving yet more potential for recognition of links between dissociation and other mainstream areas of psychology. The changes in DSM-III-R indicate that there has been greater consideration of the dissociative disorders in this respect, however, there still appears to be debate over whether a 'general' model may desirable and applicable for use in diagnosis and therapy of clients who have experienced 'traumatic events', e.g., the fact that there seems to be different response patterns (and aspects of dissociation) depending on the type of trauma.
REFERENCES


APPENDICES
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
APPENDIX B  DES Scores in the General Population

YEAR 2 EMPIRICAL STUDY / RESEARCH

A PROCESS-BASED STUDY OF THE HIV TESTING EXPERIENCE OF HETEROSEXUAL WOMEN AND THE ROLE OF A COUNSELLING PSYCHOLOGIST
A process-based study of the HIV testing experiences of heterosexual women and the role of a counselling psychologist

ABSTRACT

Much of the research carried out relating to HIV testing has focused on discrete aspects of the testing procedure, been of a quantitative nature and concentrated on outcome studies. This article reports on a qualitative study viewing the testing procedure as a whole dynamic process, consisting of a number of inter-related secondary processes. As part of the exploration of this process, the experiences of seven heterosexual women who tested HIV positive were analysed using thematic content analysis. Findings are reported on the strengths and short-comings identified throughout the process; the role pre-test counselling may have played in helping the women reach an informed decision about testing; and the potential place counselling psychologists might have in post-test counselling and follow-up.
A process-based study of the HIV testing experiences of heterosexual women and the role of a counselling psychologist

INTRODUCTION

Thornton & Flynn (1993) identified four main areas of psychological input in the literature which has received attention in the 'management' of HIV and AIDS-related issues: surveying the extent and levels of distress; investigating aspects of adjustment in people with HIV / AIDS; (a variety of) psychosocial factors relevant to the above; and specific interventions in working with this population.

The HIV testing process is an aspect included within the above areas. In their review of HIV testing research Beardsell & Coyle (1996) noted that the focus has often been on specific aspects of the testing trajectory. These aspects include issues such as decision-making processes in going for a test (Lupton et al, 1995; Wortley at al, 1995); investigating the variety of reactions and coping mechanisms on receiving a positive result (e.g., Chidwick & Borril, 1996; Perry et. al., 1990; Jacobsen et. al., 1990; Green et. al., 1996) and disclosing HIV seropositivity to others (e.g., Hayes et al, 1993), to name a few. An alternative to this approach is to view the procedure as a whole, consisting of micro contributory processes throughout. In using this process approach, links may be made between the identified contributory aspects, giving a more dynamic outline and conceptualisation of various impacting factors throughout the course of the testing. Indeed, Duffy (1994) recognised this kind of continuum, identifying thirteen 'crisis points' ranging from becoming aware of risk behaviour through the testing procedure to decision-making related to terminal care. Her work has implications for health care
professionals in recognising the fluctuating level of stress throughout the process and therefore in helping to prepare a client for the possibilities of this. The latter is important and links with the issue of pre-test and post-test counselling in the HIV testing process (For a more detailed discussion of the term 'HIV counselling' see Bond, 1992).

The World Health Organisation guidelines (1990) state the general aims of pre-test counselling as:

"To provide individuals who are considering being tested with information on the technical aspects of screening and the possible personal, medical, social psychological and legal implications of being diagnosed either HIV positive or negative."

(In Bor et. al., p905).

Several researchers suggest that pre-test counselling should also have an educational role in providing information about risk reduction (e.g., Green, 1989; Bisset & Gray, 1995). However, as Beardsell and Coyle (1996) commented, there does not appear to be agreement about the objectives of the counselling at this stage in the process.

As with pre-test counselling there seems to be great variation in the extent and content of post-test counselling (Beardsell & Coyle, 1996) without a clear consensus of opinion about an agenda. However, Green (1989) outlined twenty important issues to be integrated into the initial post-test counselling session(s) following a
positive test result. In summary, these aspects include: provision of factual and practical information about HIV, and support services; exploration of the effect being positive has on the client's life at psychological, social and behavioural levels; discussion of who and how the client may tell, as well as social support networks in general; helping with obtaining the support and provision the client might need at that time and in the future.

Alongside these debates, questions have arisen relating to which health care professionals would be most suitable in providing HIV counselling and at which stages during the testing process, e.g., Bor et. al., (1991) question whether a professional counsellor is required at the pre-test counselling stage, as the content of the sessions is seen as information-based. In turn, this has implications for the level of continuity within the process, and what preferences clients might have about seeing the same person for pre-test-, post-test counselling and follow-up.

In the main, studies have focused on gay or bisexual male service users with scant consideration of the impact on women going through the whole process. As Beevor & Catalan (1993) reiterated, there are several issues particularly pertinent to women such as reproductive choices (contraception, pregnancy and child-rearing), which have not been addressed in adequate detail. Bond (1992) refers to the account of Pat Tyson (a social worker and HIV Co-ordinator in Gateshead) who noted that isolation seemed to be a major concern for women (in her sample). This appeared to be a result of the low numbers of other HIV positive women in the geographical area in which the study was conducted. Given that there is a need for more services for women (Kennedy et al, 1995), it might be assumed that isolation is a problem in
other areas of Britain. And indeed, the problem has been apparent for several years: in recounting her experiences of being HIV positive Kate Thompson (1994), project manager at Positively Women (a self-help group for HIV positive women), cited the difficulties she faced, and the isolation and anger she felt after discovering her HIV status in 1987. She felt this was exacerbated by the total lack of resources for women. Some have suggested that traditional gender roles have influenced the perception of the relationship between HIV and women and how the issues are viewed by society (Squire, 1993; Patton, 1994). For example, in the context of HIV and AIDS-related issues, women have often been seen as carers, partners of HIV positive heterosexual men, transmitters of the virus perinatally to their children, and generally distanced from being involved. Although recognition of this is increasing, the need for services considering the unique issues raised for women is crucial.

In this article I aim to consider the interplay of three main areas: to highlight some of the strengths and short-comings identified throughout the HIV testing process by a group of heterosexual women; discuss the role of pre-test and post-test counselling in helping the client make informed decisions about the implications of being tested and to prepare them for their result (as far as it is possible to do); and to consider the possible role that counselling psychologists might play in the testing process and follow-up.

**METHOD**

**Design**

The decision to use a qualitative approach was influenced by Beardsell and Coyle's (1996) paper, which made recommendations for more process-based research of
HIV testing services. The idea being to give a broader view of the dynamics and interrelationships of various aspects of the testing process, rather than outcomes related to specific parts of the process.

A substantial qualitative project (at present still drawing its conclusions) aiming to appraise HIV testing services in London and Essex, enlisted service users varying in gender, risk behaviours and sexual identity (see the aforementioned paper for the scope of the issues focused on in the project). This present paper presents findings from a specific group of service users who participated in this larger project, using a qualitative process-based design.

Subjects
Sixty service users participated in the above project and had been tested within the former North East Thames Regional Health Authority (NETRHA) in the past two years. Of these, seven heterosexual women who had tested HIV positive formed the basis of the present paper.

The mean age of the seven respondents was 29.1, ranging from 25-31. Over half were in employment in a variety of jobs such as sandwich maker, escort and clerical assistant. Ethnic backgrounds varied though included black/african, coloured and white, with countries of origin embracing Italy, Africa, Australia and England. The types of risk behaviours reported involved sharing injecting equipment and/or unsafe penetrative intercourse. One respondent was unsure of her risk behaviour.
Procedure

Subjects were recruited by Beardsell and Coyle from services within the NETRHA. There was a diversity of centres ranging from several internationally renowned HIV centres, such as the Middlesex Hospital and the Royal Free Hospital to less well known Genitourinary Medicine clinics (GUM's) and Drug Dependency Units (DDU's). Female respondents were also recruited via a variety of publications in circulation in the area, such as 'Ms London'. All respondents were interviewed and offered twenty pounds payment for their participation in the study.

The interview schedule (Appendix A), was devised by Beardsell & Coyle after consideration of existing literature in the area of HIV testing, and through formal and informal communication between the two researchers and other professionals also involved in HIV-related service provision in NETRHA. The main areas covered in the interview schedule included the following: Testing history, motivations for testing, choice of service, accessing testing, pre-test counselling, giving a blood sample, waiting for the result, same day testing, post-test counselling and behaviour change. Various measures were taken to ensure the interview schedule encompassed important factors relevant to the whole testing process. These involved focus group discussions and consultations relating to testing issues, and also piloting of the interview schedule with small samples of service users.

The face-to-face interviews comprising of mainly open-ended questions, were conducted and transcribed by the two researchers and their team. It should be noted that on some occasions, due to individual respondents circumstances, the interviewer was unable to follow the standard format of the interview schedule.
These circumstances included one respondent who was recalled by the Blood Transfusion Service and informed that she was HIV positive (and therefore had not made a decision to be tested and received no pre-test counselling). Another respondent was given an HIV test as her daughter had tested positive; part of the process discussed at interview contained references to the paediatric testing process. In these cases the researcher who transcribed the interviews integrated and allocated the details into the relevant headings.

Given that all the respondents had been tested sometime in the previous two years before the above-mentioned project was started, an attempt to increase accuracy of recall was integrated into the interview schedule (an issue discussed by Abraham and Hampson (1996)). The method of context reinstatement was used, which suggests that recall of an event is enhanced if the context in which the event takes place is evoked as part of recall. Thus, the interview schedule included questions requiring the respondent to describe specific physical aspects of their surrounding at various point throughout their testing process, e.g., the appearance of the waiting room.

Data Analysis

The analysis of the interview transcripts of the seven HIV positive women focused upon in this paper was undertaken by the author (LH), this involved subjecting them to thematic content analysis. This entailed identifying recurring sets of beliefs or themes in the data, and in noting patterns across responses. Exemplars of the themes were selected from the transcripts, whilst the variety and unique quality of the experiences was retained. It should be noted that the aims of the study were
primarily to illustrate the diversity of testing experiences and not to reproduce experiences that may be generalised to all people involved in the testing procedure. For this reason, and because of the small sample size and diversity of the data, it was decided not to quantify findings. Some researchers, such as Kruegar (1994), suggest that initiation of quantification into qualitative research data should be avoided, and instead, as implemented in the current analysis, adjectival phrases used. This approach avoids the problem of not having measures giving adequate indication of the extent to which a pattern or theme needs to surface before it is considered 'significant enough' for inclusion.

In the process of identifying, categorising and interpreting sets of statements and recurring systems of beliefs, an experienced rater familiar with the field of HIV testing process and in qualitative research methodologies was consulted. Regular supervision and negotiation of these aspects of data analysis were obtained in an attempt to maintain an appropriate and accurate level of analysis.

RESULTS
The following abbreviations apply to text with quotation marks ("):
'I' denotes the Interviewer, 'R' denotes the Respondent. Material in square brackets is clarificatory; empty square brackets indicate where material has been omitted.

- The initial decision-making process
There was wide variation in the decision-making processes determining whether the respondents went for a test. Several respondents claimed factors such as deterioration in their health triggered thoughts about issues related to HIV (thoughts
which had not been previously entertained). For some of the respondents, HIV and AIDS-related concerns were not the main reason or concern behind getting tested, and as such preparing for a positive HIV result was not considered at this point:

I: "So what actually made you go?" [for the test]

R: "Hepatitis C was what made me go [ ]. It was because I wanted to know cos I was sure I'd be negative, but I just wanted to do it and get it out of the way so I knew I was negative, you know"

Some respondents reported that one of the reasons they thought about HIV was as a result of taking notice of external cues around them (such as family communications, media coverage or information they had been sent), and not because of the risk behaviours they may have been involved in:

R: "My mum knowing all about this [past high risk behaviours] and obviously [my ex-partner's] funeral was last year. She's often said, you know [ ] Had you thought of having one."

One consistent aspect coming from a number of respondents was that if they did decide to have a test, it was to confirm that they were negative, and that on some occasions the decision had been made in a somewhat blasé manner:

R: "I was going for just a general check-up and you know, I said 'well why not have an HIV test?', which I should have thought about a little more [ ]. You just don't think it's gonna come back positive"
In some instances part of the expected decision-making 'process' of having an HIV test had been missed out i.e., any thoughts about HIV before deciding to go for a test and the process of making a decision to be tested. For example a health care professional had strongly suggested to one of the respondents that she might have a test (as somebody else in the family had tested positive). However, one respondent, who had not previously thought seriously about HIV and AIDS had no cues until she read some information about blood donations after having lived in certain countries. On making a decision to go for a test she was told she "was being silly", that "it was not necessary" and that:

R: "It was as if, you know I was being paranoid or that it was something that didn't affect me."

On that occasion she tested negative. It was not until she was recalled by the Blood Transfusion Service (six years later), that thoughts about the possibility of HIV were seriously entertained and she stopped to think about the reasons for being recalled.

• Discussion with anyone before having the test (before any pre-test counselling)

Some of the women had discussions with friends or family about HIV. The nature and specificity of these discussions varied, although there was a tendency to explore the topic of HIV and AIDS in a general way, i.e., not specifically about the implications of being positive or the feelings that such a suspicion may have generated. There was also a reluctance to discuss specific details with others because if the result was positive the respondents did not necessarily plan to tell people:
R: "I talked to some friends, yes but I meant in general [. Because we wouldn't tell them when the results came out positive."

(Note this was specifically related to the respondent's daughter being tested and so does not directly indicate the respondent's own experience)

• Feelings when waiting for pre-test discussion/counselling

(The waiting time varied between test centres from almost no delay after asking for a test to several days).

There was a distinct shift in the feelings and behaviours of a number of respondents in this part of their experience, though this was not the case for all as some still believed that test results would be negative:

R: "Well, I suppose I was a bit anxious. I mean, I was anxious but I really honestly didn't think that it would be positive, I really didn't think it would be, you know."

For other respondents there were experiences of feeling anxious, frightened, scared and for some it was difficult and confusing to specifically identify what they were feeling:

R: "I think I felt okay..."
On enquiry about what the waiting room / atmosphere was like (using the method of context reinstatement), this respondent elaborated:

"Um, yeah, it was, um-I don't really know. I think I was in a bit of a - I wasn't - I was in a bit of sort of automatic mode you know."

Another respondent who had an appointment with the Blood Transfusion Service the next day reported:

R: "It's really hard to say [how I felt] because I kind of went into overdrive"

In fact this particular respondent became convinced that she was going to be told she was HIV positive the next day and on realising this she said she felt:

R: "Scared, yeah, but I, like I say, I kind of went into this very organisational mode..."

**Pre-test counselling**

As there was a variety of questions asked by the interviewers about this part of the testing procedure, the results present a summary of some of the responses. There were inconsistencies in the amount and type of questions asked of the respondents by the health professional as well as the information they were given.
• Information given to the respondents

This was 'patchy', with some respondents being told more about aspects relating to HIV and AIDS than others. This included outlining what the test tested for, general information about HIV, and information about reducing future risk. It was particularly noticeable that most respondents reported that they were not given advice about the implications a positive test might have in applying for life insurance, mortgages and travelling or living abroad. There was some knowledge of these issues, though generally this area was not covered by the health professionals at this stage and was certainly not clear in the respondents minds before they had the test.

• Confidentiality

This seemed to be one of the first issues discussed with a number of respondents and most felt that the assurance of confidentiality was adequate. Only one of the respondents did not discuss this but assumed it was (confidential) as people to be tested were given a number, rather than giving their name. It was also apparent that a number of respondents initially used false names, as they were concerned about how all the information held about them might be used:

R: "Although they tell you that, you know, you're protected, it's confidential, but then there's other people say that your name has to be sent to the Home Office and you have to be listed as a drug user and so I never know what happens, so I kept it, kept my name out of it."
In some cases the belief that the test would be negative seemed to have lessened
the concern about confidentiality as the implications of a positive test were not
considered:

R: "I suppose at that stage I just wasn't really thinking of that [confidentiality],
you know, because I just didn't think, you know, this was going to turn out
this way."

- Consistency and choice throughout the testing process

Given that there would be practical limitations in testing centres, e.g., staffing levels,
some respondents felt it would be desirable to see the same person for pre-test
counselling, receiving their result and for the post-test counselling. This has the
advantage of increasing the feeling of confidentiality and possibly leading clients to
feel more at ease and comfortable with discussing sensitive issues. Most of the
respondents did receive their result from the same person who had given the
pre-test counselling and on the whole (when questioned about their preference)
there was endorsement for this continuity (reasons for this were not directly stated
by the respondents and therefore are the author's interpretations of the data). In the
main it seems that having a 'reasonable' experience in the pre-test counselling (and
therefore having no particular reason to want to see someone else) was enough
reason for preferring continuity and familiarity.

On the issue of choice, it was clear that few of the respondents were given a choice
of whether they could see a male or a female for their pre-test counselling. Although
several did not object to this, others felt that particularly when being given their result, seeing a female may have been preferable:

R: "Maybe if it had been a woman cos I didn't know that I was gonna end up feeling embarrassed by him looking at me [after he gave me the result] cos I wanted to cry and in my own way and, you know, I felt I couldn't let go and he was telling me to and I didn't want to"

Interestingly, one respondent felt the experiences of dealing with HIV and AIDS-related issues in HIV positive gay men might play an extremely useful role in post-test counselling:

R: "Maybe it would help if gay HIV positive men did the diagnosis, you know, did the positive - told, you know, helped, did the talk [ ] someone who's actually positive and knows."

• Opportunity to ask questions

Among all respondents, it was felt that there was plenty of scope to ask questions if they wished.

• Exploration of how respondents thought they might react to a positive result and the effect it might have on them.

Most of the pre-test counselling sessions had included some exploration of this area, although at a personal level the information did not appear to have been accommodated.
R: "I really didn't know [how I would react] because I don't think I was really prepared for it. I almost went thinking, you know, I was gonna be OK."

This topic was not discussed in some of the pre-test counselling sessions so there was not even a chance to attempt any kind of preparation for a positive result in some cases. Of the women who had discussed it with the health care professional, the possible reactions included several references to depression and isolation (on an individual and societal level). Some had not considered being positive until the day they were due to receive their results, when the possibility "flashed" across their mind:

R: "I don't think I thought hardly at all that if it happened to me, I mean, I would've thought 'Oh that would be really terrible' and things but I wouldn't have thought in depth about it."

There was some indication that the amount of knowledge the respondent expressed about HIV-related issues may have been an influencing factor in the extent of pre-test discussion, including effects of HIV on people; one respondent thought:

R: "He [the counsellor] might have said more if he hadn't known that I'd seen my friends go through it, so he obviously realised that I was fairly aware of it and so perhaps he said less [about the possible effects of HIV on the respondent] than he would've to somebody else."
Although an interesting observation, generalisations are clearly not possible, though it presents some important implications for the format of pre-test counselling.

- **Discussion of who the respondent might tell if they were positive.**

This was not discussed with all respondents, although a few women had had some thoughts about it before having the test (possibly if the respondent had discussed the topic of HIV with others before going for the test). Some had only thought about this issue when asked as part of the pre-test counselling, and again this appears to reflect the belief that they would be negative.

- **The extent to which the pre-test counselling helped in the decision to proceed with the test.**

On the whole, most respondents (who had the opportunity) had already made their decision to have the test before they had gone for their pre-test counselling. Some were unsure of the influence their counselling, but all felt that the final decision had been left up to them:

R: “Well, I can't say 'no' [that the counselling helped me to make a decision about whether or not to be tested]. It's just up to you, the actual decision.”

Another respondent felt:

R: "It [the counselling] didn't really help in any way. I just wanted to get it out of the way and have the test really."
With this in mind it seems that there may have been some kind of preparation taking place before the respondents had received any pre-test counselling, at least to the extent that they would go ahead with having a blood sample taken.

- The extent to which the pre-test counselling helped prepare the respondent for a positive result.

R: "It [the pre-test counselling] prepared me for all, everything - my result and my reaction at the end."

This opinion was quite unique [in this sample], with several respondents reporting that although they may have discussed the possibility of receiving a positive result, the quality of the preparation for the possibility of this result was inadequate:

I: "Do you feel that you didn't have all the information you needed to actually make a proper decision about whether you wanted to go ahead?"

R: "No definitely [she didn't have the information]"

The theme of believing the result would be negative surfaced again, possibly hindering any preparatory process:

R: "I was so adamant that I was gonna be negative that maybe someone wouldn't have been able to sort of sway me that way to thinking about what it would be like. I mean obviously I had to think about it, but it's still not the
same as it turned out to be so, I don't think it's something you could pre-empt, you know - very difficult."

WAITING FOR THE TEST RESULT

The waiting time between giving a blood sample and receiving their test result ranged from 2/3 hours to about one week. Of those respondents who did not undergo the entire testing process in one day, none contacted the test centres or were contacted during this time. Only one woman explicitly stated that she felt it would have been helpful to have spoken with someone in this time, though did not feel she could approach anyone. None of the respondents seriously considered not going back to receive their results.

In terms of preparation for their test result, there were variations in the amount that respondents thought about this and the extent to which they toyed with the possibility of being positive:

R: "Well obviously I thought about it a lot and was a bit nervous. Still didn't think - never thought the worst - was very optimistic."

Another respondent described ambivalent feelings, sometimes believing she was okay with some times of doubt:
"I suppose there might have been a couple of times when, you know, my subconscious sort of gave in and said 'hang on a minute' [...]. But really I was putting it to the back of my mind but maybe, you know, deliberately."

Others reported that they did not think about their test at all. However, it does seem that there may have been small shifts in the extent to which some respondents thought about the 'what ifs' of their test result. This did not appear to extend as far as preparing in any depth for the possibility of receiving a positive test result and the implications of this.

RECEIVING THEIR RESULT

The focus in this section will be on linking the extent of any preparation carried out in the earlier stages of the process to the role it may have played after a positive result was given.

• Receiving the test result

The most frequent reaction described by all respondents was of shock:

R: "Total shock. Complete and utter shock"

A number of respondents expressed a disbelief at their results:

R: "I was just, I just kept saying 'I can't believe it. I can't believe it. I can't believe it', like this and then I started crying."
However one respondent’s description of her reaction seems to encapsulate a common response (of complete shock) in the majority of respondents who had expected a negative result:

R: [She felt] "Well shock. Shock was the main thing really. I didn't know how to react. It was just like 'Oh' - didn't know what to say. It was just unexpected. As I said before, I wasn't prepared. I didn't prepare myself."

Another respondent who felt that she had prepared herself to a certain extent (though still believing she was negative) recalled how she felt:

R: "Terrible, absolutely terrible, gutted" [ ] "I mean at first I just went 'Oh God, oh fuck, oh shit, oh' - you know, I was really swearing really loud [ ], uncontrollably swearing and then crying and then sort of staring at the wall, thinking, you know, 'Where? How?' and everything"

For the few that felt that their result might be positive, the reactions appeared to be similar to those expecting a negative result:

R: "Shocked. I just felt so depressed. I was shy with him. I was embarrassed with him, to get the results from him."

For the respondent who had been recalled by the Blood Transfusion Service who had already prepared herself for a positive result, hearing confirmation of her fears was still a blow:
R: "Kind of shocked. Almost sort of panic. I could feel my heart racing, even though I kind of knew that that was what I was gonna be told, it still had that sort of panic effect on me."

So, in the majority of responses there was a common theme of not having felt prepared to actually hear the health professional give an HIV positive result, even if there had been some inclination that the result was going to be positive.

POST-TEST COUNSELLING AND FOLLOW-UP

It seems that for most of the respondents the all but unexpected result often severely disrupted their capacity to take in significant aspects of the post-test counselling that was offered:

R: "I just wanted to walk out to be honest with you. I didn't want to think about it, you know. I didn't know how [ ] I didn't know what I wanted."

On all occasions the health care professional did attempt to discuss aspects of how the respondent might begin to start dealing with the result, exploring some of the implications from various angles, including at a psychological level. Particular attention was paid to who the respondent might be able to tell after they had left the test centre, and whether they would have some support.
In all but one instance, the respondents were offered counselling or an opportunity to stay and talk after receiving the result. The responses to this offer varied, with several making definite statements that they did not want to stay:

R: "No I wouldn't have wanted to talk about it - just the sort of person I am. I needed to go away and just be by myself and come to terms with it."

Others felt obliged to talk to someone, making it unclear whether they wished to stay or not:

R: I felt I should [stay], you know, and talk to somebody."

Several respondents described experiences such as "feeling numb" and as if they were "dreaming", i.e., some kind of derealization. It is interesting to note that whilst a number of respondents expressed some confusion about what they may have needed at that time, there were some clear messages relating to what they did not want, e.g., several respondents were hugged by their health care professionals, which was not welcomed. There were other examples of what might be construed as the health professional making assumptions about what the respondent might be needing:

R: "I felt like he was forcing me to see the doctor another day cos he was saying 'I think it'd be better for you - cos you might not take it in today - for you to see the doctor another day' and maybe he was right [ ]. I felt like I had to say 'O.k., I'll see the doctor another day'.
The respondent who received her result from a doctor at the Blood Transfusion service appeared to go through a series of highly unsatisfactory experiences until she was referred (on her request) to a counsellor. It was also apparent that the attitude and assumptions of the doctor did not suggest a helpful or non-judgemental stance:

R: "She asked me if my partner had been black and when I said 'Yes', she said 'Yeah, because they tend to have more sexual partners'"

The quality of the information the respondent received is discussed below, although on seeing a counsellor (at a hospital), the situation changed:

R: "That was like a breath of fresh air. It was unbelievable. It was just so different and so much more positive."

• *Nature and extent of discussions relating to women and HIV*

This ranged from no explicit comments to some exploration of areas such as pregnancy, HIV transmission probabilities (e.g., between mother-child or female-male), and change in sexual behaviours. In the pre-test counselling, only a few of the respondents had discussed the issue of having children, although it seems that most women considering this had already made a decision about the possibility of having a baby at this stage:

R: "They said 'It's all up to you if you do want to' [have a baby], and I said 'No. I wouldn't think of that now.'"
Another respondent who had not discussed the topic in the post-test counselling made her decision some time after receiving her result:

R: "I also decided all of a sudden that I wanted a baby and I wanted it then and there and that, you know, that not only was my biological clock ticking away, but my life one was too."

Other discussions in this area related to very specific issues, such as details about the research carried out on mother-child transmission of HIV:

R: "She told us [ ], if a baby is born HIV positive, then the mum has to be HIV positive too."

The majority of respondents had some discussion of safer sex / safer injecting in the future, though there were differences in the attitudes and knowledge that respondents had about safer sex (in particular):

R: "I would feel perfectly comfortable with having unprotected sex. I feel that the risk factors of [ ] woman to man transmission are so low that I would be quite happy to do that from my point of view."

In others there was confusion over the effect the result might have on their relationships and fear of rejection from current and future partners:
R: "Just the fact that he knew and I felt strange. I can't really describe how I felt but - I don't know. I just didn't want him to know." They [future partners] would leave me [if she told them of her HIV status] and I don't think I could handle that. I've always been careful. I mean, with the boyfriends that I've had after that, I've always used condoms but I couldn't tell them."

• Information given in the post-test counselling and follow-up

All respondents were given leaflets relating to HIV and AIDS at some stage in their post-test counselling. The individual needs of the respondent indicated that the desire for this kind of provision varied according to a number of factors, e.g., the amount of information they already knew, the amount they wanted to know and the quality of the information given:

R: "I would've wanted more information []. I just went out of there in, you know, 'what am I gonna do?', you know, 'I've got the whole weekend with nothing. Nothing's open you know. I got these fucking leaflets', you know."

At a Blood Transfusion service, the leaflets given to one respondent were inappropriate, and out of date:

R: "[One] looked as if it'd been designed in the 1970's and was kind of 'What is AIDS?' on the front of it and was a very basic 'You can't catch AIDS from sharing cups'. [] The other thing I was given was [] an article photocopied from a magazine, written by a gay man in 1987 and she kind of gave this to
me and she said 'Oh this is an article by someone who's open about their HIV status.'"

This highlights an important theme arising from a number of respondents relating to the lack of information relevant to women with HIV:

R: "I also remember thinking that I must be the only woman in the world. I hadn't heard about women and HIV and especially then I'd just been given something by a gay man so I've got this thing that gay men get."

This latter point was noted by several other respondents:

R: "The gay men try and dominate the HIV thing and, you know, 'It's our illness and we're the spokespeople for it'."

Most respondents (though not all) were given information about various support groups or organisations for people with HIV (and by the time they were interviewed had already attended one or more). Most frequently mentioned was the women's group run by Body Positive although there were several others but not ones that seemed to directly address women's issues. As with the information leaflets, a need for more services tailored to women's issues and needs had surfaced:

R: "Heterosexual people have different issues to address, particularly women and there's no other women in the group."
It is interesting to note that on some occasions it did not appear to be the sexual identity or gender imbalance that was a problem, but the nature of the group, especially on where the participants were in their own processes of living and dealing with HIV and AIDS:

R: [The first support group the respondent went to] "Wasn't really a forum for me to talk about how I feel right now about being diagnosed. [ ] But this newly diagnosed group really did work and it didn't matter that I was the only woman and it didn't matter whether the men there were homosexual or heterosexual because we were all going through the same sort of processes."

It was also apparent that some of the factors deterring a few respondents going to, or staying with some support groups were the experiences they had, or imagined they might have about the other people in the group:

R: "There was me and this other guy and this other guy was particularly negative, very depressed - oh paranoid about it and I found myself [ ] giving him support. [ ] I wasn't getting anything out of him. He was draining me."

Others did not ever attend any groups:

R: "I have a [mental] picture of seeing people around pretty depressed and miserable and start, you know, talking about their feeling ill. [ ] I just don't wanna hear that."
• *Follow-up appointments*

The opportunity for follow-up was given to all respondents, though there was wide variation in what was offered in terms of psychological input (as opposed to medical and more social/practical help). It should be noted that many respondents did not generally report having fixed contracts with a counselling psychologist or counsellor. Indeed only one respondent actually mentioned being introduced to a psychologist. Several respondents received regular after-care at services other than the one they had received their result from. The bulk of support appears to have been from a mixture of sources, such as friends, health care professionals (more often than not, either nurses or health advisors, rather than counselling psychologists or counsellors) and from a support group the respondent attended.

As with other parts of the testing process, there were obviously individual differences in the preferences the women had or what they felt they needed, and thus how satisfactory the follow-up was perceived to be. On some occasions the immediate follow-up that was offered was not perceived as adequate and may have seemed somewhat rejecting:

R:  "I felt that I was sent away with an appointment to come back in two weeks but with this devastating news [ ]. She said I could see her for six appointments and then she has to pass me on to somebody else or something."

In this case the respondent was given her result at 5:00 p.m. on a Friday leaving her to deal with her result over the weekend. This kind of experience was apparent for
other respondents, leaving some women feeling isolated and without any professional support:

R: "I spent that Friday, Saturday and Sunday in my room, just in tears and, you know, sort of desperate."

In terms of counselling, sometimes this appeared to be integrated into other support or help the respondent received, rather than being a formal agreement to meet for psychotherapeutic work for a certain period of time:

R: "I talk sort of thing and he listens, you know."

On several occasions this 'informal' therapeutic input was not from the person who had conducted the post-test counselling, though it did seem to take place regularly:

R: "The lady's a specialist nurse but she's also a counsellor. I'm not theoretically having counselling yet but it does end up being - she does end up doing that, helping me."

Some women reported that they received very useful input and offers of future support that addressed their needs at the time:

R: "She [the counsellor] gave me all the services and all the support [a] person could offer which was really nice and it really touched me."
In terms of the whole testing process one respondent felt totally satisfied:

R: "The way the pre-counselling, the after result counselling and support and just the care that they took on me. I thought it was great."

One respondent declined follow-up offers, feeling that she was able to cope in her own way:

R: "No I wouldn't have wanted to discuss it - just the sort of person I am. I needed to go away and just be by myself and come to terms with it."

The theme of continuity was invoked by some respondents, rather than specific references to the extent and adequacy of follow-up:

R: "I just feel safe with them because they've been following me all the time and my daughter."

**DISCUSSION: PRE-TEST COUNSELLING**

There was a variety of experiences and the summary presented below gives an overview of the type of input the respondents found particularly useful (this may refer only to individuals or to several respondents).

- *Attitude of the health professionals towards the women*

At one centre the respondent praised the support she received:
R: "It was a service that was there for me"

And although not all respondents reported such a feeling about the testing procedures in general, none of the respondents felt that any pressure had been put on them to have the test. Another respondent felt that at a specific stage in her experience, the "friendly approach" had helped her feel stronger about what was happening and gave her support. Having the chance to discuss and participate in some of the decision-making aspects of testing seemed to be useful for a few respondents, e.g., one woman asked the doctor if she could be "tested for everything", giving her a sense of control over some aspects of her health.

**Implications for counselling psychology**

The majority of the respondents saw a medical doctor for their pre-test counselling, and only one woman reported seeing a counsellor. The length of sessions ranged from between 10 minutes to one hour, and the content seemed to be mostly informative. Given Bond's (1992) recommendations about the scope of the term 'HIV counselling' the features of the pre-test counselling in the present sample gave weight to Bor's (1991) contention that employing professional therapists at the pre-test stage might not be the most efficient use of their skills. If this was preferable, and there did not seem to be a specific need for a professional, such as a counselling psychologist at this stage, part of the preparation at this time, might lie in informing the client that there is a referral facility available at the post-test stage. However, in basing pre-test counselling at an informative level, this might well limit consideration of some important issues, such as preparation for the possibility and ramifications of receiving a positive test result. Indeed, there was over-all
endorsement by the respondents of the usefulness in discussing aspects of how they might react and cope if they were tested positive. This general viewpoint was muddied slightly by ambivalence in a number of respondents about whether anyone can really be prepared for receiving news of this kind. However, it seems realistic to posit that well conducted preparatory work might enhance effective coping reactions if the result was positive result. It might be argued that exploration of issues using therapeutic techniques, such as looking at future scenarios in dealing with receiving a positive test result, would best be conducted by a professional with specific skills training in that area, such as a counselling psychologist.

**DISCUSSION: POST-TEST COUNSELLING & FOLLOW-UP & IMPLICATIONS FOR COUNSELLING PSYCHOLOGY**

- *The post-test counselling*

Some respondents felt that the post-test counselling was satisfactory and there were no suggestions at interview about what (if any) improvements might be useful. It seems that this feeling was fostered by a number of factors, although the experiences respondents received from the health care professionals appear to have played a significant role. The majority of respondents received their test result from the same person who gave the pre-test counselling, though this was not always the same person who gave the post-test counselling.

If another health care professional was introduced to give post-test counselling (after the test result had been given), the main reason [in this sample] seemed to be related to the assumption that helping the client to deal with the shock of her result
would be somehow 'better' from a female. Indeed, on the several occasions when a male health care professional had given the test result, subsequently he had left and fetched a female to give the post-test counselling. There were no stated reasons for this, although it might give some support to Bond's (1992) finding that one of the issues identified as causing counsellors difficulty in post-test counselling was 'women's issues' and possibly something which some health care professionals may shy away from addressing. In hindsight there was a suggestion from some respondents that they would have preferred to see a female at the post-test counselling stage. The basis of this preference appeared to relate to the relative ease of allowing some expression or release of their feelings on hearing the result with another female health care professional. The importance of an empathic response led one respondent to suggest the possibility of involving an HIV positive gay male in this part of the process.

In general the respondents expressed a preference for continuity in the process, that is, being able to see the same person for pre- and post-test counselling. Obviously this would vary according to the relationship between client and health care professional. However, in consideration of some of the above preferences for seeing a female, a further issue arises in a conflict between offering a service with choices (e.g., gender of health care professional) and working within the constraints of a service, such as lack of funding. As previously noted, this continuity was not apparent in several cases, where informal counselling was sought from other health care professionals. This may suggest that referral options, which include seeing a different person for post-test counselling or follow-up, may be a viable option. Indeed, the shock which most of the respondents reported on receiving a positive
result, and the frequent disturbances in their ability to 'take in' some of the information given immediately after, suggests further attention needs to be given to the timing and content of interventions at this stage. An example of this might entail immediate support, but on-going therapeutic issues to be discussed slightly later, when the information might be more easily accommodated.

• Follow-up & the implications for counselling psychology

Whilst remaining mindful that after receiving their test result a number of respondents did not enter into formal psychotherapeutic contracts with a trained counsellor or counselling psychologist, there still remains the question as to whether or not counselling psychologists might play a role at some stage in the process. In view of the slight confusion as to the preferences of seeing the same person throughout pre- and post-test counselling, there does seem to be a niche.

This attraction of continuity seemed to be satisfactory as long as the respondent's experience of the whole process had run satisfactorily. Of the respondents who felt (in retrospect) that seeing a different person for post-test counselling / follow-up might have been preferable, some mentioned that they felt uncomfortable with the health care professional - they had not had the time to form a sufficiently stable relationship. Given that with one of the main foci of counselling psychology is the importance of the relationship between client and therapist (Watts & Bor, 1995), the opportunity of referral to a professional who may have more time to concentrate on specific issues than others, needs to be considered. In this scenario, a counselling psychologist would be assuming a consultative position, i.e., not necessarily a full time member of the centre's staff, but being available as a referral source for clients
who have received a positive test result. In considering work with this client group, input might include helping the client to explore possible areas of concern and how they might deal with them, e.g., role-play might be used to help the client in disclosing their HIV status to others, such as partners, family and friends. Certainly problems in the area of disclosure to others was mentioned by several respondents, although none reported any offers of specific psychotherapeutic intervention regarding this issue. As well as work with individuals, involvement in educational programs about HIV and AIDS-related issues may be a potential area to address, especially as the women in this sample reported a dearth of up-to-date relevant information specifically relating at women and women's issues. Several researchers (e.g., Bury, 1992; Deren et. al., 1993) have found that attempts to educate women (and men) about the choices women can have, and the changes they can make in areas of their lives, such as their sexual identity and role and in child-rearing decisions, play an important role in behaviour change. Thus the counselling psychologist might also play a part in looking at the wider context in which individuals live, and targeting women who may or may not have HIV or AIDS in behaviour change using cognitive-behavioural based interventions. In following up this kind of intervention, the use of skill-building groups for women might be a consideration, giving an opportunity gain an insight into how changes affect them, and to reinforce behaviour change. An extension of the role of working with clients, and something not within the scope of this article, might also consider the potential of a counselling psychologist in providing support and / or supervision for 'formal carers' working with clients involved in the process, where several important issues have been identified (Bond, 1992; Ussher, 1993).
The strengths of respondent's experiences throughout the process seemed to have their basis in the care given to them as individuals from the health care professionals. Thus the friendly welcome given in the test centres, the assurance of confidentiality, the information given at pre-test counselling and the after-care support were all commented upon in a positive light. However, some inadequacies in the provision available to the women were apparent: notably, in the lack of relevant up-to-date information, the attitude of some of the health care professionals, and poor post-test counselling and follow-up support. This highlights the diversity of individual requirements and the need for further attention to these areas.

It was difficult to know the extent to which the pre-test counselling helped the women in making an informed decision about getting tested, as most had already decided to proceed before any formal counselling. However, it was apparent that a number of women were not informed about important ramifications of being tested or testing positive before proceeding. In terms of preparation for a positive result, one of the main difficulties seemed to be in the adherence several women had to their belief that they would be negative. In retrospect, a number of respondents doubted whether they could ever be prepared for a positive result, even if it had been expected. However, further exploration would be desirable in an attempt to gain a clearer view as to what kind of interventions (at the pre-test counselling stage) might be most useful in terms of informing and preparing clients about going through the HIV testing process. It seems that there needs to be a balance of the informative aspect of pre-test counselling so that the client has a clear
understanding of the relevance, aims and role of counselling at this stage, but also adequate preparation for an unexpected test result. At the post-test counselling stage, there are obviously a variety of related and new issues to be addressed, and it seems that the possible niche that a counselling psychologist might occupy would be as a referral source if needed either in post-test counselling or at follow-up). That is, as Corney (1996) suggests, having input at secondary and tertiary levels in the preventative medicine paradigm, contributing in a variety of ways. These might include specific therapeutic issues such as loss, death and dying or anger (working with individuals and groups), although might also involve a supervisory role for the professional and voluntary carers. It also seems that there may be some kind of role in educating people about behaviour change and helping to run intervention programs which reinforce change, through methods such as skill-building, groups.
REFERENCES


APPENDIX A

code no: HIV POSITIVE

Service:

AGE
RISK

OCCUPATION
IF UNEMPLOYED, WHEN HAD LAST JOB?
WHAT WAS IT

COUNTRY OF BIRTH
ETHNIC GROUP

1. TESTING HISTORY
1. How many times have you been tested for HIV?

2. MOTIVATIONS FOR TESTING
2. Did you decide to have the test yourself or did someone suggest that you have it?

➢ If someone else suggested test: Who? Why?

Had you thought about having a test before it was suggested?

How did you feel about them suggesting you have a test?

➢ If respondent decided: what made you consider having an HIV test then?

3. Had you ever seen any written information about HIV testing?

Did it influence your decision to have a test? How?
APPENDIX A

4. Did you talk to anyone about having the test before you actually went for it?

Did they influence your decision?

CHOICE OF SERVICE

5. Why did you go to [testing centre] rather than somewhere else?

6. How did you hear about [testing centre]?

7. Where else do you think you could have had the test?

Why didn't you decide to go to your GP?

> For drug users who did not test at specialist drug services: Why didn't you go to a drugs service?

8. Attitudes re community sites (shops/home etc)

3. ACCESSING TESTING

9. What did you have to do to arrange the test?

10. From [your first contact with the testing centre], how long did you have to wait for an appointment for a test?

How satisfied were you with the waiting time?

11. How easy/difficult was it to get to [testing centre]?
APPENDIX A

How easy was it to find the clinic/service itself?

12. When you got to [testing service], how were you treated by reception staff?

How long did you have to wait in the waiting room?

How did you feel when you were waiting?

What was it like in the waiting room/atmosphere?

How satisfied were you with the waiting time?

13. Who did you see next?

If not person who pre-test counselled: what see for?

Did you see anyone for pre-test counselling / talk about the test before you had it?

How long did you have to wait to see them?

How satisfied were you with the waiting time?

4. PRE-TEST COUNSELLING

15. From when you first walked into the room, what happened? What did **** say to you?
APPENDIX A

16. Did they ask why you had come for a test/why you thought you were at risk?

Did they say how much at risk they thought you were?

Did this change how much at risk you had thought you were?

17. Did you talk about how your confidentiality would be protected?

How satisfied did you feel with this?

18. Did you talk about what the test tested for? (HIV not AIDS)

Did you know anyway?

If no: would some information have been useful?

Did you talk about the fact that it takes 3 months for the virus to be detected by the test?

Did you know anyway/wait 3 months?

Did the counsellor tell you anything you didn't already know about the test?

19. Did you talk about what a positive test result means?

Did you talk about the difference between HIV & AIDS?

Did you know anyway?
APPENDIX A

> If no: Would it have been useful to discuss it?

Did the counsellor tell you anything you didn't already know about HIV or AIDS? What?

20. Did you talk about how you might react if the test result were positive?

Had you thought about this before?

> If no: Would it have been useful to discuss it?

21. Did you talk about what effect being HIV would have on you?

Had you thought about this before?

> If no: Would it have been useful to discuss it?

22. Did you talk about who you would tell if you were positive?

What about present/past sexual partners / people you share(d) with?

Had you thought about this before?

> If no: Would it have been useful to discuss it?

23. Did you talk about how you would tell these people if you were positive?
APPENDIX A

Had you thought about this before?

➢ If no: Would it have been useful to discuss it?

Did the counsellor offer to help you tell them or tell them for you?

Did they say what they would do? What? How did you feel about this?

24. Did you talk about whether you had been at risk of getting any other sexually transmitted diseases/hepatitis?

Did the counsellor suggest that you should be tested for other sexually transmitted diseases/hepatitis?

25. Did you talk about whether HIV testing or test counselling might affect life insurance and mortgages?

Did it make you think about not going ahead and having a test?

➢ If no: If you thought having a test might make it affect insurance/mortgages - would it have put you off having the test?

26. Did you talk about not being able to visit certain countries if you tested positive?

Did it make you think about not going ahead and having a test?

➢ If no: If they had, would it have put you off having the test?
APPENDIX A

27. During the pre-test counselling/discussion, did you talk about safe sex/injecting in the future?

Did you talk about safe sex/injecting between then & coming back for the result?

28. Did you talk about what was going to happen after the pre-test counselling? What did the counsellor tell you about what would happen when you had the test?

29. Was anything else discussed?

30. Did you understand everything that the counsellor said to you?

31. Did you feel that you had enough opportunity to ask questions?
   - If no why not? What questions would you have liked to have asked?
   - If yes: Did you ask any?

32. Did you feel that [the counsellor] put any pressure on you to be tested or not? Why?

33. Did you feel that you could have changed your mind at this point and not had the test?

Did you have to make up your mind there and then whether or not to have the test or were you given the opportunity to go away and think about it?

34. Did you have to sign a form to say that you gave your consent to be tested?
APPENDIX A

35. How long did this pre-test counselling/discussion take?

36. How satisfied did you feel with the pre-test counselling/discussion that you received?

37. Did the pre-test counselling/discussion help you to make a definite decision about whether or not to have the test?

38. If pre-test counselling/discussion was provided by a doctor: Would you have preferred to have had this counselling/discussion with a counsellor or health adviser rather than a doctor? Why?

If pre-test counselling/discussion was provided by a nurse: Would you have preferred to have had this counselling/discussion with a counsellor or health adviser or a doctor rather than a nurse? Why?

If pre-test counselling/discussion was provided by a health adviser or counsellor: Would you have preferred to have had this counselling/discussion with a doctor or a nurse? Why?

39. sex of SP:

Would you have preferred to see a man/woman?

Were you given the choice?

40. Is there anything else you want to say about the pre-test counselling/discussion?...

41. Were you given any information to take away?

Was it useful? How?

What sort of information would have been useful/more useful?
APPENDIX A

5. **GIVING A BLOOD SAMPLE**

42. From the time you had the pre-test counselling/discussion, how long did you have to wait for your blood test?

How did you feel about the length of time you had to wait?

43. Was the blood taken [at the testing centre] or did you have to go elsewhere?

> If elsewhere - Where? How did you feel about having to go there?

44. Who took your blood?

How did they treat you?

> For injecting drug users: Did they have any problems taking the blood?

Did they (or you) suggest that you did it yourself?

45. How satisfied were you with what happened?

46. In some centres, the person who provides the pre-test discussion/counselling also takes the blood: Would you have preferred that to happen? Why?

47. If respondent was offered STD/hep screening:

   Were you tested for other sexually transmitted diseases/hepatitis? / Evaluative comments

6. **WAITING FOR THE RESULT**

48. How long did you have to wait from the time you gave blood until the time you were given the result?
APPENDIX A

49. How did you feel during this time?

What, if anything, did you do to cope with those feelings?

Who, if anyone, did you talk to?

50. Did you have contact with [the testing centre] during this time?
   ➤ If no, would it have been helpful? Why/why not?
   ➤ If yes, did staff here do anything to help you cope with having to wait for your result?

SAME DAY TESTING

51. If had same day test:
Did you come here specifically because you could get the result in a day?

Looking back, are you glad that you had a same day test? Why?

If did not have same day test:
Did you know that there are places where you can get the result of your HIV test on the same day that you have the test?
   ➤ If yes: Why did you go to [the testing centre]?
   ➤ If no: Would you have preferred a same day service? Why?

52. Did you ever consider not going back for the test result?

7. POST-TEST COUNSELLING
APPENDIX A

53. When you went for your result, what result were you expecting? Why?

54. Who did you see first?

How long did you have to wait to see them?

How did you feel while you were waiting?

What was it like in the waiting room/atmosphere?

55. Who gave you your result?

Was it the same person who gave you pre-test counselling?

➢ If yes - would you have preferred to see someone else? Why?

➢ If not - would you have preferred to see the same person? Why?

Had you seen them before?

➢ If not - how did you feel about getting your result from someone you had never met before?

56. Can you tell me what happened from the minute you walked through the door? How did they tell you the result -what exactly did they say or do?

57. How did you feel when they told you? What thoughts went through your head?

How satisfied were you with the way you were told your result?
APPENDIX A

58. What happened then - did you stay and talk with them or did you have to see anyone else?

Did you want to stay and talk about the result or would you rather have just left?

59. What sorts of things did they say to you?

Did you talk about how you were feeling right then?

60. Did you talk about how your health might be affected by your HIV diagnosis?

Did they discuss how you might be affected psychologically by your HIV diagnosis?

Did you talk about who you would tell?

Did you talk about when/how you should tell them?

Do you think this influenced your decision whether or not to tell your partner(s) afterwards?

Did they offer to help you tell them?
APPENDIX A

Did you talk about telling (past) sexual partner(s)/people that you shared works with about the result?

Did you talk about how you should tell them?

Do you think this influenced your decision whether or not to tell them afterwards? How?

61. Did they say anything about safer sex/safer injecting in the future?

BEHAVIOUR CHANGE
62. After you had the test, did you change your sexual/injecting behaviour in any way?

63. Did they give you condoms/works?

64. Did you understand everything that was said?
   > If no - why not?

65. Did you feel that you had enough opportunity to ask questions?
   > If yes: Did you ask any?

How satisfied were you with the answers?
   > If no why not? What questions would you have liked to have asked?

66. How long did they spend with you in the post-test session?
APPENDIX A

67. How satisfied were you with the post-test session?

68. Did you see anyone else?
   Did you see a doctor/nurse?

Were any tests done?

69. How did you feel afterwards?

What did you do?

Who did you talk to?

70. Did you go back to see the same counsellor again?

What happened in these later sessions?

Would you have preferred to see another counsellor? Why? Were you given the choice?

If no:
Were you given any information anywhere you could get any support or counselling?

Did you see anyone else (here or elsewhere) for counselling, support or advice afterwards?

If no: Would you have liked to see someone? Why?

If yes:
APPENDIX A

Where did you go? Who did you see? What sort of support did they give?

Would you have preferred to see the same counsellor? Why?

> If they saw someone away from the testing centre:
   Would you have preferred to see someone [at the testing centre]?

Did the [testing centre] arrange for you to see them?

How was this done?

Were you happy with the arrangements?

From the time you had post-test counselling - when did you see a doctor about medical care for HIV?

How did you feel about the time you had to wait?

71. Did you receive your medical care at [the testing centre]?

> If no: Where did you have to go?

Would have preferred to have it [at the testing centre]? Why?

Did the [testing centre] arrange for you to go to [where medical treatment provided]?

How was this done?

Were you happy with the arrangement?
APPENDIX A

72. What do you think were the main positive points about the way in which the whole HIV testing process was handled?

In what ways do you think it could have been improved?

73. Do you have any other comments?
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
YEAR 3 EMPIRICAL STUDY / RESEARCH

FROM A HANDSHAKE TO A HUG: CONSIDERATIONS IN THE USE OF TOUCH IN THE THERAPEUTIC PROCESS
From a Handshake to a Hug: Considerations Influencing the Use of Touch in the Therapeutic Process

Abstract
This paper explores issues of touch within the therapeutic process, by drawing on dilemmas and decision-making processes therapists encountered in their clinical work. Data was gathered through in-depth, semi-structured interviews, consisting of mainly open-ended questions, conducted with ten chartered counselling psychologists in the south-east of England. Interpretative Phenomenological Analysis was employed to examine decision-making processes and how sense and meaning was made of the influences affecting these considerations. The interviews were transcribed and analysed for recurrent themes which captured the nature of issues that surfaced. Clarkson's (1996) conceptual framework of the five kinds of therapeutic relationship that may exist in a psychotherapeutic meeting was also considered in the analysis. That is, exploration of whether using touch might be considered or withheld depending on what type of relationship may be existing at any one time in the therapy room. The main themes revealed the importance of negotiating a shared understanding about the meaning of touch for the client in order to minimise the risk of misinterpretation. On a theoretical level, there was some evidence that, in considering the issue of touch, the participants were using some kind of conceptual framework which held various similarities to that outlined in Clarkson's framework.
From a Handshake to a Hug: Considerations influencing the Use of Touch in the Therapeutic Process

• Introduction

The topic of touch in the psychotherapies is traditionally a controversial one. Freud was known to stroke his patients on occasions, or to let them touch him, however he came to believe that touch interfered with the transference in the psychoanalysis. By touching a patient the therapist was gratifying the patient's wishes and not remaining as a blank screen to the projections (Wilson, 1982); physical contact was thus considered a taboo and not a useful therapeutic tool. Sandor Ferenczi has become renowned for his use of physical contact in psychoanalysis. He emphasised the negative consequences of not responding to patient's feelings of emotional distance, especially in people who had suffered physical and sexual abuse. In examining the development of this issue, it may be seen that the touch taboo has somewhat lessened (e.g., Searles, 1965; Forer, 1969). Although this has not necessarily been the case within the whole area of touch.

A significant amount of the recent literature has outlined the 'positive' aspects of this form of communication when used appropriately. E.g., Horton, et. al., (1995); Freeman, (1995); Clarkson, (1996); Kertay and Reviere, (1993). Thus the prevailing view may now question so much whether touch should be used, but how and when it might be used effectively. This shift has been evident in the aforementioned recent literature with even some psychoanalytic practitioners advocating the indirectly supervised use of appropriate physical contact in-session, e.g., Woodmansey, (1988). It may be seen that a number of the studies carried out in
the late 1970's and in the mid 1980's were analogue designs investigating specific
effects of touch, e.g., Hubble et. al., (1981); Bacorn & Dixon, (1984); Stein &
Sanfilippo, (1985). There were a few which specifically investigated the effects of
counsellor / psychotherapist touch on counselling outcome, e.g., Stockwell & Dye,

Much of this research has explored the effects touching a client might have on the
‘therapeutic relationship’. This term appears to cover a multitude of aspects in the
therapy, such as perceived trustworthiness of the therapist (Suiter & Goodyear,
1985); perceived level of expertise (Hubble, Noble & Robinson, 1981) and effect of
touch on level of self-exploration (Pattison, 1973). The emphasis in these studies
did not generally take account of when in the process touch might or might not be
useful. Some studies have addressed more process-type issues, outlining specific
times in the process when touch might be considered (definitions are outlined
below): e.g., in forming the working alliance and trust-building (Freeman, 1995;
Clarkson, 1996; Wilson, 1982); in the person-to-person or real relationship
(Woodmansey, 1988; Clarkson, 1996); in the developmentally needed / reparative
relationship (Winnicott, 1965; Goodman & Teicher, 1988; Clarkson, 1996). Some
have specifically explored client's experiences of appropriate use of touch in therapy
which, in the main, have given positive feedback, and highlighted the usefulness in
strengthening the therapeutic ‘bond’ (Horton et. al., 1995).

As noted above it has been apparent that in recent years focus has shifted towards
research exploring the potential effects touch might have on what has often, rather
generally, been described, as either the therapeutic relationship or working alliance.
This paper attempts to examine this further by using Clarkson's (1996) conceptual framework of five different kinds of therapeutic relationship, of which one or more may exist at any one time in a therapy room. These relationships, described by Clarkson are as follows:

- **The working alliance**: The part of client-psychotherapist relationship that enables the client and therapist to work together even when the patient or client experiences strong desires to the contrary.

- **The transferential / countertransference relationship**: The experience of unconscious wishes and fears transferred to or into the therapeutic partnership.

- **The reparative / developmentally-needed relationship**: Intentional provision by the psychotherapist of a corrective, reparative or replenishing relationship or action where the original experience was deficient, abusive or overprotective.

- **The person-to-person relationship**: The real relationship or core relationship - as opposed to object relationship.

- **The transpersonal relationship**: The timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual dimension of the healing relationship.
(There is not scope enough in this paper to consider this framework at length and the interested reader is directed toward Clarkson's book 'The Therapeutic Relationship' which is solely dedicated to exploration and applications in considering these relationships).

• Definitions of the nature of touch in therapy

The nature of a touch may be incidental or, as in therapies such as Reichian therapy, intentional and routinely used in the therapeutic process (West, 1994). A person may be patted, brushed, squeezed or stroked (Nguyen, Heslin & Nguyen, 1975), and the duration of touch in therapy has varied from 3-5 seconds (Bacorn & Dixon, 1984) to 8-10 seconds (Stockwell & Dye, 1980). The areas of the body touched and deemed appropriate and nonerotic has also varied though has included the following: Touch to the hands, arms, legs, shoulders, lower & upper back, semi-embraces, light contact with the hand or shoulder and full body embraces (Willison & Masson, 1986).

• Other factors influencing the use of touch in therapy

- Cultural factors

Although this important issue has been mentioned in various studies, there seems to be virtually no empirical studies specifically focusing on cultural variations in use of touch in therapy. This paper did not attempt to research this in great detail, although the topic was considered.
- Gender and sexuality issues

There have been a greater number of studies which have included specific manipulation of gender variables, e.g., Abbey & Melby (1986). On the whole, for example, it has been suggested that male therapists are more likely to touch female clients, than female therapists touching male clients; various explanation have been discussed in relation to this, including social and cultural influences. It is also apparent that there has been gender biases in many studies, with female clients represented more frequently than males. Much of the research has focused on heterosexual dyads although some studies have included research on same sex heterosexual pairings (Rabinowitz, 1991). There is a seemingly sparse amount of research carried out into touch that might occur in homosexual dyads and whether, as in heterosexual opposite sex pairings, the perception of risk of a sexual encounter resulting from appropriate touching might be increased.

- Methodologies used in previous research

Methods of investigation have varied: earlier studies tended to use dichotomous variables, i.e., no touch condition versus touch condition (Hubble, Noble & Robinson, 1981) and have been criticised for inadequacies such as the variation in operational definitions of touch and their ecological validity. Some studies have used a case vignette approach (e.g., McDonald, 1993), presenting real instances of touch being used in therapy (either using actors videotaped in manipulated experiments, or a written account of therapy session where touch was used). Both 'therapists' and lay people have been asked (either by questionnaire, interview or both) for their reactions, opinions and their own attitudes to the presentations. These have also met problems of validity and reliability, as well as biases resulting from
methodologies using secondary sources and self-report data. There also appears to be a conflict between designs which aim to explore appropriate touch and its effects, as well as controlling for a variety of other factors, but that can reveal the subtleties of spontaneous use of touch in therapy (e.g., Hoffman & Gazit, 1996).

Several hypotheses are presented in this paper, based on an assumption that counselling psychologists were an ideal sample to draw on because of the emphasis of working with the relationship between themself and their clients (Watts & Bor, 1995). The research questions detailed below therefore considered this assumption and were significantly shaped by it.

- Counselling psychologists have awareness of the importance of the relationship in therapy and possibly of the types of therapeutic relationship that might exist at any one time in the therapy process. They will have views as to the appropriate use of touch in therapeutic work that are influenced by this knowledge.

- This awareness of the importance of relationship, and the type that might exist at any one time in the therapy process might help in (or impede) a counselling psychologist's decision to use appropriate touch in therapeutic work.

- If appropriate touch is used, or considered in the therapy, it will be deemed more therapeutically useful and effective at certain points in the therapy process and therapeutic relationship.
• Method

• Design

The qualitative method of Interpretative Phenomenological Analysis (IPA) was employed, as it was considered to be particularly appropriate for this type of exploratory project (see Flowers et. al., 1997; Smith et. al., 1997; Smith, 1996, for more specific discussion of IPA and it's relationship and distinction to other qualitative approaches. Also see Krippendorff, 1980; Mostyn, 1985 and Bryman, 1988 for detailed discussions on qualitative research designs). IPA aims to allow the participants (counselling psychologists) to convey their own self-reflections, perceptions and experiences about the topic under investigation. In the present study, considerations and or, use of touch in the therapeutic process; the idea being to gain an understanding of meanings, rather than facts and descriptions. However, as the name IPA suggests, there is recognition and allowance for the researcher's inevitable imposition of some of their own interpretation and sense-making on the process of teasing meaning out the material.

IPA was also considered to be particularly relevant approach to explore and reflect the practices within the profession of counselling psychology, due to it's capacity to accommodate both phenomenological and interpretative aspects of the material under discussion. This paper seeks to gather the variety of phenomenological experiences which counselling psychologists have had in their considerations about using touch in the therapy process. It also attempts to extract some of the meanings attached to using touch and how this might influence therapeutic decisions about whether to use touch or not. The theoretical basis which has influenced the research process has been from two major sources: Clarkson's (1996) model of the five
different types of relationship that might individually exist at any one time in a therapeutic encounter. The second is the authors own personal experiences in the domain of touch in therapy, as well as commentary by other mental health professionals. Further discussion of this is included below.

• Procedure

Ten interviews were conducted with chartered counselling psychologists from within London, Surrey and Berkshire who appeared in the Register of Chartered Psychologists (1996) or who are due to appear in the 1997 version. All interviews were conducted by the author (LH) and took place either at the respondent's homes or workplace. All identifying features from the interviews have been removed to ensure confidentiality and anonymity. The respondents were initially invited to consider taking part in the research by means of a letter sent out to all chartered counselling psychologists in London, Surrey and Berkshire (see Appendix A). A follow-up telephone contact within two weeks of sending the letter was made by the author enquiring whether those contacted might be willing and able to take part. If this was so, a convenient time and location was arranged. A total of eighty-three letters were sent out and of those, twenty-three contact numbers were incorrect or unobtainable for various reasons, e.g., the person was ex-directory. The author either spoke directly to the contacts or a left message. Five people contacted the author by E-Mail, three by letter and the rest by telephone. It was assumed that contacts who did not respond to the initial letter or telephone call were not willing on unable to participate. Ten contacts stated that they were not willing to participate, and eight contacts were unable to because they did not have the time. One contact
who was known to the author, but not in the 1996 register, was approached and agreed to participate.

As the latter comment highlights, a number of potential participants were excluded either because they had chosen not to be in the register or because they were not in the 1996 edition. The sample was also limited by the restrictions placed on the time available for the author to travel to potential participants, and therefore contacts were recruited from chartered counselling psychologists in London, Surrey and Berkshire. The age range of the participants was between 31 and 60+ years, all were white and were from British, Australian, Irish or European origins. The sample consisted of four females and six males. Training backgrounds varied but included British and Australian Psychological Societies, United Kingdom Register of Psychotherapists, Association for Humanistic Psychology, British Association of Counsellors and the Institute of Group Analysts. There were a variety of other trainings which participants had completed in specialist areas such as clinical psychology, co-counselling, primal integration, education and educational psychology, supervision, family, couple and sex therapy and training. The types of current work contexts of the participants included private practice, N.H.S., educational settings, and Employee Assistant Programmes. Past work contexts included legal setting (e.g., juvenile detention), medical / health, crisis centres and training / educational. The theoretical orientations which best described participant's current practice were broadly split between Humanistic and Psychodynamic, although specifically the approaches participants used included integrative, transactional analysis, personal construct theory, primal integration, problem-solving and existential-phenomenological.
The interviews were recorded on audio cassette, which required the participants to read and sign a consent form outlining details about confidentiality and anonymity of all materials (see Appendix Bi). The interviews lasted between forty minutes to one and a half hours. A brief outline of demographic data and details of the participants trainings and work backgrounds was gathered after the interview (see Appendix Bii).

The interview schedule (see Appendix Ci & Cii) was devised by the author after consideration of existing literature in the area of touch and through formal and informal contact between the author and psychology colleagues (e.g., peers, tutors and supervisors). It was influenced by the author's own personal therapy, supervision and client work experiences. The main areas covered in the interview schedule included the following: definitions of appropriate or acceptable touch, clients variable influencing the use of touch, boundary and ethical issues and other factors, such as how context and type of therapy of therapy might affect use of touch, as well as other influences such the participant's training and supervision. Consideration of the possible influence of Clarkson's framework of the therapeutic relationship on the issue of touch was recognised and did shape aspects of the interview schedule. However, in order not to impose the author's interpretations on the participants precautions were taken as outlined below.

Initially the interview schedule was briefly piloted on other people involved in the author's training course. Slight alterations were necessary as it was found that most people considered using touch more often than they actually used it. In light of this and in an attempt to ensure the interview procedure was clear and gave adequate scope for participant's to discuss their views based on their practice, two variations
of the interview schedule were used (both were based on the amended original interview schedule): The first included enquiry about examples of times when touch had been used in the process on a number of occasions. The second incorporated the word "consideration" rather than "use" into the questions, e.g.,

Interview schedule 1 - *Use* of touch: Are there any certain client problems or presentations that might lead to a decreased likelihood of you *using* touch?

Interview schedule 2- *Considerations* in the use of touch: Are there any certain client problems or presentations that might lead to a decreased likelihood of you *considering* the use of touch?

The two variations were discussed and briefly piloted as described earlier, although no formal validity or reliability checks were conducted. Seven participants felt interview schedule 2. was most appropriate and the remaining three felt interview schedule 1. would be appropriate.

The face-to-face semi-structured interviews, comprising mainly of open-ended questions were conducted and transcribed verbatim by the author, after which the audio-tapes were erased as agreed.

The individual transcripts were read through thoroughly a number of times until the author felt well acquainted with the material. Following this key words, phrases and constructions were identified, coded and noted down in a way that reflected the specific nature of these *emerging themes*. This procedure of finding emergent themes was performed on each interview transcript so a set of emergent themes
was produced. Shared understanding and meanings were identified by matching emergent themes that surfaced *recurrently* between interview transcripts. Attempts were made to provisionally 'shelve' the two main influences of Clarkson's model and the author's own personal experiences during the interview process and this part of the analysis. The author was also very deliberate in not using Clarkson's terminology pertaining to 'relationship' (working alliance, transference / countertransference, developmentally-needed / reparative, person-to-person / real, transpersonal) in the interview itself, unless it was to summarise what a participant had already said. In this way it ensured that the information gathered was, as far as possible, from the participant's own frame of reference.

In this early stage of enquiry into the topic of touch using an interpretative - phenomenological approach, the production of experiences that might be generalised and / or used in all therapeutic situations was not an aim. Taking this into account and accepting the small size of the sample, quantification of findings was not considered appropriate. As Kruegar (1994) has suggested, in discussion of quantification into qualitative research, the use of adjectival phrases was employed. This approach avoids the problem of not having measures giving adequate indication of the extent to which a pattern or theme needs to surface before it is considered 'significant enough' for inclusion.

The results section presents examples of the recurrent themes which emerged between interview transcripts and care has been taken to select exemplars which reflect these themes accurately. These themes reflect the shared meaning, views
and explanations participants gave in the interviews and will not necessarily have been themes shared by all the participants.

• Results

The following abbreviations apply to text with quotation marks ("):

Material in square brackets is clarificatory; empty square brackets indicate where material has been omitted.

In attempting to present a coherent and manageable picture of the material revealed by the participants about various aspects of touch within the therapeutic process, the main recurrent themes are described below. These main themes begin with a variety of views about actual practice of using physical contact with a discussion of the intended meaning behind these contacts. It is perhaps not surprising that the number of possible meanings described by participant's about what touch might convey included much variety. This variety of possible meanings will be examined and some of the implications of this on actual practice will be briefly contrasted. It was also clear that there were a large number of influences affecting the actual use of, and possible use of touch by the participants. These will be reviewed within the three main recurrent themes outlined above. Final comment in this section will be made about how the use of touch by counselling psychologists may be seen to map onto one or more of the Clarkson's five relationships. It is acknowledged that the different types of relationship outlined by Clarkson may be seen to cut across the recurrent themes discussed below. The rationale behind presenting how the framework may be useful in terms of the themes in a separate section was for
reasons of clarity rather than because it was considered as a separate theme in itself.

• Actual Use of touch and intended meaning

The participants had their own very clear ideas about what kind of touch they had used and would be prepared to use within the process. Three 'categories' of touch may be identified and will be discussed: handshakes; touch to hands, arms, shoulders and hugging, holding or cradling by the therapist.

Several participants reflected on the fact that, in reality, they did not tend to use touch 'very often', although it was clear that the majority felt a handshake on greeting and as a farewell was acceptable. It seems that the message a handshake conveyed and its appropriateness within the therapeutic process was based on an assumption of the common social understanding that the action has in society:

"About the most neutral [kind of touch] you can get is a handshake, which is a sign of greeting or a sign of leaving. And you might shake hands with someone you've never seen before and probably will never see again."

So a handshake was construed by some as a social action that is safe, formal and something that was not considered to be out of bounds by any of the participants. However, it was not something that would necessarily be initiated by the therapist, and on some occasions the client's initiation, and use of this communication with its meaning was used (by participants), as material in the therapy process:
"[He] would always shake my hand as though it had been a business meeting. And it was very useful to look at that; that it was very safe to keep it like a [ ] very formal kind of business meeting because that kept everything in it's place."

Touch applied to areas of the body such as hands, arms and shoulder was considered acceptable by the majority of participants (and this was consistent with the current literature e.g., Willison & Masson, 1986), although this would be very deliberate behaviour with a specific intended meaning behind it. A therapist placing a hand on one of these areas had the intention of conveying one or more messages, sometimes because there seemed no other way to communicate. One participant who had carried out some work with chronically ill people described a situation where he had put his hand on top of his client's hand, but on reflection considered how atypical the situation was:

"To a large extent it [touch] might seem contraindicated because they're sitting there in their pyjamas often [ ] and it was because they didn't actually have the energy to sustain dialogue and it was a way of kind of making connection with them."

This may be seen to have commonalities with the social acceptability of a handshake; touch in the above situation was permissible as a social construction within that particular context and set of conditions.
For some, rather than touch being the only way to communicate a particular message, it was used as another therapeutic tool at the therapist's disposal. In an attempt by the therapist to convey a message of being "with" their client, and to acknowledge a client's pain (for example) without disrupting the client's experience, touch was sometimes employed:

"If somebody's going through a very deep intense emotional experience and they have felt such an absolute aloneness [ ] rather than interrupting and speaking, touch is another way of saying 'I'm here with you'."

Some participants felt that some messages might be conveyed in a non-verbal manner which did not involve using touch, such as "lots of eye contact and touching in other ways that are not physical". Possible influences on these views will be discussed in a later section. For some participants the 'extent' of their use of touch included the use of handshakes, brief and light touches to a client's hand, arm or shoulder. That is, they were unlikely to consider hugging for example, as it seemed to cross a boundary of some kind; this mainly appeared to relate to fears about misinterpretation. Participants did occasionally engage in actions described as "hugging", "holding", "embracing", "cradling" and "parenting" and did so with specific reasons in mind. Often this seemed to be related to a client being in very deep anguish of some kind, and where verbal communication from them was not possible:

"[I might use] holding or cradling of somebody who is just in very deep distress and all they're doing is crying and deep sobbing and nothing else [ ]"
I might actually hold them in my arms as a way of giving them support and protection in that crisis."

Another participant framed their use of holding a client as, in part, a reflection and acknowledgement of the agonising some clients might go through in making the decision to go into therapy, and the time it might take before they actually get to the therapist:

"Someone has arrived and collapsed in tears on my door step and sobbed for the whole [first] session. And [they] couldn't really talk to me and I've held them for the whole session, and my theory on that was that was what they needed to do"

One participant described their use of touch, again in a very deliberate way, but in a manner that was influenced by the theoretical orientation and a specific model of working. Deliberate physical contact would be applied to a part of the body, identified by the client as being painful, with the intention of "intensifying something that was happening in the body." This had been an attempt to help the client understand more about their pain and what it might be about, i.e., to clarify meaning. A number of therapists described how they had, or could envisage themselves engaging in a degree of hypothesising with the about client what touch might mean to the client, especially if they had some concern about touching or being touch, i.e., "what would it be like if that person were to touch you? What would it be like if I were to touch you?" And although this was another approach to exploring the issue of touch with a client it might not have actually involve touch, but
involved something such as the therapist increasing their physical proximity to the client or in some other measured way.

- **Possible meanings: care, relationship dynamics and damage**

It may be seen that the therapist's ability to communicate care towards a client was one the possible meanings behind using or considering touch. Touch might have been used as the primary form of communicating this care or, as an adjunct to a verbal intervention:

"[Possibly after an intense emotional session [ ] just a kind of reassurance and [I might ] say 'okay take care until I see you again next time' and sometimes with a hand clasp or something just to communicate warmth and concern."

"I think it is important to communicate respect and validation of the client and reassurance that they're, you know, an okay person [ ] and that might be a situation whereby touch might be appropriate."

As noted previously, some of the actual practices of the sample ranged from "conveying support" to "holding" and "containing". It seemed that some of those kinds of messages from the therapist might have been conveyed in a manner which did not necessarily involve touching a client physically, and were communicated and received at some other non-verbal level "There are various props like a little box of sweets and a box of tissues and things like that that can be used and that have a symbolic use in terms of care." It may be that as part of the process, a therapist
would resist using touch, not necessarily because they think the meaning might be misconceived but that it might not be helpful to touch the client physically, and to convey a sense of caring in other more subtle ways. One participant commented that he had chosen not to touch a client, not because he did not want to, but that he felt *not* touching them would convey a message of care, containment and his ability to tolerate the client's distress:

"And I've resisted [ ] because I don't think that in the long run it would actually be helpful. But what is very important is to be able to cope with that [the client's enormous suffering] without wincing and without withdrawing in embarrassment."

• *Dynamics within the therapeutic relationship*

A variety of aspects within the therapeutic process were considered to be important factors in the possible meaning that touch might convey. A commonly mentioned dynamic of this, and an issue which embraces a number of other issues, was that of power. In considering the possible meanings that touch might have in relation to this, a variety of factors were included, e.g., the possibility that touch might be requested, initiated or felt to be appropriate or needed by both client and therapist, further adding to the complexity of the interaction. However, all participants were aware of issues surrounding the power differential that exists between therapist and client (e.g., as discussed by Masson, 1993). How individuals worked with that in relation to their use of touch varied, but asking the client's permission to touch was cited by all those who used touch (other than handshakes) as a way to attempt to limit the power difference:
"I don't think any touch is acceptable unless you ask them first. So I would say something like 'would you like me to come and sit next to you?' 'would you like me to hold you?' ‘would you like to come and sit with me?’ And so I give them the power."

However, emphasis was generally placed on the need to consider specific situations and the negotiated meanings in that situation rather than specific ways of dealing with power issues:

"It will depend, I think, on the individual relationship because it might be that touching one client makes [for want of a better word] the therapist actually very weak and vulnerable and touching another client makes the client very weak and vulnerable."

Various pieces of research carried out over the years, particularly in social psychology suggest, for example, that people of perceived higher status will tend to touch people of perceived lower than visa versa (e.g., Henley, 1977). Participants did express high awareness of issues such as power and some of the implications it might have in relation to using touch. This was the case when it came to client initiated touch; indeed it was seen that there could almost be potential for a role reversal if this occurred. The perceived usefulness of such attempts on the part of the client was generally viewed as useful rather than alarming. Most participants expressed the view that a client's need for touch might be discussed and used as material in the therapy, giving a picture of meaning and need behind touch, both for therapist and client. Indeed, using a reflexive method of working was deemed to be
particularly fruitful in exploring material that the client might not openly discuss. This was seen to allow the client to enter into negotiation and possibly move towards a greater shared understanding of the dynamics in the therapeutic encounter:

"[I might say] What I really want to do right now is hug you and I think it's important that I acknowledge that because what it means is I guess what I want to do is take the pain away or I want to make everything okay for you."

Several participants believed that appropriate touch might help or encourage the client to move towards more of a sense of control in some aspects of their lives and this was also related to power: "I see touch as a transaction or as an intervention or as a technique to enable and empower the individual."

So far, the possible meanings of touch have generally been presented in a fairly positive light, although it was clear that there was also much thought given to the potentially negative or damaging meanings it might convey. All participants were well aware of the potentially abusive and exploitative nature of using touch in therapy (e.g., Rutter, 1991) and reasons to use or not to use touch included a variety of other factors. The main concern was of misinterpretation of touch by the client through ambiguity of meaning or shared understanding. For several participants this was one of the main reasons why their use of touch was almost exclusively limited to handshakes:

"In a counselling room with two people, touch can have all sorts of other connotations that potentially move beyond a therapeutic relationship to
something else. [ ] [Without touch] the relationship maintains itself as a therapeutic relationship rather than friendship...

An influence which all participants commented on, and one which was often linked to power dynamics, was the issue of gender (male or female), and the potential for misinterpretation between opposite sex dyads. A number of participants identified this as a major area for potentially negative meaning to be attributed and / or damage to occur. It seems the perception of the potential for exploitation or abuse of a client was seen as most likely in a male therapist-female client (heterosexual) scenario:

"Because of my own orientation [ ] I feel less of a need to be cautious with men than I would with women [ ] I feel that anything that could be interpreted as an advance [in a sexual way] is more liable to take place between male and female.

Whilst perception of potential misinterpretation of touch surfaced as an issue more frequently in female therapist-male client (heterosexual) scenario:

"[with male clients] I tend not to [ ] use touching [an] arm, but perhaps a handshake as the end of a session or at the end of therapy [ ] and there's no risk of misinterpretation."

It was interesting to note that in this sample, the trend suggested by other research, that male therapists seemed to touch female client more often that female therapists
would touch males, did not seem to gain full support. On the whole female participants did report touching men less often and in less ambiguous ways, e.g., handshakes (which was fairly consistent with the existing literature, e.g., Jehu, 1994). However, male participants in this sample appeared to be extremely aware of the gender issues when working with female client and indeed expressed some wariness of how they might touch and how touch might be interpreted (which was not in support of existing literature).

The issue of sexual orientation of a client, i.e., same sex therapist and client was a concern for only some of the therapists, and several of the female participants expressed the need for very clear shared understandings of touch and therapeutic boundaries when working with lesbian clients "I would be concerned [if someone was a lesbian] because I'd want to know that there'd be a very clear boundary [ ] I would need to negotiate how to touch the person."

One participant recognised that whilst he felt comfortable with his own sexual orientation, being both a gay therapist and male might potentially arouse concerns for some of his clients:

"I don't entertain sexualised kinds of hypotheses when I relate to women so those issues of transference don't occur to me. As a consequence I don't make assumptions about the impact of gender but I think that probably the bulk of my clients do. So I actually think that being a male therapist [ ] would be more difficult for women; that it would be much more likely to be a risky
therapeutic exercise or strategy to use touch. At the same time I also think it's extremely threatening for men as well, in relation to men."

Physically touching someone does involve crossing through socially and culturally defined boundaries of proximity (Hall, 1966). It was apparent that a number of the participants who generally only used handshakes also perceived an increased likelihood that touch might be interpreted as an infringing a client's personal and psychological space:

"It [touch] could add another dimension which is unnecessarily obtrusive, ambivalent, causing worries, causing concerns about something."

For several participants, the influence of their own personal therapy affected their views and practice about touch. One participant reflected on an experience of un-invited touch in their own personal therapy. They had felt it was invasive and had influenced their considerations, as a therapist, about the potential impact of touch on a client within the therapy process:

"[ ] Because when that happened [the respondent was touched] [ ] my reaction was to almost say to her 'oh I'm really glad you touched me it would be nice if you were able to do that more. [ ] What I was actually thinking was 'for Christ's sakes you touched me and I didn't ask you to touch me'. So you might touch someone [ ] and they might look relaxed and they might be thinking God only knows what inside."
Influences affecting the meanings ascribed to touch and on the use of touch

There were many influences on the participant's likelihood of using or considering the use of touch, however, it is not the intention to repeat previously discussed themes. The discussion presented below reflects some of the most commonly cited influences given by participants and is not an exhaustive list. It was noted by most participants that the possibility of using touch necessarily meant exercising caution, particularly in the current social climate or epoch. The threat of touch being misinterpreted was a common consideration based not only on factors outlined earlier but on a perceived risk of being sued by a client:

"[The] evidence of clients resorting to legislation is another [issue to consider]. We're surrounded by so many of these that I think it puts touch in a rather compromising position, if you're going to use it."

Participants' concern reflected possible reason for greater caution in using touch in therapy given the dynamic nature of therapy process and changes which might occur within it. Staying mindful of this dynamic process seemed to be particularly important:

"When you get the client going through whatever process into a negative feeling about the therapist they can reinterpret all their past experience with the therapist. And what was fine at the time, now in a negative light can look very different. So [ ] it's the possible future client who might change their mind."
There was comment from most participants about an issue of 'safety in numbers', which was linked to fears about how touch could be misinterpreted. On the whole touch was considered to be a safer tool to use if it was used in a group setting as opposed to one-to-one therapy:

"I would definitely take more risks in a group because there's other people around to see fair play and to kick up a shin-dig if there's something improper gong on."

It was commented upon that some kind of authorisation to use touch had been useful, whether it was gaining a qualification in massage or touching in front of another therapist: "Perhaps I needed permission or a third party present to make it [touch] acceptable."

Several participants commented on how their knowledge and / or experience during the 1970's might have influenced both their use and their ideas about the messages which could be conveyed by touch:

"[I came up through] Encounter groups, Gestalt groups, Psychodrama groups [ ] there was a lot of touch involved in those kinds of groups and so that was where I learnt my trade. [ ] I think it was about 1985 when all this Alice Miller stuff started coming up [ ] and encouraging people to notice that some of things that they were doing were actually quite abusive."
Participants reported how their own personal responses to being on the receiving end of some a therapist's liberal use of touch affected their current practice and thoughts on using touch:

"I have seen group leaders using touch enormously to the extent that I have often felt very uncomfortable. [ ] Those situations made me feel 'you have to ask permission matey before you touch anybody' [ ] So it was that kind of visceral reaction as a participant in workshops years and years ago that made me think very carefully about [ ] what's appropriate and what's not appropriate."

"These Encounter groups and what I would see as the excesses of them, [ ] has influenced me mostly I think running counter to touch but in some cases enabled me to put it into perspective."

Clearly there were variations in the extent of the influence the above-mentioned experiences might have had on considerations about the use of touch. However, it was recognised by all participants that the use of touch certainly did hold the potential to be damaging, even if a therapist might believe that they were practising ethically and responsibly. It was also apparent that practitioners use of touch was executed in a measured way, and that it could be used without damaging the client. What is important is that the potential 'uses and abuses' seem to have been clearly recognised by participants.
• The therapeutic relationship

As outlined earlier, Clarkson (1996) proposed an integrative framework which outlined five different types of relationship where at least one might exist within the therapeutic relationship at any one time.

Although not stated overtly (and therefore are some of the author's inferences), most participants felt that if they were going to consider using touch, it would be something that would not occur until the middle or towards the end of therapy. Basically, when the participant felt that there was a good working alliance between themself and the client: "Only when I've got a very good therapeutic alliance established with the client [ ] yes, when there is a good working relationship." And in terms of the process, use of touch was not generally considered appropriate until some time into the therapy, after a strong working alliance had been established: "I think it would be well into the therapy process after the relationship has been built up and they're feeling safe enough to work on some very deep issues." For most participants the length of the contract was a significant influence on their consideration about touch, mostly suggesting that touching was not a tool to be used in short term work: "I mean we're talking years." [before the participant would consider using touch]. And even though this trend emerged, it was clear that contracting with a client from the start, not necessarily specifically to do with touch, but in clarity of issues such as boundaries was an important part of establishing a working alliance (and something already noted in existing literature, e.g., Safran, 1993) :"It's almost like [ ] you use it and you know you're using the and the other person knows you're using it for therapeutic purposes". 
Behind several interventions of using touch a number of participants fully acknowledged a *reparative or developmentally-needed* influence on their actions and maybe not surprisingly this related to actual and / or perceived age of the client:

"I actually did give her a hug [] and helped to go a little way towards repairing incredible damage she'd experienced as a badly abused child."

"If someone is in their Child-Ego state and is feeling quite little and fragile and vulnerable and cold [] they may like to be wrapped in a blanket and held."

"If someone said [] 'I'm feeling very frightened, I'm feeling very alone, I'm feeling very little' by this stage I would probably know that their history was that when they were in this stage there was no-one there. So I might hold them."

On the whole reparative work appeared to be one of the main influences on participant's making a decision to use of touch. It is conceivable that this kind of touch may have been used because the participants seemed to feel very clear about their client's needs and how therapist touch might be interpreted. So in terms of recurrent themes outlined in previous sections, what might have been seen as a dilemma for the therapist in terms of, for example, power, fear or damage, may not have applied quite so much in the above types of example.
It has already been suggested that one of the recurrent themes which surfaced in the interviews was of touch being used as a way to communicate a sense of the therapist caring about the client in some way. It is possible that on some occasions, use of touch might have been viewed as an aspect of the *person-to-person or real relationship*. It was noticeable that often participant's did not actually deem the use of touch to be within the therapeutic process (and therefore maybe not within the therapeutic relationship), and that it was something that was to do with being 'human':

"It might be [ ] like reaching out in a compassionate way to somebody who is experiencing a lot of feelings, just to support them in the feeling."

Participant's who might initially have described their extent of touch as being handshakes were often able to recall examples were it had felt appropriate to touch, but did not see this as part of the actual therapy, but something they did because it seemed an appropriate and natural thing to do: "They [the client] were very tearful and upset so I did comfort them [ ] but that was very unusual [within the context of the participant's work]"

A number of the participant's responses reflected a recognition that a therapist had to be comfortable with using touch for it to be effective, and also to be perceived as genuine by the client:
"[ ] the client is going to sense that this person is doing it because they feel they have to and they don't want to and what's wrong with me? You know, this therapist doesn't want to touch me."

Indeed some participants learnt from their own experiences of being touched when it did not feel genuine: "[I felt] It doesn't have anything to do with how I am, I don't like it so it's almost meaningless, it's not authentic." It was believed that touch that was not genuine or authentic would probably be sensed by the client and might risk the client feeling rejected and/or stigmatised. Although the need for therapist flexibility was also seen as important and that this flexibility would not necessarily mean being inauthentic (Lazarus, 1993).

The influence of the transpersonal relationship in relation to touch was quite a complicated one and is maybe one that for some people is a complicated relationship to think about in it's own right. However, there was certainly evidence of something that was conceptualised, by several participant's, as being part of the non-verbal communications within the therapy, which emerged on several occasions as influences on considerations about touch:

"So I think the sort of space you're in [affects considerations about touch] and I suppose you can think about space as being first of all physical space, secondly an interpersonal space, thirdly a mental space [ ] and fourthly a psychotherapeutic space [ ] as all really influencing the meaning [and consideration about touch]."
One way of interpreting this may be that it was not necessarily something physical the participant, as a therapist, carried out that affected touch in the process, but something that was communicated in another way. The nature of this 'other way' may have been seen as a bit of a mystery to the therapist in that was not a concrete entity. Nonetheless something seemed to exist, which several participants saw as reason enough not to use touch:

"I just have this feeling that [ ] you can touch them [clients] on many levels without physically touching [ ] and you often touch people very deeply or you're touched by them [ ] so that's really difficult."

Finally, and possibly related to the transpersonal relationship, was the influence of the transferential / countertransferential relationship on considerations in touch. Again it was clear that this type of communication was used on a regular basis by the participant's as an attempt to gain a measure of what was happening for the client. And it was as part of this process that considerations about touch were often made; mainly it seemed, in terms of the therapist using internal or self questioning techniques about what might be going on in the process, and then possibly making a decision about ways to deal with that. For instance, in becoming aware of feelings about an urge to communicate closeness, nurturing or support, one participant described how he dealt with these feelings:

"What I've done is really use that desire to want to touch a client as a kind of way of providing myself with feedback about what I think is going on there. And so what I've done is find other ways to support that client."
All participants who described using the transference and countertransference appeared to work with it in a questioning mode, that is, there was clear awareness of examining either their own need to touch or a client's verbal or non-verbal request for touch. This awareness was also evident in participant's overt avoidance of using touch in circumstances where it had been clear that to them that the material was transferential:

"You would use it as material and don't get tricked into doing what, perhaps, the majority of other people the person comes up against, does. [ ] If you have a stereotypically beautiful person sitting on the chair in front of you dressed very seductively, well I think that needs to tell you something about the way the client is in the world. It's not a straight invitation and it mustn't be because then you can not work."

Other uses of participant's own feelings or countertransference reactions towards clients did appear to affect their considerations about using touch in various ways. The theme of safety emerged for several participants, notably in relation to potentially violent clients or clients who therapists felt scared of:

"I'd be very cautious about even getting closer to them never mind touching them because violent people have a bigger bubble round them than other people do [ ]. Experience themselves as being invaded much more readily."

So in terms of this particular type of relationship, it seems that it is one that can provide information about the issue of touch for the client and about the client. In
considerations about touch, the message seemed to be one which initially required exploration, amongst other things, of the reasons behind the client's need or therapist's need, for touch. In learning more about what touch might mean to a client, it is possible that the risks of misinterpretation, if touch is used, would be lessened.

• Discussion

The main themes revealed the importance of negotiating a shared understanding about the meaning of touch for the client in order to minimise the risk of misinterpretation and potential damage. And whilst this might make intuitive sense and seem obvious, historically this has not always been the case. As one participant noted in their concluding comment: "What I call the Alice Miller turn [in about 1985] can hardly be over-estimated [with] the revelation that therapists could be abusive". Indeed many of the participant's were extremely aware not only of the 'negative' affects of using touch inappropriately, but of the risks against them in terms of legal action. Perhaps paradoxically, if the recognition of the many different meanings that touch might have has increased, it may have become clearer as to some what is considered acceptable and where boundaries are drawn. It may, however, be viewed in such a way that because of the diversity, total clarity will not really be gained and that therapists can afford to use different types of touch as long as all attempts have been made to determine a shared understanding about it. How a therapist might go about negotiating the shared understanding would inevitably vary between therapists, and is a possible topic for future research. However, it would be essential that the views of both client and therapist would need to be clear for shared understanding to be generated. This task might be made easier if the
therapist has a satisfactory understanding of what they believe using, or not using touch, might mean with the aid of, for example, some kind of theoretical framework.

The exploration of the views and experiences of therapists produced some consistencies about when using touch might or might not be therapeutically useful. It is these proposed that it is these types of consistencies that may help other therapists in negotiation of meaning with their clients. It is acknowledged that the methodology used in this study was not intended to clarify this situation in a distinctly 'do or do not touch' manner. Rather it served in an attempt to capture individual thoughts and responses to situations therapists had encountered, and whether they may have considered the possible use of touch, based on some kind of theoretical framework. The responses that were given may provide a starting place to clarifying a particularly grey area.

It is also acknowledged that the limitations of generalising findings is pertinent with regard to IPA, and the use of other methodologies, with larger more controlled samples might well reconcile some of these problems (It is also recognised that attempts at using strict controls in an area such as the one in question would bring a number of other difficulties). Although the sample size in the present study was small, IPA is a methodology which, by its in-depth and intense nature, is not a methodology that would be particularly appropriate with larger samples. However, a number of consistencies did emerge from the large amount of qualitative data gathered, and possibly it is those aspects which might be investigated further with the use of quantitative analysis alongside the qualitative analysis in building a more 'concrete guide' for therapists to consider.
On the whole, attempting to consider the following influences: the exploration of the meanings that might be attributed to touching, as well as thinking about other aspects of a therapeutic encounter, it appeared that the participants were drawn into what might be seen as two different groups (perhaps reflecting the aforementioned paradox): Those who described the extent of their touch to be handshakes (and on exceptional occasion to comfort someone with a hand on the shoulder) and those who would use interventions from a handshake to reparative holding. Obviously this is an extremely simple distinction, although one that appeared to be present in this sample. This is another finding that might be interesting to explore further in future work in this area.

In considering the original research questions it is acknowledged that no formal hypothesis-testing approach was conducted. It was felt that at this initial stage of exploration, capturing the in-depth rich material was most useful, especially in terms of searching for the meanings that might be underlying the use of touch. It was also acknowledged that the author's own training included significant input related to Clarkson's framework and that wider issues needed to be examined along side this personal knowledge. It was assumed that as chartered counselling psychologists there would be awareness of the importance of the relationship between therapist and client. It was not assumed that participants would be able to express a specific knowledge or conceptualisation of Clarkson's framework. Rather that they might refer to these aspects of the therapeutic relationship in a slightly different form. And on this theoretical level, there was some evidence that, in considering the issue of touch, the participants were using some kind of conceptual framework which held various similarities to that outlined by Clarkson's framework. The influences were
probably most clear in examining the considerations the participants gave to touch when the reparative / developmentally-needed and the transferential / countertransferential relationships were apparent. From this, it was clear that there was high awareness of the importance of the relationship between therapist and client, and this knowledge did seem to influence consideration about using touch. Indeed, there were several examples of instances where therapists did not use touch for clearly thought-out reasons and because ultimately it did not seem as though it would be useful. In a similar vein, the general feeling reported was that if touch was going to be used in the therapy process, it would be done so when a strong working alliance had been established and usually towards the middle and end of the therapeutic contract. Further investigation might aim to 'tighten' the application of such a theoretical framework into a clearer set of recommendations or guidelines.

• Conclusions
A central theme to come out of this paper was one that highlighted the need for negotiation between therapist and client about what touch might mean in the therapeutic relationship. There are a multitude of meanings, interpretations and influences involved in this process and to a certain extent some of these might be dealt with in discussion with the client, in supervision or with colleagues. External influences, such as a changing social climate, are at the very least, difficult to challenge effectively, let alone change. There may be increased public awareness and sensitivity to exploitation and abuse in therapy, as well as greater understanding and ease of access to formal complaints procedures to address
these issues. This seems to have lead to a position where touch is perceived as quite a risky behaviour, and one which needs to be very clear in its objectives.

Some participants shared various strategies they sometimes drew upon in order to guide them and their supervisees in their use of touch:

"Imagine that standing in the corner is a reporter from the 'News Of The World' and supposing standing in the corner was a reporter from the 'News Of The World', would you still do it [touch]?"

"One rule about touch is that you would only ever touch the bony bits"

And while these strategies may be viewed in a somewhat light-hearted manner the meaning behind them is a complex and important one.
• References


Dear

I am currently in my final year of the Practitioner Doctorate in Psychotherapeutic & Counselling Psychology at the University of Surrey. As you will be aware research is an important element in the course and it is your participation in my research that I am contacting you about. I am also aware that you will have received several other requests for help in research projects and appreciate your time to consider this one.

The aims of this exploratory study are to investigate a number of issues concerning the use of appropriate physical contact between a client and their therapist. Thus participants will be practitioners who have used touch in their therapeutic practice (touch in this research being any form of physical contact excluding welcoming handshakes). This is not a new topic of debate; a number of studies have examined the use of appropriate physical contact in therapy, though have often focused on various outcome variables. In this research I hope to explore issues related to the use of appropriate physical contact in the context of the therapeutic relationship and the therapeutic process. Thus the study will not only, for example, enquire into aspects such as the frequency with which appropriate physical contact may or may not be used. It will also attempt to look further into the basis on which such decisions might be made when they occur in the therapeutic process. With your participation it is hoped that this research will be published and help in clarifying issues in this controversial area. Copies of the final study will be available to those who agree to take part.

At this preliminary stage the research will involve seeking information from chartered counselling psychologists in the 1996 Register of Chartered Psychologists. I will be conducting audio-taped in-depth individual interviews consisting of mainly open-ended questions. It is envisaged that the interview will be no longer than one hour and whilst this method is somewhat time-consuming it is anticipated that it will provide rich and varied data. All data collected will be treated in the strictest of confidence and anonymity will be maintained.

I will be contacting you by telephone in the very near future. If you can spare one hour of your time and agree to be interviewed, a time and venue convenient to you will be arranged and we will take it from there. In the meantime, if you have any queries or questions you would like to ask, do not hesitate to get in touch through any of the above contact sources.

Thank you for your consideration, I look forward to speaking to you.

Yours sincerely,

Lynne Harrison
Psychotherapeutic & counselling psychologist in training.
The aim of this research is to explore issues of touch within the therapeutic process. It will draw on your therapeutic experiences and work with clients looking at the following:

• The various dilemmas you may have had in thinking about using or not using touch in the therapy process

• The processes and rationale behind your decisions about whether or not to use touch in therapy.

• Where possible, examples of times when you have used touch in the therapy and the considerations you went through in that process

In order to address these issues you are asked to take part in a semi-structured interview consisting of mainly open-ended questions. The interview will be audio-taped then transcribed verbatim, so that the richness of your experiences can be cited directly and accurately. Any identifying information will be changed so as to protect your confidentiality, and anonymity will be maintained. Once the tape has been transcribed the audio-tape recordings will be erased. When the assessment procedure is complete the consent form will be destroyed.

If you have any questions so far or feel you would like further information about this research, please feel free to ask any questions.
APPENDIX Bi

Research Consent form (2):
Considerations of the use of touch in the therapeutic process

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

I agree that the purposes of this research and what my participation in it would entail has been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about issues relating to the use of touch in the therapeutic process. I also consent to an audio-tape being made of this discussion, and to all or parts of this recording being transcribed for the purposes of this research, with the promise that anonymity is protected and recordings erased after transcription.

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

On behalf of those involved with this research project, I undertake that, in respect of the audio-tapes made with the above participant, professional confidentiality will be ensured and anonymity of the participant will be protected, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only.

Signed ............................................... Date .............................
APPENDIX Bii

CONFIDENTIAL

Considerations of the use of touch within the therapeutic process

Factsheet / information

- Sex: M □ or F □

- Age: 20-25 □ 26-30 □ 31-35 □ 36-40 □ 41-45 □ 46-50 □ 51-55 □ 56-60 □ 60+ □

- Race or ethnicity: ____________________________________________________________

- Current work context (e.g., private practice, NHS) ____________________________

- Past work contexts __________________________________________________________________________

- Training background (e.g., UKCP, BAC, BPS, BAP, social work): __________

- Years of clinical work (as a Counselling psychologist): ______

- Other qualifications: ____________________________________________________________

- Code: __ __

- No. of interview: __ __

- Date: __ / __ / __

- Location: __________________________________________________________________________
APPENDIX C1

Interview schedule 1: Use of touch in therapy

A/ DEFINITIONS OF (APPROPRIATE) TOUCH

1. Although it may be difficult to generate hard and fast rules, please describe your ideas of what you think appropriate or acceptable touch in therapeutic practice might include. (probe: nature, context, type, where on the body, duration)

2. Please describe your ideas of what you think inappropriate or unacceptable touch in therapeutic practice might include. (probe: nature, context, type, where on the body, duration)

B/ USE OF TOUCH BY CoP’s

3. What kind of touch have you used? (probe: nature, context, type, where on the body, duration, meaning)

4. Would you say that you use touch on a regular basis in your therapeutic practice?
   ➢ If yes: how frequently might this be in a month, for example?
   ➢ If no: What are the reasons for this limitation?

5. What, if anything, has influenced your decision to use touch in the therapy process? (probe: particular reason, context and possibly personal norms, e.g., being a 'touchy/feely' person)
   What other influences might affect your decision to use touch in the therapy process? If you can please give any examples of having made these kind of decisions?

6. Have there been any times when you have resisted using touch with any of your clients?
   ➢ If yes: What kinds of factors influenced your decisions?
     If you can, please give examples of times when you have resisted touching a client
     What other influences might effect your decision not to use touch? (prompt: fear of consequences, misinterpretations, fear of getting sued)
   ➢ If no: Are there any points in the therapy process when you think there may be a greater likelihood that touch will occur?

7. Are there any points in the therapy process when there would be a greater likelihood of you using touch?
If yes: When might these be? (probe beginnings, middle, endings) What is your reasoning behind these thoughts? How would you go about making this decision?

8. Are there any points in the therapy process when there would be less likelihood of you using touch?
   ➢ If yes: When might these be? (probe: beginnings, middle, endings) What is your reasoning behind these thoughts? How would you go about making this decision?
   ➢ If no: Are there any points in the therapy process when you think there may be less likelihood that touch will occur?

9. In what ways do you think using touch might effect your relationship with a client?

C/ CLIENT VARIABLES IN INFLUENCING THE USE OF TOUCH

10. How might the gender of your client affect your considerations in using touch, if at all?

11. How might the cultural background of your client affect your considerations in using touch, if at all?

12. How might the sexual orientation of your client affect your considerations in using touch, if at all?

13. How might the age of your client affect your considerations in using touch, if at all?

14. How might the socio-economic background of your client affect your considerations in using touch, if at all?

15. Are there certain client problems or presentations that might lead to an increased likelihood of you using touch?
   ➢ If yes: What are they? What are your reasons for this? If this has occurred, please give examples?

16. Are there certain client problems or presentations that might lead to a decreased likelihood of you using touch?
   ➢ If yes: What are they? What are your reasons for this? If this has occurred please give examples?

17. Has a client ever asked you to physically touch them in any way?
If yes: How did you respond to your client? What influenced your response? What was the most important consideration in making your decision? How did your client respond to your decision?

If no: How do you think you might respond if a client did ask you to physically touch them?

18. Has a client ever initiated touch with you?
   ➢ If yes: How did you respond? What were your interpretations about this, if any? How did this affect your perception of the dynamics within your relationship, if at all?

D/ BOUNDARY AND ETHICAL ISSUES

19. What effects, if any, do you think using touch could have on power dynamics within a psychotherapeutic relationship?

20. What effects, if any, do you think choosing not to touch a client could have on power dynamics within a psychotherapeutic relationship?

21. Have you ever discussed with a client the issues of touch between you and the client?
   ➢ If yes: What prompted this discussion? What sort of things did you discuss? What was the outcome?
   ➢ If no: Other than the fact that it may not have surfaced as an issue, are there any other reasons that might inhibit discussion of this issue?

22. Which major theoretical orientation do you consider best reflects the way you work clinically?
   What influence does theoretical orientation have on your likelihood of using touch in therapy, if any?

23. Which ethical guidelines and code of practice which you adhere to in your therapeutic practice?
   Are you aware of any references to the area of touch in these guidelines? What influence do these ethical guidelines and codes of practice have on your likelihood of using touch in therapy?

E/ OTHER FACTORS

24. How do you think the context of the therapy affect your likelihood of using touch, if at all? (Probe: NHS setting, private practice etc.).
25. How do you think the type of therapy you might be using could affect your likelihood of using touch, if at all? (e.g., group vs. individ)

26. How adequate do you feel your understanding of issues influencing the use of touch in therapy?
   ➢ If inadequate: How might this be improved, how might this be achieved?
   ➢ If adequate: How did that come about (e.g., through experience)

26. Do you feel that your training addressed this issue adequately?
   ➢ If yes: What aspects were useful?
   ➢ If no: What would have been useful?

27. Do you supervise other practitioners?
   ➢ If yes: If the issue of touch ever surfaced as a problem for any of your supervisees, how has this been addressed and resolved, if at all?
APPENDIX Cii

Interview Schedule 2: Considerations in the use of touch

A/ DEFINITIONS OF (APPROPRIATE) TOUCH

Research has been carried out on various aspects and definitions of what touch involves. I'd like to ask you a few questions about your views on this.

1. Although it may be difficult to generate hard and fast rules, please describe your views of what you might consider to be appropriate or acceptable touch in your therapeutic practice. (probe: nature, context, type, where on the body, duration)

2. Please describe your views of what you might consider to be inappropriate or unacceptable touch in your therapeutic practice. (probe: nature, context, type, where on the body, duration)

3. Have there been any times when you have resisted using touch with any of your clients?
   - If yes: What kinds of factors influenced your decision to resist using touch?
   - If you can, please give examples of times when you have resisted touching a client
   - What other influences might effect your decision not to use touch, if any? (prompt: fear of consequences, misinterpretations, fear of getting sued)

4. Are there any points in the therapy process when the likelihood of you considering using touch would be greater?
   - If yes: When might these be? (probe beginnings, middle, endings) What is your reasoning behind these thoughts? How would you go about making this decision?
   - If no: Even though you may not have considered this in your own practice, are there any points in the therapy process when you think touch might be more likely to occur?

5. Are there any points in the therapy process when the likelihood of you considering using touch would be lessened?
   - If yes: When might these be? (probe: beginnings, middle, endings) What is your reasoning behind these thoughts? How would you go about making this decision?
   - If no: Even though you may not have considered this in your own practice, are there any points in the therapy process when you think touch might be less likely to occur?
6. Is there anything you have not already discussed that has, or might influence your decision to consider the use of touch in the therapy process? (probe: particular reason, context and possibly personal norms, e.g., being a 'touchy/feely' person).

B/ CLIENT VARIABLES IN INFLUENCING THE USE OF TOUCH

7. How might the gender of your client affect your considerations in using touch, if at all?

8. How might the cultural background of your client affect your considerations in using touch, if at all?

9. How might the sexual orientation of your client affect your considerations in using touch, if at all?

10. How might the age of your client affect your considerations in using touch, if at all?

11. How might the socio-economic background of your client affect your considerations in using touch, if at all?

12. Are there certain client problems or presentations that might lead to an increased likelihood of you considering the use of touch?
   ➢ If yes: What are they? What are your reasons for this? If this has occurred, please give examples?
   ➢ If no: Even though you may not have considered this in your own practice, are there any client problems or presentations that you can think of which might lead to an increased likelihood of touch being used?

13. Are there certain client problems or presentations that might lead to a decreased likelihood of you considering the use of touch?
   ➢ If yes: What are they? What are your reasons for this? If this has occurred please give examples?
   ➢ If no: Even though you may not have considered this in your own practice, are there any client problems or presentations that you can think of which might lead to an decreased likelihood of touch being used?

14. Has a client ever asked you to physically touch them in any way?
   ➢ If yes: How did you respond to your client? What influenced your response? What was the most important consideration in making your decision? How did your client respond to your decision?
   ➢ If no: How do you think you might respond if a client did ask you to physically touch them?
15. Has a client ever initiated touch with you? (Inc. shaking hands)
   ➤ If yes: How did you respond? What were your interpretations about this, if any? How did this affect your perception of the dynamics within your relationship, if at all?

C/ BOUNDARY AND ETHICAL ISSUES

16. What effects, if any, do you think using touch could have on power dynamics within a psychotherapeutic relationship?

17. What effects, if any, do you think choosing not to touch a client could have on power dynamics within a psychotherapeutic relationship?

18. Have you ever discussed with a client the issue of touch between you and your client?
   ➤ If yes: What prompted this discussion? What sort of things did you discuss? What was the outcome?
   ➤ If no: Other than the fact that it may not have surfaced as an issue, are there any other reasons that might inhibit discussion of this issue?

19. Which major theoretical orientation do you consider best reflects the way you work clinically?
   What influence does this theoretical orientation have on your likelihood of using touch in therapy, if any?

20. Which ethical guidelines and code of practice do you adhere to in your therapeutic practice?
   Are you aware of any references to the topic of touch in these guidelines?
   What influence do these ethical guidelines and codes of practice have on your likelihood of using touch in therapy?

D/ OTHER FACTORS

21. How do you think the context of the therapy might affect your likelihood of considering the use of touch, if at all? (Probe: NHS setting, private practice etc.).

22. How do you think the type of therapy you might be using could affect your likelihood of using touch, if at all? (e.g., group work Vs indiv)

23. How adequate do you feel your understanding of issues influencing the use of touch in the therapeutic process is?
   ➤ If inadequate: How might this be improved, how might that be achieved?
   ➤ If adequate: How did that come about (e.g., experience)
24. Do you feel that your training addressed this issue adequately?
   ➤ If yes: What aspects were useful?
   ➤ If no: What would have been useful?

25. Do you supervise other practitioners?
   ➤ If yes: If the issue of touch ever surfaced as a problem for any of your supervisees, how has this been addressed and resolved, if at all?
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