A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation of ‘Decision-making in planned lesbian parenting: An interpretative phenomenological analysis’

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This portfolio is dedicated to my parents and my brother, who always believed in me, and without whom this degree would have never been possible.
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Introduction to the Portfolio

This portfolio represents a selection of work carried out in partial fulfilment of the Practitioner Doctorate (Psych.D) in Psychotherapeutic and Counselling Psychology at the University of Surrey. It contains three dossiers that correspond to the three main areas of training: Academic, Therapeutic Practice and Research.

The Academic Dossier includes papers, which resulted from work from the following courses: Advanced Theory and Therapy and Psychopathology.

The Therapeutic Practice Dossier contains descriptions of all the clinical placements as well as a personal account of the integration of theory, research and therapeutic practice.

The Research Dossier comprises of three research papers: A literature review and two empirical studies.

Due to the confidential nature of the therapeutic work, the anonymity of clients has been protected throughout this portfolio. Where client material has been used to exemplify my therapeutic practice, names and other identifying information has been altered or omitted to preserve confidentiality. This rationale was also applied to the participants of the empirical research presented in this volume.
ACADEMIC DOSSIER
The Academic Dossier contains three academic papers and one report. The first paper discusses the concept of ‘anger’ in psychoanalysis, as it was theorised by Klein and Winnicott and the implications of both theories for therapeutic practice. The following two papers address different aspects of the therapeutic relationship. In particular, the former explores different psychoanalytic views on ‘counter-transference’, while the latter evaluates the role of the therapeutic relationship in cognitive therapy. The report examines possible diagnoses that relate to a case study, using standard psychiatric classificatory schemes (DSM-IV and ICD 10).
Compare and contrast the theoretical aspects and clinical implications of the concept of ‘anger’ as conceptualised by Klein and Winnicott

The concepts of ‘anger’ and ‘aggression’

During the last century, concepts like ‘anger’ and ‘aggression’ have preoccupied psychoanalysts of different schools. The present paper has been written in an attempt to compare and contrast these concepts as they were defined and presented by two very influential people in the domain of psychoanalysis; namely, Melanie Klein and Donald White Winnicott. In the second part of this paper, there will be a discussion of the implications that the theoretical definitions of these concepts -as given by the above-mentioned psychoanalysts- might have for clinical practice. However, before one can proceed with such a challenging task, the reader has to be informed about the established definitions of these two concepts. Within psychoanalysis, ‘aggression’ has been defined as a:

“Hypothetical force or instinct or principle imagined to actuate a range of acts and feelings. It is frequently regarded antithetical to sex or libido, in which case it is used to refer to destructive drives. Even when being used as a synonym for destructiveness, controversy exists as to whether it is a primary drive ... or whether it is a reaction to frustration” (Rycroft, 1995, p.5).

‘Anger’ has been defined as a:

“Primary emotion, provoked typically by frustration. Surprisingly frequently confused with hate, despite the fact that it is a short-lasting emotion, ... whereas hate is a lasting sentiment” (Rycroft, 1995, p.8).

Both ‘anger’ and ‘aggression’ come from the latin root ‘ad-gradior’ which means ‘I move toward’ (Rycroft, 1995). In the course of this paper, the terms are going to be used interchangeably, reflecting the way in which they have been used so far in psychoanalytic literature.
Nature or nurture?

One of the oldest debates in the history of psychology can be summed in the well-known phrase 'nature or nurture?' which reflects the study of whether psychological phenomena can be attributed to innate factors and heredity, thus, 'nature', or to environmental influences, thus, 'nurture'. When applied to the concept of 'aggression' the question can be formulated into asking whether aggression is an instinct and thus, innate or whether it is a reaction to frustration and thus, regulated by environmental conditions. The reader then should not be surprised by the realisation that this debate forms the core of Klein and Winnicott’s opposing viewpoints as far as human aggression is concerned. For Klein, infants are potentially aggressive from the moment of birth and entertain destructive fantasies of great intensity, which originate from innate aggressiveness (Storr, 1968). Whereas Klein did not dispute the significance of environmental factors, when called to justify what distinguishes the intensity of aggression from one infant to another, she clearly pointed that this was dependant upon the amount of innate aggressiveness that each infant inherited (Winnicott, 1989). This was one of the main points of disagreement between Winnicott and Klein. For Winnicott, aggression had two meanings. By one meaning it was seen as directly or indirectly a reaction to frustration. By the other meaning, it was seen as one of two sources of an individual’s energy (Newman, 1995). Thus, without disagreeing with the proposition that aggression might be originating from ‘within’ the individual, he placed tremendous emphasis on the specific environmental circumstances that promoted its expression.

Classicism versus romanticism

Although one might assume then, that Klein’s and Winnicott’s disagreement was merely a matter of placing different emphasis on the origins of aggression, in reality it was more than that. Actually, Klein and Winnicott’s viewpoints represent two completely opposing philosophical traditions – namely, classicism and romanticism. According to classicism, the sense of truly living one’s life is dependent on the ability to come to terms with fate. On the other hand, romanticism emphasises the possibility of undoing the damage inflicted by fate (Strenger, 1997). In psychoanalysis, the classicist viewpoint, as represented by Klein, sees the infant as a
machine of destruction, full of greed, envy, and aggression. The romanticist viewpoint, as represented by Winnicott and others, asserts that the infant is not just a bundle of raging desires, but that its most basic strivings are to feel alive and to be in contact with the other (Strenger, 1997, p.210). As a result of these opposing philosophies, the classicist psychoanalyst sets completely different goals in therapy compared to the romanticist psychoanalyst. However, the therapeutic implications of these different positions will be analysed in the second part of this paper. At present, Klein and Winnicott’s theories of aggression will be examined in more detail.

**Melanie Klein and the classicist viewpoint**

In Klein’s theory of human development, aggression has been regarded as the critical factor in development or its inhibition. For Klein there was clear evidence of the infant’s aggression which was manifested in “trying to destroy its mother by every method at his disposal of its sadistic trends –with teeth, nails, and excreta” (Hinshelwood, 1991, p.50). In addition, as mentioned above, Klein considered aggression to be an instinct, which is innate in man and most animals. Thus, she described how the baby angry that the breast does not supply him with what he wants, cries and screams and becomes aggressive thus, “automatically, explodes ... with hate and aggressive craving” (Klein & Riverie, 1937, p.8). Klein went even as far as claiming that some infants may experience strong resentment about any frustration and show this by being unable to accept gratification, because of the fact that these infants have stronger innate aggressiveness and greed than those infants whose occasional outbursts end sooner (Klein, 1975).

**Aggression and relevant concepts in Kleinian theory**

*Death instinct*

Since 1932, Klein regarded the first year of life as the ‘year of the maximal sadism’ (Hinshelwood, 1991). This happens as a result of the trauma of birth, which stirs up aggression as a manifestation of the ‘death instinct’. In Kleinian terms the ‘death instinct’ can be defined as a “wish to dissolve, annihilate oneself” (Rycroft, 1995, p.31) and is a force in the personality that drives towards the destruction of the ego (Hinshelwood, 1991). Moreover, aggression is viewed as synonymous with envy, hate
and sadism, which are all manifestations of the death instinct. As a concept, the 'death instinct' was first developed by Freud. However, for Freud (1914) it was a mute and silent instinct. On the contrary, Klein argued that it could be manifested in clinical work on the transference and when observing children in play.

The paranoid-schizoid position and aggression

According to Klein (1975), because of the presence of the death instinct, the infant experiences persecutory anxiety whenever some form of deprivation occurs. In order for the infant to cope with the overwhelming anxiety it experiences, the ego splits itself in a primitive defence mechanism. In such a way, the bad –that is the sense of fear and frustration- is projected into the breast, which becomes the bad breast. Since the breast is simultaneously the source nourishment, it is also the good breast. However, at that primitive level of ego organisation, the breast is split into two parts and is perceived by the infant as two separate objects: the good breast and the bad breast (Weininger, 1984). In that way, through the mechanism of projection, the death instinct is converted into aggression towards an external object – the breast. Thus, when the breast is felt to be threatening the ego, this gives rise to feelings of persecution (Segal, 1973). This occurs when feeding does not come soon enough and thus, the baby experiences badness. At the same time, a part of the death instinct still remains within the self and becomes aggression directed at the persecutors. This split between good and bad is necessary for that stage of development since the good object (or breast) is that way protected from badness. It should be mentioned that Klein saw aggression as necessary for survival since, the initial splitting and projection of the bad leaves a hostility which when incorporated into the libido, gives rise to 'becoming' and growth. According to Klein, “without aggression, we would perish” (Weininger, 1984, p.23).

The concepts of 'envy', 'greed' and 'gratitude'

In Kleinian theory, 'envy' is the most primitive and fundamental human emotion and is one of the factors, which were regarded as constitutional. It occurs in the paranoid-schizoid position as envy for the breast. In envy, anger results from the feeling that someone else, that is the mother, possesses things, which are desirable to the infant (Weinenger, 1984). In the feeling of envy not only is the possession desired, but there is also an urge to spoil other people's enjoyment of the coveted
object (Klein, 1975). Clearly related to envy is ‘greed’, which is manifested as an excessive craving beyond what the subject needs and the object is willing to give (Mitchell, 1986). “Greed seeks to rob and take, while envy seeks to rob but put badness ... and make the object less desirable and enviable” (Weinenger, 1984, p. 59).

If envy is strong, goodness cannot become part of an individual’s life. If the infant cannot allow the good object to be safe from attack, then he cannot properly introject it undamaged (Hinshelwood, 1991). Envy is directed against creativeness and impairs the ability to experience gratitude. ‘Gratitude’ involves belief and trust in the good object and ability to love it without envy interfering. Gratitude is enhanced by the gratification that the object gives (Hinshelwood, 1991). While envy and greed are destructive impulses, gratitude is a constructive impulse and signifies normal development.

*The depressive position and aggression*

In the depressive position, the infant is involved in the process of ego integration. Thus, at this stage the infant starts to recognise a whole object and relate to it. In other words, he sees that both his good and bad experiences come from the same person, the mother. As the ego becomes more integrated the infant begins to feel sorrow and guilt about the demands and attacks on the loved object (Segal, 1973). This inner awareness of his own power to hurt brings about the anxiety that he may have destroyed the loved object. In Kleinian terms, this then results in ‘depressive despair’ which gives rise to the need for ‘reparation’. Thus, for Klein the depressive position is seen as a constant struggle between the destructive fantasy, which includes both guilt and aggression and the wish for reparation (Weinenger, 1992). As the infant repeatedly experiences loss and reparation, then his fantasy of harming the mother is no longer so frightening. Hence, hostility is decreased, and the infant “no longer becomes a screaming, howling bundle of aggression. His love is maintained and he has assimilated the good object into his ego” (Weinenger, 1992, p.43).
The oedipal phase and aggression

Klein's conception of the Oedipal phase is in accordance with Freud (1905). Thus, she claims that during this phase, the infant becomes aware of the relationship between his father and his mother. Then, and since the infant perceives his parents based on his own projections, their relationships stirs feelings of jealousy and envy, because the parents are perceived to give one another gratification that the infant wants for himself. This results in an increase in aggressive feelings and fantasies (Segal, 1973). In fantasy, the parents are being mutilated, even murdered but because at the same time they are introjected, they are viewed as internal persecutors who punish the infant. This tangle of fear, envy and sadness underlies the aggression of the early Oedipal period (Weinenger, 1992). Later on, feelings of jealousy and hatred are experienced towards the parent of the same sex. To reduce the anxiety, the infant makes even further symbolic equations. The developmental step of the Oedipal phase is that anger is directed towards real objects in relation to frustrations and it can finally be redirected to other symbols. As the infant becomes more able to deal with his own aggression, this leads to a capacity for sublimation (Weinenger, 1992).

Donald W. Winnicott and the romanticist viewpoint

For Winnicott aggression “begins in the womb and is a synonymous with activity and motility” (Abram, 1996). In the course of development, aggression changes its quality and this change is dependent on the kind of environment in which the infant grows. In an environment with good-enough mothering, aggression becomes integrated. In a depriving environment, aggression is manifested in destructive ways. In such a way, Winnicott strongly disagreed with Klein’s ‘death instinct’. Instead, he maintained that only under conditions of extreme maternal failure the infant might experience a ‘threat of annihilation’. This is a very real anxiety, which results from the failure of the mother to be ‘good-enough’ and to provide a facilitating environment (Winnicott, 1958).

For Winnicott what becomes aggression is at first inclination and wanting to join in, to explore and to contribute (Newman, 1995). In his first paper on ‘aggression’, Winnicott gives examples of how what he refers to as ‘primary aggression’ manifests itself in external relationships but at the same time, talks about an inner world where
aggression manifests itself through fantasy. Moreover, he explores the fantasy of destruction involved in primary aggression but differentiates it from the destruction that is acted out (Abram, 1996). In an attempt to describe 'primary aggression' Winnicott uses terms such as 'primary appetite-love', 'instinctual aggressiveness' and 'mouth love'. Thus, he explains that the aggressive behaviour of a child is never a matter solely of instinctual aggressiveness. In the same way, he continues by arguing that when the infant bites, it is usually excited rather than frustrated and although this might be seen by the observer as 'cruel, hurting or dangerous' from the infant this happens by chance (Winnicott, 1957). In other words, one of the most basic distinctions Winnicott makes is that there is no intent on the part of the infant to hurt the mother, or the good object. Therefore, earliest aggression is conceptualised as part of appetite and love, what he refers to as 'mouth-love' (Abram, 1996). Actually, Winnicott (1957) argues that as soon as the infant becomes aware of the fact that he can hurt then, immediately the inhibition of aggressive urges becomes active to protect what is loved and in danger. In such a way, one of the basic points of disagreement between Winnicott and Klein is that for the former instinctual aggressiveness is part of appetite whereas for the latter it is a projection of the death instinct. In addition, what Klein refers to as greed, Winnicott (1957) calls 'theoretical greed' or 'primary appetite-love' which although may be cruel, happens by chance.

**Winnicott's view of aggression in relation to emotional development**

In his 1950-54 paper, Winnicott makes a definitive statement about aggression. He argues that aggression can be traced at various stages of ego development:

- **Early**
  - Pre-Integration
  - Purpose without concern
- **Intermediate**
  - Integration
  - Purpose with concern
  - Guilt
- **Total person**
  - Inter-personal relationships
  - Triangular situations
  - Conflict, conscious and unconscious”

(Winnicott, 1958, p.205-206).
Early Stage
During the early pre-concern stage, Winnicott refers to ruthlessness and unconcern since the infant does not realise that what he destroys is the same object from which he obtains gratification. At this stage, aggression is seen as 'part of love' and the infant is not aware of his ruthlessness. Winnicott considers this stage as very important in emotional development given that there is a 'good enough environment' that can tolerate the infant's aggression. Otherwise if the infant has to hide his ruthless self, then the latter will become dissociated in later development (Winnicott, 1958).

Stage of Concern
This stage was described by Klein as the 'depressive position'. Winnicott was quite explicit about his preference to replace Klein's term by his own term 'stage of concern'. In this stage, as ego integration is sufficient for the infant to appreciate the mother figure as a whole, he experiences a sense of guilt for the damage he feels he has done to the loved person. This sense of guilt in the healthy infant leads him to discover his ability to give, construct and mend. In this way, aggression is transformed into social functions (Winnicott, 1958). Actually, in a talk given to the Progressive League in 1960, Winnicott suggested that this stage is characterised by aggression, guilt and reparation. In his talk, Winnicott acknowledged Klein's contribution in the area of human destructiveness. Moreover, he emphasised how constructive activity such as creative play, makes it possible for the child to get over the experience of his destructiveness (Winnicott, 1986).

Anger
Following his description of emotional development, Winnicott described anger at frustration, claiming that frustration as part of the human experience provokes both innocent aggressive impulses towards frustrating objects and guilt-productive impulses towards good objects. Then, he maintained that because of frustration splitting into good and bad might occur as a defence against guilt. Thus, in this point Winnicott appears to be in total opposition with Klein since for Klein the infant splits good and bad from the beginning, whereas Winnicott claimed that this splitting occurs only as a result of frustration or rather as a result of the outside world as opposed to the inner world (Abram, 1996).
Aggression in later stages of development

In a paper written in 1964, Winnicott explained how in later stages of development the child dreams as a more mature alternative to aggressive behaviour and that in dreaming destruction and killing are experienced in fantasy. Moreover, through play the child learns to accept the use of symbols. However, Winnicott never forgot to emphasise that in order for healthy development to occur, 'the good enough mother' has to take the infant through the difficult stages of early development and give the infant time to realise that the world is beyond his magical control. In this way, "aggression is actually seen as an achievement" (Winnicott, 1984, p.98).

Winnicott’s appreciation and criticism of the work of Klein

Winnicott (1986) stated that “it was Mrs. Klein who took up the destructiveness that is in human nature and started to make sense of it in psychoanalytic terms” (p. 80). However, despite his appreciation of Klein’s contribution, Winnicott had strong disagreements with her theory, which can be summed in the following: for one thing, he claimed that the word ‘envy’ could not be used for the description of the early infant life and secondly, that the idea of inherited aggression completely overlooked the interplay between personal and environmental factors (Winnicott, 1989). In such a way, Winnicott argued that what Klein calls envy of the good breast, should be called intolerance of an external representative for something, which initially is felt to be part of the self. Thus, in his view the infant cannot be said to experience envy of the good breast but instead, anger with the mother for her technical failure. In addition, he argued that since the mechanism of ‘projection’ is operating, the infant experiences the good breast as a projection of the self –provided that the mother is good enough and thus, meeting the projection. In Winnicott’s (1989) words, “there is no room for envy here” (p. 453).

As far as Klein’s proposition that aggression is inherited, Winnicott argued that it even lacked in scientific validity. In his view, to argue that since everything is inherited, some persons might be born with more innate aggressiveness begged the whole question of aggression and its evolution in the developing individual (Winnicott, 1989).
Clinical Implications of Klein's and Winnicott's theories on aggression

The Kleinian analyst

As it has been presented in detail throughout this paper, according to Klein's view of development, humans are essentially aggressive and destructive beings. In such a way, through psychoanalysis, children and adults can work through the conflicts and anxieties experienced during the first year of life (Klein, 1975) and thus, can successfully adapt to the given reality. In some ways, the psychoanalytic frame reflects this reality since, rules and regulations are a given. As a result, the Kleinian analyst focuses on the ways in which 'patients' refuse to accept the frame of psychoanalysis.

And what techniques does the Kleinian analyst use to help the patient adapt to reality? Klein herself has suggested that the analyst should constantly interpret the patient's destructiveness, envy and hidden guilt and also stick to the givens of the frame as close as possible. In Klein's words:

"It is surprising how sometimes children will accept the interpretation put forward with facility and even marked pleasure. The reason is that (for young children) communication between the conscious and the unconscious is yet comparatively easy" (Klein, 1969, p.30).

Moreover, Klein maintained that only after very strong and obstinate resistances have been surmounted the child would be able to see that his aggressive acts were aimed at the real, human object.

The main principles of both child and adult analysis as put forward by Klein are consistent interpretation, steady resolution of resistances and constant reference back to the transference (Klein, 1969). According to the Kleinian analyst, the infant's total dependence is recreated through the analytic situation and so are envy, rage and destruction. Thus, any kind of protest put forward by the patient is identified as an attempt to destroy the analyst's analytic capacity or as a denial of the patient's dependence (Strenger, 1997).
The Winnicottian analyst

For the followers of Winnicott, human nature is essentially innocent, and environmental failure is what spoils this innocence (Strenger, 1997). Throughout Winnicott’s theories the parallel between the growth of the child in a ‘good enough environment’ and the course of effective therapy, is evident. Thus, the Winnicottian analyst provides space with secure boundaries so that trust in the relationship can be experienced. Like the ‘good enough mother’, the analyst has to adapt to the patient’s needs and to what a patient can take or wants. Thus, the impingements of the external world are experienced in ‘small doses’, and the analyst lets the patients discover for themselves (Jacobs, 1995).

Since for Winnicott the reality principle involves the individual in anger and reactive destruction, in the analytic setting the patient’s destructive activity is an attempt to place the analyst out of the area of omnipotent control (Winnicott, 1971). The issue then is whether the analyst is going to survive the patient’s attacks or not. After all, it was Winnicott’s belief that positive changes in psychoanalysis do not depend on interpretative work but rather on the analyst’s survival of the attacks. Actually, Winnicott has argued that when the analyst in this occasion makes interpretations, he can spoil the process for the patient. Of course, Winnicott also emphasises that equally important to the survival of the analyst is the absence of any attitude which reflects retaliation. For Winnicott this process of destruction and survival is reflected in the following quotation:

“Hullo object! I destroyed you. I love you. You have value for me because of your survival of my destruction of you ...’ (Winnicott, 1971, quoted in Burack, 1993, p.439).

Actually, Winnicott has even made an analogy between the therapist and a human basket where the clients can put all their eggs, testing out to see whether he will be reliable or whether, he will repeat traumatic experiences of the past. Finally, Winnicott’s view of the role of the analyst is summed up in some of the following guidelines quoted below:
“You get to know what it feels like to be your client.
You become reliable for the limited field of your professional responsibility.
You concern yourself with the client’s problem.
You accept hate and meet it with strength rather than with revenge.
You tolerate your client’s illogicality, unreliability, suspicion, muddle, fecklessness, meanness, etc. etc., and recognise all these as symptoms of distress” (Winnicott, 1965, p.229).

Final remark

If one attempted to reach a conclusion about the epistemological validity of these two theories on aggression, one would be bound to come up with criticisms about both Klein’s and Winnicott’s theoretical positions. Indeed as Winnicott had pointed out Klein overlooked the impact of environment on human aggression. Actually, Klein always warned against the overestimation of external factors. At the same time, she seems to have argued that the part played by internal factors is greater in favourable experiences rather than in experiences of deprivation. In that way, one arrives at the paradoxical conclusion that arises from her conceptions – which is that unfavourable external factors have a greater effect than do favourable ones. This would stem from Klein’s assertion that innate quantities of aggression can be increased by deprivation, whereas real satisfactions have no effect on gratitude and love. Of course, this assertion leads to an even more important contradiction that is inherent in her writings. Since Klein has never referred to any notion of a favourable change determined by experience, it is difficult to understand how she might have accounted for the therapeutic change, which occurs through psychoanalysis (Petot, 1991).

On the other hand, a Kleinian analyst might criticise Winnicott for having presented a very benign view of the baby and having at the same time, idealised the mother. Actually, the overemphasis that Winnicott has given on the concept of the ‘good enough mother’ has been a ground for which he has been criticised by feminist psychology for decades. According to Segal, “Winnicott becomes quite persecuting to real mothers, who find no recognition of their badness or discomfort” (quoted in
Jacobs, 1995, p.108). Finally, with regards to the therapeutic relationship Winnicott has been criticised for having idealised the holding and protective function of therapy. At the same time, since Winnicott emphasised the significance of adaptation to the client's needs, other psychoanalysts have argued that he did not take into consideration the therapist's needs (Jacobs, 1995).

In the end, the informed reader can reach a conclusion on his own about which view of human aggression more accurately reflects reality, always keeping into consideration that classicism and romanticism are two different experiences of life. Thus:

"Their validity is to be sought in the extent to which individuals can recognise their lives under these descriptions, and the therapeutic effectiveness of the therapeutic approaches based on these visions" (Strenger, 1997).
References


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

**Counter-transference and the therapeutic relationship**

It has been almost a century since Freud (1910) first came up with the concept of 'counter-transference' to describe the feelings that arise in the analyst as a result of the patient's influence on his unconscious feelings. According to Freud, counter-transference should be recognised and monitored or else it could become a hindrance for a patient's analysis. However, although once considered a stepchild or an unwelcome guest of psychoanalysis, counter-transference has witnessed a surprising turnaround, moving at the heart of psychoanalytic debates over the past decades (Wolff-Bernstein, 1999). Having referred to the popularity of the concept, Jacobs (1999) suggested that, for the future historian of psychoanalysis, the latest part of the twentieth century might be designated as the 'counter-transference years.' What is it then about this concept that has stirred up so many debates in the field of psychoanalysis over the years?

There is no simple answer to this question. One might argue that one of the primary reasons for which 'counter-transference' as a concept has been so controversial is related to its power to potentially undermine psychoanalysis' claim for scientific respectability. Another reason might be that depending on where one stands on the counter-transference debate, there are significant implications for his or her understanding of psychoanalytic theory and practice. Other controversies in psychoanalysis, such as whether the therapist should adhere to the principle of 'neutrality' and adopt a 'blank screen' approach or whether he or she should engage in a more human relationship with patients are closely linked to beliefs about 'counter-transference' both in terms of its operational meaning but also, in terms of its therapeutic utility.

This paper has been written in an attempt to discuss different views on 'counter-transference'. As the definition of the concept has changed remarkably since Freud (1910) originally introduced it one single definition is not going to be provided. Instead, the potential reader will be provided with different definitions of the...
concept, in the discussion of the ways in which different schools in psychoanalysis have implemented it. After all, at the core of the debates over counter-transference lies the issue of its definition. For the purpose of this paper, different views on counter-transference have been organised in three main positions, namely the scientific, the middle and the humanistic positions. This distinction is rather arbitrary and the categories themselves are non-exhaustive. Instead, it is merely an attempt to classify the central assumptions that different theorists make for the therapeutic relationship and consequently, their position on counter-transference.

**The scientific position**

The main principles of the 'scientific' position are neutrality on the part of the therapist and strict adherence to the therapeutic frame. According to this position, counter-transference is seen as disruptive, with its detection and elimination being necessary to relieve the blockage of therapy (Natterson, 1991). Thus, it is argued that the concept of counter-transference should return to its original definition as provided by Freud and thus, regain its original critical significance (Smith, 1991). This position has been distinguished as 'scientific', since it argues in favour of control of the therapeutic frame in a similar way that researchers argue in favour of total control of variables in experiments. In other words, its emphasis lies on using the scientific method in pursuit of the 'truth'. The first advocate of this position was evidently Freud, who stated that the analyst should be "opaque to his patients like a mirror and show them nothing but what is shown to him" (Lane & Storch, 1986, p.34). Just as transference was initially regarded by Freud as a hindrance to the patient's ability for free association, counter-transference was regarded as an obstacle to the therapist's ability to understand the patient. However, unlike transference Freud never regarded counter-transference to be a useful therapeutic tool (Sandler, Dare, & Holder, 1992). It should also be clarified that for Freud, counter-transference was a classificatory rather than an explanatory concept. Thus, it was conceptualised as being a behaviour, instead of the cause or explanation of a behaviour (Smith, 1991). This distinction is a crucial one given the position that other psychoanalytic schools have taken on the concept's meaning, as it will be discussed later in this paper.
Another advocate of the scientific school was Annie Reich. In three influential papers (1951, 1960, 1966), she clarified the view of counter-transference that existed among traditional analysts. At the time that she published these papers in the United States, in Europe there was already a trend towards the opposite direction - that is towards considering counter-transference a useful tool in therapy (Jacobs, 1999). Reich acknowledged that counter-transference is inevitable. However, she suggested that it should be mastered, as it represents the arousal of conflicts in the therapist that interfere with his or her ability to hear and respond to patient's unconscious communications.

One of the most passionate advocates of the concept of therapist 'neutrality' and the need for strict adherence to the boundaries as defined by the therapeutic frame is Langs (1978) and the communicative school in psychoanalysis. In putting forward the concept of the 'bipersonal field' he conceptualised counter-transference as an interactional phenomenon and not solely in the realm of either the patient or the therapist. The 'bipersonal field' refers to the temporal-physical field within which the therapeutic interaction occurs. This view is more egalitarian in that it points out that perception of unconscious communication is not only the therapist's privilege. Smith (1991) explained how Langs offered another alternative to the dominant views that counter-transference is either pathological or useful. The third alternative was a notion encompassing the therapist's ongoing pathology. Thus, Langs replaced the term of counter-transference with that of 'therapist madness'. According to the communicative approach, therapists must be ready and willing to confront their madness because their patients reflect the madness back to them through their unconscious communications. For Langs then, the extent to which a therapist is able to manage the ground rules of the therapeutic frame is a clear indication of his or her madness or sanity (Smith, 1991). What is implicit in this approach then, is that a therapist can never be free from neurotic conflicts but that through adherence to the principle of neutrality and the maintenance of the frame, these conflicts are monitored and do not stand as an obstacle to a patient's treatment.
The middle position

According to the middle position, there are two different kinds of counter-transference. Counter-transference is seen as both neurotic and potentially damaging if not analysed and eliminated or reduced but also as providing therapeutic understanding of basic importance, thereby adding greatly to the process of therapy (Natterson, 1991). This position suggests that the therapist should be able to distinguish between feelings that are stirred up in him or her because of his or her personal conflicts but also, be in tune with feelings that are stirred up that are directly related to the patient's personality. While the former should be monitored and explored through the therapist's personal analysis, the latter constitutes a valuable tool into the patient's unconscious.

Stern (1924) first spoke of two kinds of counter-transference - that stemming from the therapist's personal conflicts and that arising in response to the patient's transference. He argued that while the former constitutes an obstacle in therapy, the latter is useful in promoting deeper understanding. For Stern, the therapist must meet the patient's transference with a transference of his or her own thereby, allowing his or her unconscious to resonate with that of the patient in order to grasp the latter's unconscious communications (Jacobs, 1999).

Winnicott (1949) also, distinguished the idiosyncratic from the therapeutically useful counter-transference by suggesting that some counter-transference reactions were objective responses to the qualities of the patient and not neurotic in origin. In that way, he went beyond the traditional view and legitimised counter-transference feelings by making an excellent case for their therapeutic usefulness (Epstein & Feiner, 1988). Specifically, Winnicott emphasised the important role that negative counter-transferences play in the treatment of disturbed patients by discussing how certain patients arouse intense hate in the therapist and by suggesting that for these patients the evocation of hatred is a necessary part of their treatment. In a way similar to Stern (1924), Winnicott distinguished between the objective and subjective components of counter-transference.
Heimann (1950) wrote one of the most influential papers on counter-transference. She provided a definition of counter-transference to cover "all the feelings that the analyst experiences towards his patient" (p. 81). Her basic assumption was that the therapist's unconscious understands that of the patient and that the therapist must use his or her emotional responses to the patient - that is his or her counter-transference - to understand the patient. Thus, counter-transference was presented as a creation of the patient's inner world rather than a manifestation of the therapist's conflicts. Of course, in the end of her paper Heimann warned that her approach is not without danger in that it could be used to rationalise the therapist's shortcomings. However, she maintained that if the therapist had worked through his infantile anxieties and conflicts in his own analysis, he or she would not impute to the patient what belonged to himself or herself. Hence, Heimann acknowledged the possibility that counter-transference could also be a manifestation of the therapist's unresolved conflicts when he or she has not managed to satisfactorily work them through in analysis. She also suggested that counter-transference feelings are of value to the patient if used by the therapist as insight to the patient's unconscious and defences. However, she never suggested that these feelings should be communicated to the patient. The communication of these feelings, in her view, would be a burden to the patient. Overall, the main emphasis of her paper was on the therapeutic value of counter-transference as a key to the patient's unconscious.

Another advocate of the middle school in the United States was Kernberg (1965), who attempted to integrate competing views on counter-transference. On the one hand, he argued that the broadening of the term to include all emotional responses in the therapist would add to the confusion and cause the term to lose its meaning. At the same time, he also argued against older views that suggested counter-transference was indicative of a 'blind-spot' in the therapist. He agreed with Winnicott (1949), in that he believed that the full use of the therapist's emotional response can be of diagnostic importance in the assessment of patients suffering from severe personality disorders or psychotic patients (Sandler, Dare, & Holder, 1992).
The humanistic position

The humanistic position places special emphasis on the human, real relationship between the patient and the therapist. In such a way, counter-transference is seen as an inevitable and normative phenomenon. Every therapist is believed to have abundant idiosyncratic responses to every patient, which play a fundamental role and shape the process of therapy (Natterson, 1991). Concepts such as the 'analyst's pathology' (Little, 1951) and the 'wounded healer' (Jung, 1976) are put forward as it is implied that the therapist's own hurt gives him or her the ability to be able to 'cure' (Sedgwick, 1994). Within this position, there are more radical thinkers who argue that sometimes it is therapeutically valuable to communicate counter-transference feelings to the patient (Maroda, 1991).

Ferenczi (1919) was the first one to advocate much greater involvement between patient and therapist and specifically, to argue for disclosure of some of the therapist's subjective experiences. He also experimented with mutual analysis, with the patient for some time becoming the therapist's therapist. These views of course, being rather radical for their time remained outside of the mainstream of classical analysis for many decades (Jacobs, 1999).

Little (1951) placed the therapist's counter-transference at the centre of therapeutic work with severely disturbed patients. She suggested that not only does the therapist hold up a mirror to the patient but that the patient also, holds one up to the therapist. In addition to the fantasies a patient might have about his or her therapist, the patient also becomes aware of real feelings in the therapist even before the therapist is even fully aware of them (Epstein, & Feiner, 1988). For Little, counter-transference inevitably contains a mixture of pathological and normal elements derived from the psychologies of both patient and therapist. In that sense, her view is closer related to that of the middle position. However, her suggestions about the handling of counter-transference contributed to her discussion in the humanistic part of this paper. Little believed that when a therapist makes a mistake, for example, when an interpretation is wrongly emphasised, the therapist should admit this error to the patient - and unless this is contraindicated - explain its origin in his or her unconscious counter-transference. Thus, she was the first radical in favour of
disclosure of counter-transference in certain cases and in a paper she published in 1957 she even argued that the success of an analysis depended on satisfactory working through of the therapist's pathology (Jacobs, 1999).

As early as the late thirties, Sullivan (1953) had introduced the concept of 'participant observation'. Applying this concept to psychoanalysis Sullivan presented the notion of the therapist as participant observer, whose task is to concentrate on how to optimise his or her participation for the patient's benefit. One might claim that Sullivan humanised the therapist by pointing to the significance of the therapist as a 'real object'. In doing so, he rejected the idea of the neutral and anonymous therapist as a position impossible to maintain.

Racker (1953, 1957) was the first one to refer to the relationship between unconscious perception and counter-transference. For Racker there are many psychological similarities between patient and client, as they both have mature and infantile aspects to their personalities. Thus, he claimed that it is a distortion of the truth to argue that in therapy, there is an interaction between a sick person and a healthy person. Racker also criticised Heimann's views as he considered them one-sided and not taking into account how in the same way that counter-transference is a 'creation' of the patient's unconscious, transference is a creation of the therapist's unconscious (Smith, 1991). Thus, it was Racker who first placed emphasis on the interactive dimension of the therapeutic relationship and its implications for our understanding of concepts such as 'transference' and 'counter-transference'.

Searles (1975) also being influenced by the interpersonal school noted that patients intuit much about their therapists. For Searles all people possess an innate need to heal or cure others and the lack of fulfilment of this need during childhood is the main cause of emotional disorders. Thus, he argued that for patients to benefit from therapy they must have the opportunity to act as therapists to their own therapists (Smith, 1991).

Jung (1976) argued not only that the patient may intuit the therapist's own ways of approaching problems but also, that in a similar way the therapist should not and indeed cannot remain unaffected by the patient. In Jungian analysis, great emphasis
is placed on the therapist's vulnerability in that it is no longer the therapist's knowledge or mental health that is the major determinant of therapeutic effectiveness but rather the therapist's own hurt that gives the measure of his or her power to heal (Sedgwick, 1994). The archetype of the 'wounded healer' is very present in the Jungian school as it is maintained that the patient's illness must activate the personal wounds of the therapist who, in order to help the patient, "must show him the way, thus, being simultaneously a guide, a role model and a catalyst for the patient's inner healer" (Sedgwick, 1994, p.26). This is evidently the completely opposite view to that of the 'scientific position' which speaks of the importance of the therapist's neutrality in the therapeutic relationship.

Some final thoughts

As it was mentioned in the beginning of the paper, the above classification of theorists into different positions on the issue of counter-transference is rather arbitrary and does not cover all the different dimensions of the debate. For example, while Langs (1978) has been placed on the scientific position, whereas Searles (1975) and Little (1951, 1957) have been placed on the humanistic position, these theorists share a common understanding of notions of unconscious communications, in that they all maintained that it is not only the therapist's privilege to be able to perceive the patient's unconscious communications but that the opposite is also the case. In a similar fashion, all schools accept the fact that therapists are 'wounded healers' in that they have experienced and hopefully worked through their own neurotic conflicts. What differs is the extent to which they consider these human characteristics of therapists as useful in terms of their utility in treatment.

More specifically, communicative psychoanalysts following Langs accept the presence of 'therapist madness', which is the term they use instead of the term 'counter-transference'. However, they believe that its presence in therapy should be eliminated and that when this does not happen successfully, the client will unconsciously perceive that and communicate it back to the therapist by means of a narrative. It is my understanding that communicative analysts do not assign any value to this process. Whereas the 'wounded healer' school refers to the therapist's wounds as being the means through which he or she is able to help his or her
patients, the communicative approach maintains that the wounded healer although a reality, should keep his or her own wounds aside and focus on those of the patient's. Thus, any disclosure of counter-transference feelings is considered inappropriate, as it would result in the therapist hijacking the patient's space (Smith, 1991). Moreover, the communicative school has spoken of therapists' defensive needs and how through the decades the concept of counter-transference has been used to alleviate therapists' fears of their own pathology.

It is my own understanding then, that there is an explicit need to acknowledge the reality of personal limitations on the part of therapists. As Racker (1968) stated:

"We should accept the fact that we are still children and neurotics even though we are adults and analysts"

(p.130).

And here is where my disagreement with the communicative approach, lies. It is my view that the pursuit of therapist neutrality is rather illusory. No matter what approach a therapist takes, one always runs the risk of distorting the transference to match one's intellectual views about treatment. Thus, by the mere use of a specific theory to analyse a patient's behaviour, a therapist stops being neutral. The counter-argument then might be that neutrality is advocated only in relation to the way a therapist behaves in the room. Almond (1999) has discussed in detail how every action of the therapist -even the silence- is an influence on the patient. In his paper, he also explained that therapists have expectations regarding both creating an optimal analysing situation and also, influencing that particular person's neurosis. It is his view that a therapist would not make an intervention unless he or she wanted to have some kind of impact. Winarick (1997) has also examined how the therapist's basic goal, which is to acquire insight into the patient's mind is in itself an expectation, which influences the patient's behaviour. It is my position that unless one can explain how therapist's expectations do not prevent the achievement of true neutrality, the concept of neutrality should be considered unattainable. As Wolff Bernstein (1999) suggests:
"One gains the impression that the idea of the neutral analyst was just a tease - a decoy to deflect from the intensely personal nature of the psychoanalytic encounter and lend it aura of scientific respectability" (p.280).

And as Maroda (1991) argued, the notion of the 'incognito therapist' who hides from the patient, encourages the patient to hide from him. If neutrality is a myth, then what is the alternative? It is my opinion, that hiding from the patient does not further the uncovering of truth. Thus, a therapist needs to find a balance between over-involvement and distance from the patient as he or she needs to find a balance between intense intimacy and respectful formality. There are times when even disclosure of counter-transference might be therapeutic. As Maroda (1991) suggests:

"The therapist must disclose whatever is necessary to facilitate the patient's awareness and acceptance of the truth. The timing, nature and extent of the counter-transference disclosure can only be determined in consultation with the patient" (p.87).

Otherwise, without any disclosure on the part of the therapist, the most important information about the patient remains exclusive to the silent domain of the therapist.

It is my position that the therapist's personality is one of the most important agents of therapeutic change. Together with the patient's personality it is what shapes the therapeutic process. However, the therapist should always keep in mind that the leading actor is the patient and his or her position is that of a listener and interpreter of the actor's performances. In Wolff Bernstein's (1999) words, the therapist should be aware of the influence he or she exerts on the performance and use the effects within the relationship to comprehend the play but never mistake oneself for one of the prime actors.
References


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

What accounts for therapeutic change in cognitive therapy?

Cognitive therapy has for a long time been associated with the development of a range of therapeutic tools and techniques. Whereas in most other therapeutic orientations, the therapeutic relationship is considered to be a central curative factor in the process of therapy, cognitive therapists have traditionally emphasised that the active components of treatment are what brings about therapeutic change (Persons, 1989).

In recent years, psychotherapeutic psychology has elevated the centrality of the therapeutic relationship to the heart of practice. This has occurred as a result of research that confirms that there are identifiable components of good quality therapeutic relationships and it is the presence of these components that is statistically correlated with successful therapeutic outcomes (Burns & Noel-Hoeksema, 1992; Horvarth, 1995; Horvath & Symonds, 1991; Wright & Davis, 1994). Despite this current trend, the view that in cognitive therapy therapeutic change is dependent on the active components that challenge the client's faulty appraisals as opposed to the therapeutic relationship per se is still widely held.

This paper is written in an attempt to discuss how different cognitive therapists have conceptualised what leads to therapeutic change. Hence, the traditional model of cognitive therapy as formulated by Beck et al. (1979) and Ellis (1972; 1994) will be presented in order to demonstrate the position that the main agent of therapeutic change is the use of specific skills and tools to resolve the client's dysfunctional beliefs. Furthermore, this paper will discuss how recent models of cognitive therapy have acknowledged the significance of the therapeutic relationship and emphasised that the relationship itself can be used as a tool for therapeutic change (Jacobson, 1989; Safran & Segal, 1990; Young, 1994). Special attention will be paid to the historical context in which these developments have taken place such as the
influence of the interpersonal perspective within cognitive therapy (Safran, 1990; Saffran & Segal, 1990).

**Therapeutic change is dependent upon the active components of therapy**

Cognitive therapy is based on a view of psychopathology that explains people's excessive affect and dysfunctional behaviour as originating from excessive or inappropriate ways of interpreting their experiences (Weinrach, 1988). In such a way, one of the aims of cognitive therapy is to examine the meaning that clients attach to situations and emotions and challenge clients' faulty appraisals. Wills and Sanders (1997) provide different examples of how particular types of appraising thoughts, lead to particular emotions, which in turn, influence our behaviour. More specifically, they describe how the appraisal of danger can invoke anxiety feelings and prime us for defensive reactions, whereas, the appraisal of loss is more likely to raise sadness and depressive reactions. According to the cognitive model, it is not the responses to the appraisals that are necessarily dysfunctional. It is when the appraisals themselves become exaggerated or out of proportion to certain situations, that they become problematic to the individual. Thus, the task of cognitive therapy is to try to understand why particular clients appraise events in certain exaggerated ways. In that respect, cognitive therapy is a rather individualistic approach, as it tries to understand a person's idiosyncratic way of appraising events. What follows the understanding of clients' faulty appraisals is the process of identifying and labelling negative automatic thoughts and the patterns in which they interact with emotions and behaviour. This is essential so that the client can begin to understand his or her emotions.

'Negative automatic thoughts' are cognitions that represent that aspect of conscious knowledge which is not part of logical thinking, but which occurs automatically. Another deeper cognitive structure is 'schemata' which reflect fundamental beliefs about oneself, the world and others (Blackburn & Twaddle, 1996). Schemata incline the person to interpret events in relatively fixed patterns, as they constitute a transformation mechanism that shapes all incoming data so that they fit and reinforce preconceived notions (Beck et al., 1979). To demonstrate how schemata work, Wills and Sanders (1997) use the example of how a person who has a
‘mistrust’ schema reacts to untrustworthy behaviour by concluding that their schema was confirmed in that ‘others cannot be trusted’. This is undoubtedly a maladaptive response, as it constitutes an overgeneralisation. If, on the other hand, the same person encounters trustworthy behaviour he or she is likely to consider it an exception to the rule, thereby still maintaining the existing schema of ‘mistrust’. Beck et al. (1979) have spoken extensively about how certain information-processing mechanisms aid with the distortion of experience so as to fit prior preconceived notions.

The final link in this model of emotional disturbance is the role of behaviour in the maintenance of the vicious cycle. According to Wills and Sanders (1997), often a client has an immediate behavioural response to a certain situation without being aware of the thoughts or feelings that are associated with this response. Hence, one of the tasks of the cognitive therapist is to help the client become aware of the accompanying thoughts and feelings that go with the behaviour, in order to make this process less automatic.

So what is the role of the therapeutic relationship in the traditional model of cognitive therapy? Beck et al. (1979) first came up with the idea of the ‘collaborative relationship’ meaning that client and therapist work together in an atmosphere of negotiation, as the client provides information to be investigated with the therapist’s help. In that respect, the therapist and the client form a team and the relationship itself is used as a means to an end, which is the accomplishment of specific goals. The main aim of this kind of relationship is to develop the appropriate environment so that therapeutic techniques can be applied more efficiently. Thus, the emphasis is on a working relationship, which constitutes the context for the execution of technical interventions.

However, it should be noted that Beck’s model did not underestimate the significance of the core conditions of empathy, genuineness and unconditional positive regard as conceptualised by Rogers (1957). The main way in which his view of the therapeutic relationship differed from Rogers’ is that Beck considered a good therapeutic relationship to be a necessary but not sufficient condition for change. In addition, Beck et al. (1979) maintained that other conditions that are necessary for a good
therapeutic relationship are collaboration, trust and rapport. In this model, difficulties in the therapeutic relationship, such as the occurrence of 'transference' are considered technical problems that need to be identified in a similar way to other cognitive data. Once identified the emphasis is placed on minimising their occurrence. Hence, in total contrast to their psychodynamic counterparts, cognitive therapists did not consider the therapeutic relationship as a potential tool that could be used in the service of therapeutic change but instead paid more attention to technique (Blackburn & Twaddle, 1996).

As it will be discussed in the latter section of this paper, in more recent models of cognitive therapy this original view of the therapeutic relationship has changed significantly. However, nowadays there are still models of cognitive therapy that overlook the usefulness of the therapeutic relationship. Specifically, rational emotive behaviour therapy, which constitutes a branch of cognitive therapy, still places major emphasis on individuals' irrational beliefs. Ellis (1997) suggests that unless clients are willing to recognise the dysfunctional philosophies that govern their lives and work hard to replace them, they can rarely get better.

To further support the view that the main agent of therapeutic change is not the therapeutic relationship but effective skill and technique, Ellis (1999) provides numerous examples of how over the centuries, millions of people have benefited and sometimes radically changed by listening to a lecture, reading a book or having some dramatic or even everyday experience. Hence, he demonstrates how a therapeutic relationship or the presence of any relationship is not necessary in the promotion of change.

According to Ellis (1999), whereas a good therapeutic relationship might contribute to clients feeling better, it is not sufficient to make clients get better. In other words, real therapeutic change can only originate from a good theory of what constitutes disturbance in conjunction with effective techniques of applying this theory. In this particular model, the role of the therapist is that of a persuasive teacher and the task of therapy is not only to teach clients how they can make themselves less disturbed but also, to teach them how to get there.
This section discussed how older and one recent model of cognitive therapy consider that effective skill and technique are the main agents of therapeutic change. The role of the therapeutic relationship in providing the context for the efficient execution of techniques was also explored.

**The use of the therapeutic relationship as an active agent in therapy**

In recent years, a major development has occurred within cognitive therapy, which was marked by the emergence of cognitive-interpersonal perspectives (Safran, 1990; Safran & Greenberg, 1988; Safran & Segal, 1990). This development has made the debate about the changing emphasis on the therapeutic relationship in cognitive therapy a very pertinent one.

According to the interpersonal model, the therapeutic relationship can be a crucial tool for revealing the client’s core dysfunctional interpersonal schemata (Blackburn & Twaddle, 1996). The assumption here is that, as other therapeutic models have for long pointed out, there is a strong relationship between the interpersonal factors outside the therapy situation and those within (Wills & Sanders, 1997). These ideas have strong influences from the field of developmental psychology and specifically the work on attachment (Ainsworth, 1982; Bowlby, 1969, 1973, 1980). Taking into consideration how powerful the human need for relatedness is, this model maintains that many of the key core beliefs and assumptions that individuals hold about the world are likely to be interpersonal. Safran and Segal (1990) suggest that attachment schemata are internalised and become stable, most of the time irrespectively of subsequent experience. In that way, they constitute an individual’s ‘cognitive-interpersonal style’, which determines the way in which the individual interacts with other people. This fixed way of interacting with people will most likely be repeated in the therapeutic relationship itself in the way the client will interact with the therapist. So how can the therapist then use what happens in the relationship in the service of therapy?

*Using the relationship to aid understanding*

The client’s behaviour within the therapy can provide the therapist with important information about how the client behaves outside therapy and about the nature of
his or her underlying difficulties (Persons, 1989). The therapeutic relationship is a place where the client may engage in a variety of schema-driven behaviours that mirror the client’s psychological make-up. It is the therapist’s task to be able to conceptualise the client’s pathology based on the client’s behaviour within the therapeutic relationship.

There are different examples of how certain behaviours within the session can be fairly indicative of underlying pathology. If we consider a client who regularly comes late for sessions or might tend to miss sessions often, then we can hypothesise that this client might have some underlying fear of dependency on the therapist. From this piece of information, we can then deduce that this person is likely to employ similar mechanisms in order to keep at a safe distance from others in his or her everyday life in an attempt to compensate for this fear of becoming dependent in relationships.

Another way in which the therapeutic relationship can aid conceptualisation is through the monitoring of the therapist’s feelings and behaviours in response to the client. Sometimes clients who have strong dependency feelings might make the therapist feel annoyed and resentful. It is very important for the therapist to be able to examine these feelings, as they can be very helpful in understanding how others in the client’s environment are likely to feel (Persons, 1989).

Special attention should be paid, however, to the feelings that might arise in the therapist that originate from the therapist’s own schemata and experiences. Safran and Segal (1990) have suggested that the therapist needs to be flexible enough to be able to acknowledge the role his or her own feelings play in the therapeutic interaction. In addition, the therapist, while participating in the therapeutic relationship, needs to be also able to maintain sufficient distance from it so that he or she can also act as an observant. Only then it becomes possible for the therapist to use the relationship in a way that aids real understanding of the client.

*Using the relationship as a tool for change*

Apart from offering information that aid the therapist with the conceptualisation of the client’s difficulties, the therapeutic relationship can be used directly as a tool for
change. According to Persons (1989) clients with different problems need different types of relationships with their therapists. For example, if a client has a fear of loss of autonomy they might need a more distanced therapeutic relationship as opposed to another client who might feel the need for interpersonal closeness. The only difficulty in the application of this approach is that especially in the beginning of therapy, the therapist might not have enough information to arrive at a formulation of what an individual client needs. However, when the therapist is attuned to the clues clients give regarding their interpersonal needs, he or she can obtain this essential information even with the first contact.

To support the view that therapist flexibility promotes change is not to say that the therapist should become drawn into a mode of interaction that reinforces the client’s pathology though. To get drawn into reinforcing a client’s pathological set of beliefs would definitely undermine the therapy. In that respect, a therapist should both be in tune with the client’s needs in order to facilitate a therapeutic environment that promotes change but also be careful not to reinforce those needs. Instead, both therapist and client should be working together to observe what is going on and offer solutions to the problems and difficulties facing the client (Wills and Sanders, 1997).

Even the emergence of difficulties in the therapeutic relationship is not seen as an obstacle, which needs to be removed before real therapeutic work can start. Instead it is seen as an opportunity, since the work that attempts to understand the patterns of interaction in the therapeutic relationship is considered central to the process of change (Persons, 1989).

In such a way, the therapeutic relationship becomes an active ingredient in therapy (Beck et al., 1990; Safran & Segal, 1990; Young, 1999), as it can provide a safe space in which the client can experiment with new behaviours and emotions. For example, for a client who has a difficulty expressing anger towards other people, the therapeutic relationship might constitute a safe space where he or she can test out this new behaviour. Young (1999) has described how the therapeutic relationship can offer the client a corrective emotional experience or some form of re-parenting, where existing schemata can be directly challenged. Hence, when clients manage to
resolve the difficulties they might encounter in the therapeutic relationship, they are also, acquiring a new model for solving other relationship difficulties.

This interpersonal perspective in cognitive therapy is beneficial when working with most client groups but even more so when working with clients diagnosed with personality disorders (Beck, et al., 1990). After all, difficulties in interpersonal relationships and hence, dysfunctional interpersonal schemata, are characteristic of most personality disorders. Therefore employing more traditional models of cognitive therapy that make no use of the therapeutic relationship is usually ineffective with this population. According to Young (1999), in these cases, the directive phase of the cognitive model might need to be postponed until a considerable time has been dedicated to the development of the therapeutic relationship.

This section discussed how more recent models of cognitive therapy have acknowledged the significance of the therapeutic relationship both as an aid to conceptualisation but also, as an agent of therapeutic change. Specific examples attempted to demonstrate how the therapeutic relationship can be used as an active component in therapy. There was also a discussion of how specific client groups might benefit more from the interpersonal perspective in cognitive therapy.

**What finally accounts for therapeutic change in cognitive therapy?**

This paper has explored how different schools of cognitive therapy have conceptualised what brings about therapeutic change. In the field of cognitive therapy the debate, about whether it is the active components of therapy or the therapeutic relationship that accounts for successful therapeutic outcomes, still continues.

Is this debate ever going to be resolved? One might say that part of the difficulty in resolving this debate is that the two different standpoints reflect different points of direction in which a therapist can proceed. Traditional cognitive therapists usually choose to work at a symptom level and thus, take a ‘bottom-up’ approach with clients’ difficulties. In this model, therapeutic change is indeed dependent on the active components of therapy and the therapeutic relationship serves as a context
that allows for the application of techniques. On the other hand, those cognitive therapists who work from an interpersonal perspective take a ‘top-down’ approach, using the therapeutic relationship as a tool to access deeper assumptions, core beliefs and schemata (Wills & Sanders, 1997).

In the end, what accounts for therapeutic change in cognitive therapy? Is it the active components or the system of delivery? There is no single answer to this question, perhaps because they both go hand in hand. The tools of cognitive therapy are necessary but not sufficient for therapeutic change and the same holds true for the therapeutic relationship.


With reference to the standard psychiatric classificatory schemes (DSM IV and ICD 10) discuss the various possible diagnoses that might be considered in this case. From the case material, outline the most likely diagnosis and say why you think the client fits into this particular category. Also include a brief discussion of any further information or assessments that you might think necessary in this instance.

In this report there will be a discussion of the different diagnostic considerations related to the case study (see Appendix). The diagnostic instruments that will be used to that effect are both DSM-IV (APA, 1994) and ICD-10 (World Health Organisation, 1993). Also, relevant literature will be utilised to support the acceptance or rejection of various diagnoses related to the case. In the end, there will be a discussion of further assessments that might be necessary for this case.

From all the information provided about Alice's symptomatology, the diagnosis of borderline personality disorder coded on Axis II (DSM-IV) and emotionally unstable personality disorder (borderline type) on ICD-10 seem to be the most appropriate. To support this statement, it will be demonstrated how Alice exhibits most of the symptoms associated with the above diagnosis such as instability in interpersonal relationships, extreme attempts to avoid real or imaginary abandonment and instability in affect, manifested in fluctuations from extreme outbursts of anger to feelings of emptiness and depression to name only a few. In a study conducted by Blais et al. (1999), it was found that these three criteria together with a fourth one of identity diffusion provide the best predictors for the diagnosis of borderline personality disorder.

According to DSM-IV the first criterion defining borderline personality disorder is making frantic efforts to avoid real or imagined abandonment (ICD-10, criterion 3). In Alice's case this was demonstrated in the way she reacted when the male patient she had become friends with was discharged from the hospital. Despite the fact that she did not have a romantic relationship with him, she was very distressed when he left and began making suicide threats over the phone. Wheelis and Gunderson (1998) have explained that when a borderline feels threatened regarding the
potential loss of a holding environment, manipulative acts to prevent that loss from occurring are common.

The second criterion defining borderline personality disorder is a pattern of unstable and intense interpersonal relationships characterised by alternating between the extremes of idealisation and devaluation (DSM-IV, ICD-10, criterion 2). This was also typical of Alice's behaviour if one considers how she became attached to several staff members in the beginning. However, when confronted by them on the occasions she returned late from a pass off grounds, she would then feel betrayed by that person and accuse him or her of being 'just like the rest of them'. Also, in the case of her attachment to the male patient, it was striking how Alice very quickly idealised the man and had fantasies of marrying him only to be disappointed in the end when he left, which resulted in her feeling unreal and cutting herself. According to Preston (1997), people diagnosed with borderline personality disorder tend to fall in love easily and idealise others but quickly move into a state of devaluation once they feel that the other person does not meet their needs.

The fourth criterion in DSM-IV is exhibiting impulsivity in at least two areas that are self-damaging such as substance abuse, reckless driving, spending, sex and others. This criterion again fits Alice's case. First, Alice's engagement in promiscuous sexual activity with her peer group such as participating in sadomasochistic activities can be considered one area in which her impulsivity is self-damaging. Second, Alice has admitted that she has been a frequent user of street drugs since she was an adolescent and has continued to abuse drugs even while at the hospital. Also, before first being admitted to a psychiatric hospital she had been caught by the police in a stolen car with a quantity of street drugs. Although Alice claimed that she did not know that the car was stolen, this is yet another indication of impulsivity that was self-damaging.

The fifth criterion defining borderline personality disorder is recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour (DSM-IV, ICD-10, criterion 4). One of Alice's recurring symptoms is self-mutilating behaviour, which is exhibited on the occasions that she feels unreal and experiences symptoms of dissociation. Prior to her latest hospitalisation, Alice had brief episodes in which she
felt her body was not real and cut herself in order to feel the pain and feel real. Following the revelation that she was supplying other patients with drugs, she cut herself with a soda can across her wrists again after having experienced feelings of dissociation. Alice has also made various suicide threats, specifically after the male patient left the hospital. Wheelis and Gunderson (1998) explain that these self-destructive acts should not only be viewed as manipulative attempts to bring back a loved one but also, as serving to diminish the anxieties related with insufficient self-object differentiation and dissociative experiences. In a study conducted by Dulit et al. (1994) it was found that borderline patients who mutilate themselves are at a particularly high risk for suicidal behaviour. Thus, although clinicians may be inclined to view self-mutilation as manipulative, as it was the case with some members in Alice’s team, this study highlighted the relatively severe psychopathology of patients with borderline personality disorder who mutilate themselves and suggested that clinicians should carefully assess suicide risk. This is an issue to which special attention should be paid when deciding about Alice's treatment plan.

Affective instability due to a marked reactivity in mood is the sixth criterion in DSM-IV. Again, Alice fits that criterion if one considers the outbursts of anger she exhibits. One such instance took place when she was admitted to the unit and she protested loudly using abusive language when the nurse tried to search her luggage. Impulsive outbursts of anger were depicted as being characteristic of Alice's behaviour. This is also related to criterion eight (DSM-IV) that describes expression of inappropriate, intense anger or difficulty controlling anger. Alice's behaviour meets this criterion, as she is known to often express anger at an intensity level that is out of proportion to the situation. When being that angry, Alice does or says something that she later on regrets but this does not prevent her from being periodically unable to control her anger. This impulsivity, which is so characteristic of Alice's behaviour should actually be a special reason for concern as Brodsky et al. (1997), have found that suicidal attempts in patients with borderline personality disorder are very significantly associated with the single trait of impulsivity rather than global severity in borderline personality pathology. Thus, again this factor should be considered when assessing Alice's suicide risk and relevant decisions about inpatient or outpatient treatment.
Criterion seven (DSM-IV, ICD-10, criterion 5) refers to chronic feelings of emptiness. Alice meets this criterion, as she has described experiencing feelings of emptiness throughout her life. Preston (1997) relates this sense of emptiness to the fact that borderline patients appear to have a grossly underdeveloped sense of self. For that reason, they find it extremely difficult to be alone and often prefer a frantic sense for companionship to stop experiencing these feelings of loneliness and emptiness (Vaillant & Perry, 1985).

Finally, criterion nine in DSM-IV refers to a transient, stress-related paranoid ideation or severe dissociative symptoms. This again fits Alice's profile, who following the discharge of the male patient from the hospital, experienced an episode of de-realisation and subsequently cut herself with a kitchen knife. This episode should be distinguished from previous ones, when Alice had experienced dissociation, as the previous ones were drug-induced. Overall then, one can say that Alice appears to meet the necessary criteria for the diagnosis of borderline personality disorder.

However, Hudziak et al. (1996) have suggested that a review of the borderline personality disorder literature indicates that the criteria identify a high percentage of clients who meet the syndrome definition but, unfortunately, identify clients with other disorders as well. Hence, in discussing Alice's case it is imperative to consider making a differential diagnosis. This report will now consider additional diagnoses that might be necessary in this case and the reasons for their acceptance or rejection.

First, Axis I co-morbidity will be assessed. Given the fact that Alice was using drugs throughout her adolescence and even throughout her hospitalisation, it should be assessed whether she meets the criteria for a substance use disorder. After all, borderline personality disorder has been shown to be associated with both alcohol and non-alcohol substance use disorders (Skodol et al., 1999). Since we do not have information regarding specific substances that Alice was using (they were referred to as 'street drugs') the diagnosis that can be considered is that of other (or unknown) substance abuse disorder. The basic criterion for substance abuse according to DSM-IV is a maladaptive pattern of substance use leading to clinically significant impairment or distress, which is manifested in at least one of four ways, occurring
within a 12-month period. The only criterion that seems to be relevant in the case of Alice is that of recurrent substance use resulting in failure to fulfil major obligations at work, school or home. From Alice's social history, it is evident that since seventh grade her performance at school fell significantly. However, we do not have any information regarding her performance in school prior to the hospitalisation. The only information given is that, when admitted, Alice recounted her fears that she would fail her midterm examination and be expelled from college. It is unclear whether Alice's fears were realistic or exaggerated. As there is no way to assess the actual impairment that might have occurred in her life as a direct result of the drug abuse, we cannot give her the diagnosis of a substance abuse disorder. Thus, future assessments should focus on getting a detailed history of Alice's substance use to reach a conclusion as to whether that additional diagnosis might apply. This is particularly significant given the fact that patients with borderline personality disorder who also meet the criteria for a substance-related disorder have poorer prognosis (Preston, 1997).

It was described how during the hospitalisation, Alice experienced feelings of emptiness and some vegetative symptoms of depression such as insomnia and lack of appetite. Rogers et al. (1995) found that depression associated with borderline pathology appears to be in some respects unique, in that it is characterised by feelings of aloneness and abandonment fears. Zanarini et al. (1998), having reviewed the literature regarding Axis I co-morbidity in borderline personality disorder, noted that most studies suggest that borderline patients often meet DSM criteria for major depression. Thus, it is imperative to check whether Alice meets the criteria to be diagnosed with any depressive disorder. From the information provided, Alice does not meet the criteria for a major depressive episode and hence, cannot be diagnosed with major depressive disorder. Moreover, looking at the criteria of dysthymic disorder (DSM-IV) or dysthymia (ICD-10), Alice does not meet the first major criterion, which is depressed mood for most of the day, for at least two years, as from the case there is no time specification regarding Alice's depressive symptoms. At this point then, it seems like Alice does not meet the criteria to be diagnosed with any depressive disorder (bipolar disorders are not discussed as there was no indication of a manic episode). Still, her depressive symptoms need to be further monitored to make a definite decision as to the extent of their severity.
Alice's initial complaint was experiencing brief episodes in which she felt as though her body was unreal, felt dissociated from her surroundings and felt like she was transparent. From the social history provided, it was under the influence of street drugs that Alice first started having these symptoms. Thus, a diagnosis that might be appropriate is that of substance-induced psychotic disorder (DSM-IV) or acute intoxication due to the use of hallucinogens (ICD-10). Although Alice met the criteria to be diagnosed with substance-induced psychotic disorder (DSM-IV) at the time she first experienced symptoms of dissociation, thereafter, she experienced similar symptoms that were not drug induced. As diagnosis is concerned with current rather than past symptomatology, this diagnosis is no longer valid. Hence, we will now examine whether a diagnosis of a dissociative disorder applies at present. Alice's symptoms seem to match the description for the diagnosis of depersonalisation disorder (DSM-IV) or depersonalisation-derealisation syndrome (ICD-10). However, the final criterion, which is that the depersonalisation experience does not occur exclusively during the course of another mental disorder, is not met. As explained above, severe dissociative symptoms are one of the criteria for borderline personality disorder. Brodsky et al. (1995) found that there is a high prevalence of pathological levels of dissociation among female inpatients with borderline personality disorder. In the past, sexual abuse was assumed to play an etiological role in the development of dissociative symptoms (Chu & Dill, 1990). This might be relevant in Alice's case, since she reports having been sexually abused by her stepbrother throughout her adolescence. This is a potential hypothesis as to the origin of her dissociative symptoms. In terms of diagnosis, it appears as though that the diagnosis of borderline personality is sufficient in explaining Alice's dissociative symptoms.

Alice engaged in a pattern of promiscuous sexual activity and on occasions participated in various sadomasochistic activities. Thus, we should consider whether a diagnosis of a sexual disorder applies. In order to give a diagnosis of sexual masochism, sexual sadism (DSM-IV), or sadomasochism (ICD-10), a person apart from engaging in sadomasochistic activities must suffer from clinically significant distress in social functioning as a result of the behaviours (DSM-IV) and the activity must be necessary for sexual gratification (ICD-10). In Alice's case, it seems like she went along with these activities, as she felt unable to turn down sexual advances and not because it was a source of sexual gratification for her. Also, there is no mention
of distress that was caused to her as a direct result of her sexual activities. Thus, a diagnosis of a sexual disorder does not apply.

Furthermore, we need to assess Alice for Axis II co-morbidity, as borderline personality disorder tends to often be co-morbid with other personality disorders (Frances & Ross, 1996). Histrionic personality disorder (DSM-IV, ICD-10) seems to be relevant to this case. Alice meets some of the criteria for this diagnosis such as considering relationships more intimate than they are, rapidly shifting expression of emotions and being easily influenced by others. However, the major difference between borderline personality disorder and histrionic personality disorder is that the latter is not characterised by self-destructiveness, angry disruptions in close relationships and chronic feelings of emptiness and loneliness (First et al., 1995), all symptoms that Alice exhibits. Instead, what differentiates clients with histrionic personality disorder is their flamboyant and overly dramatic quality (Frances & Ross, 1996), which does not seem typical of Alice. Again, this additional diagnosis needs to be rejected.

Finally, whether Alice meets the criteria for dependent personality disorder (DSM-IV, ICD-10) should be examined. Although she meets some of the criteria such as difficulty expressing disagreement with others out of fear of loss of approval (such as when she agreed to supply the patients in the hospital with drugs) and going to excessive lengths to obtain nurturance and support to the extent of volunteering to do things that are unpleasant (such as engaging in sadomasochistic activities), they are not enough to give her this additional diagnosis. It seems then that the diagnosis of borderline personality disorder adequately describes Alice's symptomatology and no additional diagnosis is appropriate at present.

To confirm this conclusion, the clinician could use the Borderline Personality Inventory (BPI), which is a newly developed self-report instrument based on Kernberg's (1984) concept of personality organisation, which according to the first results has very high sensitivity for screening borderline patients (Leichsenring, 1999). An additional advantage of using the BPI is its psychotherapeutic relevance. Another useful screening instrument, whose administration might be more time consuming, is the Diagnostic Interview for Borderlines, which consists of 186
questions that describe important features for borderline personality disorder. This is
yet another tool, which could be potentially used to confirm the above diagnosis
(Loranger, 1997). Finally, the Self-Harm Inventory (SHI) can be used to assess Alice's
self-destructive behaviour, as it has been shown to be especially useful in
determining high-lethal versus low-lethal self-harm behaviours (Sansone et al.,
1998). This assessment might be of great importance as Dulit et al. (1994) have
found that borderline patients who self harm are at a higher risk for suicide attempts.

In a psychotherapeutic context, the SHI could also facilitate the clinician's initiation of
a treatment contract. Other factors that should be taken into consideration when
thinking about Alice's treatment plan might be her degree of psychological
mindedness, which is usually significant for the prediction of psychotherapeutic
outcome. Finally, the Objective Behavioural Index is a tool that provides important
information about patient status and responses to treatment interventions (Marziali
et al., 1999). As this tool was developed and tested particularly on clients with
borderline personality disorders, it might be very relevant in Alice's case and could be
used to assess her progress once a treatment plan is underway. Finally, a word of
cautions might be that of course, as classificatory systems such as DSM-IV and ICD-10
are useful purely for descriptive purposes, in a similar way psychometric tools are
useful but cannot always capture progress or change, as these sometimes may not
be quantifiable. Thus, the clinician should always be informed by the information
provided by them but also, be alert to individual variation.
References


Appendix

Case Study – ‘Alice’

Alice Siegel was 22 years old when she reluctantly agreed to interrupt her college education in mid-semester and admit herself for the eighth time to a psychiatric hospital. Her psychologist, Dr. Swenson, and her psychiatrist, Dr. Smythe, believed that neither psychotherapy nor medication was currently effective in helping her control her symptoms and that continued outpatient treatment would be too risky. Of most concern was that Alice was experiencing brief episodes in which she felt that her body was not real and, terrified, would secretly cut herself with a knife in order to feel pain, thereby feeling real. During the first part of the admission interview at the hospital, Alice angrily denied that she had done anything self-destructive. She did not sustain this anger, however, and was soon in tears as she recounted her fears that she would fail her midterm examinations and be expelled from college. The admitting psychiatrist also noted that, at times, Alice behaved in a flirtatious manner, asking inappropriately personal questions such as whether any of the psychiatrist’s girlfriends were in the hospital.

Upon arrival at the inpatient psychiatric unit, Alice once again became quite angry. She protested loudly, using obscene and abusive language when the nurse-in-charge searched her luggage for illegal drugs and sharp objects (a routine procedure with which Alice was well acquainted). These impulsive outbursts of anger had become quite characteristic for Alice over the past several years. She would often express anger at an intensity level that was out of proportion to the situation. When she became this angry, she would actually do or say something that she later regretted, such as extreme verbal abuse of a close friend or breaking a prized possession. In spite of the negative consequences of these actions and the ensuing guilt and regret on Alice’s part, she seemed unable to stop herself from periodically losing control of her anger.

That same day, Alice filed a “3-Day Notice,” a written statement expressing an intention to leave the hospital within 72 hours. Dr. Swenson told Alice that if she did not agree to remain in the hospital voluntarily, he would initiate legal proceedings for her involuntary commitment on the ground that she was a threat to herself. Two days later, Alice retracted the 3-Day Notice, and her anger seemed to subside.

Over the next two weeks, Alice seemed to be getting along rather well. Despite some complaints of feeling depressed, she was always very well dressed and groomed, in contrast to the more psychotic patients. Except for occasional episodes when she became verbally abusive and slammed doors, Alice appeared and acted like a staff member. Indeed, Alice began taking on a “therapist” role with the other patients, listening intently to their problems and suggesting solutions. She would often serve as a spokesperson for the more disgruntled patients, expressing their concerns and complaints to the administrators of the treatment unit. With the help of her therapist, Alice also wrote a contract stating that she did not feel like hurting herself, and that she would notify staff members if that situation changed. Given that her safety was no longer an issue, she was allowed a number of passes off the unit with other patients and friends.
Alice became particularly attached to several staff members and arranged one-to-one talks with them as often as possible. Alice used these talks to complain about alleged inadequacies and unprofessionalism of other staff members. She would also point out to whomever she was talking that he or she was one of the few who knew her well enough to be of any help to her. These talks usually ended with flattering compliments from Alice as to how understanding and helpful she found that particular staff person. These overtures made it difficult for certain of these selected staff members to confront Alice on issues such as violations of rules of the treatment unit. For instance, when Alice returned late from a pass off grounds, it was often overlooked. If she was confronted, especially by someone with whom she felt she had a special relationship, she would feel betrayed and angrily accuse that person of being “just like the rest of them.”

By the end of the third week of hospitalization, Alice no longer appeared to be in acute distress, and discussions were begun concerning her discharge from the hospital. At about this time Alice began to drop hints in her therapy sessions with Dr. Swenson that she had been withholding some kind of secret. Dr. Swenson confronted this issue in therapy and encouraged her to be more open and direct if there was something about which she was especially concerned. Alice then revealed that since her second day in the hospital, she had been receiving illegal Street drugs from two friends who visited her. Besides occasionally using the drugs herself, Alice had been giving them to other patients on the unit. This situation was quickly brought to the attention of all the other patients on the unit in a meeting called by Dr. Swenson; during the meeting Alice protested that the other patients had “forced” her to bring them drugs and that she actually had no choice in the matter. Dr. Swenson interpreted this as meaning that Alice had found it intolerable to be rejected by other people and was willing to go to any lengths to avoid such rejection.

Soon after this incident came to light, Alice experienced another episode of feeling as if she were unreal and cut herself a number of times across her wrists with a soda can she had broken in half. The cuts were deep enough to draw blood but were not life threatening. In contrast to previous incidents, she did not try to keep this hidden and several staff members, therefore, concluded that Alice was malingering — that is, exaggerating the severity of her problems so she could remain in the hospital longer. The members of Alice’s treatment team then met to decide the best course of action with regard to the dilemma. Not everyone agreed that Alice was malingering. Although Alice was undoubtedly self-destructive and possibly suicidal and, therefore, in need of further hospitalization, she had been sabotaging the treatment of other patients and could not be trusted to refrain from doing so again. With the members of her treatment team split on the question of whether or not Alice should be allowed to remain in the hospital, designing a coherent treatment program would prove difficult at best.

SOCIAL HISTORY

Alice was the older of two daughters born to a suburban middle-class family. She was two years old at the time her sister Jane was born. Alice’s mother and father divorced four years later, leaving the children in the custody of the mother. Financial problems were paramount at that time as Alice’s father provided little in the way of
subsequent child support. He remarried soon afterwards and was generally unavailable to his original family. He never remembered the children on birthdays or holidays. When Alice was seven years old, her mother began working as a waitress in a neighborhood restaurant. Neighbors would check in on Alice and Jane after school, but the children were left largely unattended until their mother returned home from work in the evening. Thus, at a very early age Alice was in a caretaker role for her younger sister Jane. Over the next few years Alice took on a number of household responsibilities that were more appropriate for an adult or much older child (e.g., babysitting, regular meal preparation, shopping). Alice voiced no complaints about the situation and did not present any behavioral problems at home or in school. Her most significant concern was the absence of her father. Had she somehow had something to do with the divorce? How much better would her life have been if only her father was with her?

When Alice was 13 years old, her mother married a man she had been dating for about three months. The man, Arthur Siegel, had a 16-year-old son named Michael who joined the household on a somewhat sporadic basis. Michael had been moving back and forth between his mother’s and father’s houses since their divorce four years earlier. His mother had legal custody but was unable to manage his more abusive and aggressive behaviors, so she frequently sent him to live with his father for several weeks or months. Because she still entertained the fantasy that her mother and father would remarry, Alice resented the intrusion of these new people into her house. Alice was quite upset when her mother changed her and her children’s last name to Siegel. She also resented the loss of some of her caretaking responsibilities, which were now shared with her mother and stepfather.

The first indications of any behavioral or emotional problems with Alice occurred shortly after the marriage. She was doing very well academically in the seventh grade when she began to skip class. Her grades fell precipitously over the course of a semester, and she began spending time with peers who were experimenting with alcohol and street drugs. Alice became a frequent user of these drugs, even though she experienced some frightening symptoms after taking them (e.g., vivid visual hallucinations, strong feelings of paranoia). By the end of the eighth grade, Alice’s grades were so poor and her school attendance so erratic that it was recommended that she be evaluated by a psychologist and possibly held back for a year. The family arranged for such an assessment, and Alice was given a fairly extensive battery of intelligence, achievement, and projective tests. She was found to be extremely intelligent, with an IQ of 130 (Wechsler Intelligence Scale for Children — Revised). Projective test results (Rorschach, Thematic Apperception Test) were interpreted as reflecting a significant degree of underlying anger, which was believed to be contributing to Alice’s behavioral problems. Of more concern was that Alice gave a number of bizarre and confused responses on the projective tests. For example, when people report what they “see” in the famous Rorschach inkblots, it is usually easy for the tester to also share the client’s perception. Several of Alice’s responses, however, just didn’t match any discernible features of the inkblots. This type of response is usually seen in more serious disorders such as schizophrenia. The psychologist, although having no knowledge of Alice’s home life, suspected that her problems may have been a reflection of her difficulties at home and recommended family therapy at a local community mental health center.
Several months later Alice and her mother and sister had their first appointment with a social worker at the mental health center. Mr. Siegel was distrustful of the prospect of therapy and refused to attend stating "no shrink is going to mess with my head!" In the ensuing therapy, the social worker first took a detailed family history. She noticed that Alice appeared very guarded and was reluctant to share any feelings about or perceptions of the events of her life. The next phase of family therapy was more educational in nature, consisting of teaching Mrs. Siegel more effective methods of discipline and helping Alice to see the importance of attending school on a regular basis.

Family therapy ended after three months with only marginal success. Although Mrs. Siegel had been a highly motivated client and diligently followed the therapist's suggestions, Alice had remained a reluctant participant in the therapy and was unwilling to open up. One very serious problem Alice had been experiencing had not even been brought to light; she was being sexually abused by her older stepbrother Michael. The abuse had started soon after her mother's marriage to Mr. Siegel. Michael had told Alice that it was important for her to learn about sex and, after having sexual intercourse with her threatened that if she ever told anyone he would tell all her friends that she was a "slut." This pattern of abuse continued on numerous occasions whenever Michael was living with his father. Even though Alice found these encounters aversive, she felt unable to refuse participation or to let anyone know what was occurring. At the time Mr. and Mrs. Siegel divorced, when Alice was 15 year old, these instances of sexual abuse were the extent of Alice's sexual experience. She was left feeling depressed and guilty.

When Alice began high school, she continued her association with the same peer group she had known in junior high. As a group, they regularly abused drugs. It was under the influence of drugs that Alice began to have he first experiences of feeling unreal and dissociated from her surroundings. She felt as though she were ghostlike, that she was transparent and could pass through objects or people.

Alice also began a pattern of promiscuous sexual activity within the peer group. As happened when she was being abused by her stepbrother, she felt guilty for engaging in sex but unable to turn down sexual advances from either men or women. She was particularly vulnerable when under the influence of drugs and would, under some circumstances, participate in various sadomasochistic sexual activities. For example, Alice was sometimes physically abused (e.g., struck in the face with a fist) by her sexual partners while having sex. She didn't protest and, after a while, came to expect such violence. On some occasions, Alice's sexual partners would ask her to inflict some kind of pain on them during sexual activity, for example, biting during fellatio or digging her nails into her partner's buttocks. Even though these activities left Alice with a sense of shame and guilt, she felt unable either to set limits on her peers, to leave her particular peer group, or to avoid those whose sexual activities were particularly troubling to her.

By the time Alice was 16 years old, she found that she rarely, if ever wanted to spend time alone. She was often bored and depressed; particularly she had no plans for spending time with anyone else. One night while cruising a car with friends, a siren and flashing lights appeared. The police stopped the car because it had been stolen by one of her friends. A quantity of street drugs was also found in the car. Alice claimed that she had not known that the car was stolen.
The judge who subsequently heard the case was provided with information concerning Alice's recent history at home and school. He was quite concerned with what appeared to be a progressive deterioration in Alice's academic and appropriate social functioning. Because previous outpatient treatment had failed, he recommended inpatient psychiatric treatment as a means of helping her gain some control over her impulses and preventing future legal and psychological problems. In some sense, Alice was being offered a choice between being prosecuted as an accessory to car theft and possession of illegal substances or signing into a mental hospital. Reluctantly, she chose the latter.

During the first hospitalization, Alice's emotional experiences seemed to intensify. She vacillated between outbursts of anger and feelings of emptiness and depression. She showed some vegetative signs of depression such as lack of petite and insomnia. Antidepressant medication was tried for several weeks and found to be ineffective. Alice spent most of her time with a male patient in the hospital. To any observer, their relationship would not have seemed to have a romantic component. They watched TV together, ate together, and played various games that were available on the ward. There was no physical contact or romantic talk. Nonetheless, Alice idealized the man and had fantasies of marrying him. When he was discharged from the hospital and severed the relationship, Alice had her first non-drug-induced episode of feeling unreal (de-realization) and subsequently cut herself with a kitchen knife in order to feel real. She began making suicide threats over the telephone to the former patient, saying that if he did not take her back she would kill herself. She was given a short trial of antipsychotic medication, which proved ineffective.

During this first hospitalization, Alice started individual psychotherapy, which was continued after discharge from the hospital. The therapy was psychodynamically oriented and focused on helping Alice to establish a trusting relationship with a stable adult (her therapist). The therapist also attempted to help Alice work through the intrapsychic conflicts that had started early in her life. For example, the therapist hypothesized that Alice's mother had been critical of Alice's appropriate autonomous behavior during early childhood. It was believed that the mother offered support and comfort Alice only if Alice behaved in a childish, dependent, and regressive manner. This was presumed to have led to Alice's fear of being abandoned by people who were important to her, should she act in an independent or self-assertive manner. One of the therapist's goals was to show Alice that he would still be available (i.e., not leave her) when she acted in a mature, adult fashion. It was hoped that this would help Alice to feel more secure in her interpersonal relationships.

Despite these therapy sessions, Alice continued to exhibit the symptoms that had developed over the past several years, including drug abuse, promiscuity, depression, feelings of boredom, episodes of intense anger, suicide threats, de-realization, and self-mutilation (cutting herself). A number of hospitalizations were required when Alice's threats and/or self-mutilation became particularly intense or frequent. These were usually precipitated by stressful interpersonal events, such as breaking up with a boyfriend or discussing emotionally charged issues in psychotherapy (e.g., her past sexual abuse). Most of the hospitalizations were relatively brief (two to four weeks), and Alice was able to leave after the precipitating crisis had been resolved.
THERAPEUTIC PRACTICE DOSSIER
Therapeutic Practice Dossier

The Therapeutic Practice Dossier contains a description of the three year-long clinical placements, including type and duration, client population and the nature of supervision. Other professional and educational activities that took part in the placements are also outlined. An extended essay on the integration of theory, research and therapeutic practice concludes the dossier.
Year One Placement: Primary Care Services

My first year placement was within Primary Care Services in an inner London NHS Trust. The service provided primary health care to the local communities, which was delivered in GP practices. The client group comprised of adults aged between 17 and 70 years of age.

The professionals involved in the primary care services included clinical psychologists, counselling psychologists, psychotherapists and counsellors with different specialties and theoretical orientations. Each professional in the primary care services was attached to one or more of the local GP services, where referrals were received by GPs, practice nurses and health visitors. All the professionals of the service were supervised by the Psychology Department of a mental health hospital.

The client group that was referred for psychological therapy presented with a variety of mild to moderate difficulties, such as depression, anxiety, bereavement issues, relationship difficulties and sexual abuse. Clients came from a mixture of social and cultural backgrounds. The therapeutic contracts consisted of a maximum of twelve sessions. One client was seen for the duration of the placement for training purposes.

Supervision was offered on an individual and weekly basis by a psychoanalytically trained psychotherapist. Within supervision an emphasis was placed on the development of psychodynamic concepts and interventions. A manager supervisor, who was a consultant clinical psychologist and psychotherapist, further monitored the progress of the therapeutic work.

The placement experience also included the attendance of a number of workshops and seminar presentations organised by other psychologists within the Trust, as well as meetings with other trainees and the manager supervisor.
Year Two Placement: A Psychotherapy Department and a Public Primary School

My second year consisted of a main placement and an additional placement. My main placement was held within a Psychotherapy Department, which was based in an inner London mental health hospital. The service provided adult mental health for the local community. The client group served by the department included adults aged 17 to 70 years of age. The department occupied a number of psychiatrists, senior and specialist registrars, adult psychotherapists, consultant clinical psychologists as well as trainee clinical and counselling psychologists. Within the psychotherapy department the orientation taken was psychodynamic psychotherapy.

The client group presented with a range of mild to moderate difficulties including depression, anxiety, panic attacks, bereavement issues, relationship difficulties and self-harm. The duration of individual therapy was forty sessions over the course of a year and of group analytic therapy approximately two years. When it was assessed that specific clients would benefit from a short-term intervention, they were offered brief psychodynamic therapy, which consisted of sixteen sessions.

A variety of supervision experiences were offered on this placement. Individual, weekly supervision placed emphasis on the development of psychodynamic concepts and techniques. During supervision, process notes of sessions were discussed. There was also the opportunity to attend a weekly, group supervision, which was facilitated by a consultant psychotherapist. The members of this group included four specialist registrars in psychotherapy.

In the mental health hospital, there is also a Family Therapy Clinic and an Eating Disorders Unit. Additional placement activities were held in these places. The Eating Disorders Unit occupies a number of nurse practitioners and two clinical psychologists. In the Eating Disorders Unit, outpatients who have completed the in-patient hospitalisation program were referred. The outpatients' program lasts for two years. As part of the program, clients attended a weekly analytic group, which was conducted by a group analyst and myself, a counselling psychologist in training. Supervision was provided by a consultant clinical psychologist and psychotherapist.
In the family therapy clinic, families with members suffering from a variety of emotional problems are seen. The family therapy clinic consisted of three family therapists, a number of trainee family therapists, two junior doctors and three care assistants. My role within the clinic was to work as part of the reflecting team observing families with adolescents suffering from eating disorders. Supervision was offered by the qualified family therapist of the team.

My additional placement was held within a public primary school. The service, which was administered through a private charity organisation, offered psychotherapy to children in socially deprived schools in the inner London area. The charity employed a clinical psychologist, a child psychotherapist and a psychodynamic psychotherapist as well as a number of volunteers who were trainee counselling psychologists, child psychotherapists and counsellors. The children who were referred for psychotherapy were between the ages of 4 to 10 years old. The children were either self-referred or had been referred by their teachers. Common reasons for referral from teachers were either disruptive behaviour in the classroom or social isolation. The children presented with a range of emotional difficulties including parents’ divorce, unemployment, and bereavement. The type of intervention offered was communicative psychoanalytic psychotherapy, which was adjusted to work with children. The duration of therapy varied from six months to a year. Supervision was offered by a communicative psychotherapist.
Year Three Placement: Substance Misuse Services

My third year placement involved working within an alcohol advisory service and a drug service, which were both part of the same substance misuse services based in inner London. Both services offered treatment plans in the community and operated using a multidisciplinary team approach.

The teams consisted of clinical nurse specialists, medical assistants, psychiatric registrars, occupational therapists and clinical and counselling psychologists. Referrals to both teams were made either directly by the clients themselves, by their GPs or any other mental health professional.

My role in these teams was to devise specific treatment programmes to prevent relapse of clients as well as to offer psychological therapy to clients with a dual diagnosis. The clients of the service presented with moderate to severe difficulties such as drug addictions, moderate to severe depression, anxiety, low self-esteem, long histories of trauma and severe abuse as well as personality disorders. The clients were offered from ten to twenty sessions of psychological therapy.

Supervision was provided both by a clinical psychologist within the alcohol service and by a consultant clinical psychologist, who was the Head of psychological therapies within the Substance Misuse Services. Clients were conceptualised and offered treatment from a cognitive-behavioural framework, including a relapse prevention model of change of addictive behaviours, motivational interviewing and schema-focused interventions. There was also the opportunity to offer integrative psychological therapy with an emphasis on the use of the therapeutic relationship as a tool for change.

Other activities included attending multidisciplinary team meetings, psychology departmental meetings as well as workshops and seminar presentations organised by other psychologists. I also had the opportunity to take part in two audit projects that aimed at examining specific aspects of service provision.
Integrating the personal and the professional: A personal account of integration of theory, research and practice

Introduction

Different pathways to integration

In recent years, the issue of integration has received considerable attention in the fields of psychotherapeutic, clinical and counselling psychology. The pathways to integration are numerous as more than two-dozen different types of integration exist in the literature (Clarkson, 1996). An evaluation of these different pathways to integration is beyond the scope of this paper. However, a brief description of the four most popular routes will be presented in order to guide the reader through my personal approach to integration.

Theoretical integration refers to the integration of two or more theoretical models in the hope that the result will be better than the individual models themselves. Theoretical integration can be sharply contrasted to technical eclecticism. The definition of eclecticism parallels its dictionary meaning, which is “choosing what is best from diverse sources, styles and systems” (Norcross & Grencavage, 1989). Hence, eclecticism is differentiated from integration in that it endorses the use of techniques drawn from different theories without necessarily subscribing to the theories that spawned them. Theoretical integration, on the other hand, refers to a commitment to a theoretical creation beyond a technical blend of methods. The third pathway to integration is the common factors approach. This approach seeks to find elements that diverse approaches have in common. The rationale behind this pathway is that these factors may be at least as important in accounting for therapy outcome as the unique factors that differentiate among different approaches (see Goldfried, 1980; 1991). Finally, integration of psychotherapy theory and practice with basic psychological theory and research attempts to look outside of existing psychotherapy theories and into broader psychological research with the aim of enriching the practitioner's understanding of change.
Whether technical eclecticism should be considered, as one of the pathways to integration, has been rather controversial in the literature. Whereas Norcross and Newman (1992) refer to it as one of the routes to integration, others (e.g. Lazarus, 1990; Woolfe & Goldfried, 1988) see it as reflecting a completely distinct and almost opposite attitude. Whilst considering this debate, one should realise that, to some degree, a blurring of the boundary between integrationism and eclecticism is almost inevitable. After all, as an integrationist has to find a way of selecting out elements before bringing them into a whole, an eclectic has to find a way of putting together the parts that have been selected (Hollanders, 2000).

My personal integration

Arriving at a personal integrative position has not been an easy process. Throughout the training I found myself struggling with the concept of integration, as I was trying to make sense of what being an integrative practitioner entails. This process was further complicated by what I perceived to be obstacles to theoretical integration such as the contradictory assumptions about human nature, pathology and change endorsed by different approaches. Even setting aside the apparent incongruence between different approaches, I was unclear about how one decides to integrate common elements of different theoretical models and what rationale underpins such decision-making. Finding answers to these questions has been an ongoing process of personal and professional development.

The purpose of this paper is to provide the reader with a comprehensive account of the ways in which I integrated theory and research into my therapeutic practice through the course of the training. In order to achieve this challenging task, I will reflect upon the main factors that shaped the development of my personal integration. These critical factors are the discipline of counselling psychology, the training experience, and my clinical practice during the three years as informed by different placement contexts as well as the experiences of supervision, personal therapy and research. Finally, my own personal world-view is another crucial factor that underpinned the process of integration of my personal and professional self.
Counselling psychology: A humanistic value base and the scientist-practitioner model

Some of the core values of counselling psychology are respect for the individual client and emphasis on the significance of the helping relationship. This on the part of the helper is characterised by the three core person-centred qualities of empathy, congruence and unconditional positive regard (Rogers, 1951). It is exactly this move away from the medical model, in which the helper is seen as the expert who ‘treats’ the client that has marked the development of counselling psychology as a discipline.

Another crucial aspect of counselling psychology is its endorsement of the scientist-practitioner model. This model is based around the notion that an integral aspect of counselling psychologists’ role is the need to engage in an ongoing process of research in order to evaluate their practice (Barkham, 1990; Woolfe, 1996). Other than conducting research and generating knowledge, a counselling psychologist is also a consumer of psychological literature by drawing both on theories and published research in order to inform their practice. Hence, the scientist-practitioner model is an integrated approach to knowledge itself, as it recognises how theory, research and practice are interconnected (Meara et al., 1988).

Looking back over my process of development as a practitioner, it would be accurate to say that the core beliefs of counselling psychology have always informed my practice and constituted the basis for my integration. Across the three years, in all my relationships with clients I’ve tried to convey empathy, congruence and unconditional positive regard. That is not to say that there was no room for the expression of negative feelings in the therapeutic relationship. What this means, is that I have refrained from viewing my clients as sick individuals that needed a cure. Instead, the question I have always asked myself is one that Rogers (1961) suggested. In his own words:

"How can I provide a relationship which this person may use for (their) own personal growth" (p.32).
At the same time, my interventions have been guided by relevant psychological literature. However, I always read psychological literature with a critical mind and tried to find a balance between research evidence and clinical judgement. The ways in which I have adopted a scientist-practitioner stance in my therapeutic practice will be further exemplified in the discussion of different clients in the course of this paper.

**The training experience**

One of the debates within the field of integration is concerned with the method of training integrative practitioners. The one position suggests that integration should take place after training in one or more pure forms of psychotherapy has been accomplished, whereas the other view is that integration should occur from the beginning of the training (Clarkson, 2000).

Reflecting upon the training experience, I think the course combined the advantages of both positions. In each of the three years, there was an emphasis on different theoretical approaches. This resulted in an exposure to the theory and practice of three different approaches in a relatively pure form, which across the years provided me with a sense of security when working in different placements. At the same time, the philosophy of the course, as I experienced it, emphasised the development of skills of intellectual questioning and tolerance for other approaches right from the beginning. Therefore, even when I was working therapeutically from 'pure' perspectives, I never considered any potential approach I was using as the one holding the 'absolute truth' about a client. Instead, I gradually felt more confident to conceptualise clients' difficulties from a multiplicity of different perspectives, a process, which enabled me to gain a much wider understanding of clients than any single approach would have offered me.

This constant process of intellectual questioning did not only apply to the conceptualisation of clients but also to the critical appreciation of relevant psychological literature. The training that the course offered me both in qualitative and quantitative research methods in the first and second years clearly contributed to my ability to reflect upon the literature and enabled me to integrate psychological
theories and research into my practice in an informed manner. In order to further exemplify how this worked in practice, I will now offer an account of my work with clients in the three years of the training. It is hoped that this account will provide the reader with a clear picture of how theory and research were integrated into my practice depending on the different contexts I worked in. In order to ensure anonymity and confidentiality, all the names and identifying details of clients have been altered and pseudonyms have been provided.

Year I: Early days of personal integration

During the first year of training, I worked in a primary care setting at a local GP surgery. The type of therapy offered to the clients as determined by the context was brief psychodynamic therapy. Reflecting back to my way of working in that context, I can see the beginnings of my personal integration. During the first year, the theoretical emphasis of the course was mainly humanistic. Rogers’ (1951; 1961) ideas about facilitating client change through empathy and unconditional positive regard formed the basis of my practice. Therefore, in my work with clients, I attached great significance to the therapeutic relationship.

At the same time, as my supervisor’s orientation was psychodynamic, I was encouraged to begin conceptualising clients’ presenting problems from a psychodynamic perspective. Trying to reconcile these two different approaches was a challenge, as the assumptions they made about human nature were often conflicting. Hence, my task was to find a balance between using humanistic principles as the basis of my practice and also, reaching an understanding of clients with the lens of a psychodynamic practitioner. To demonstrate how this worked in practice I will discuss one of the clients I saw during my first year placement.

Ms. Brown presented with symptoms of depression and relationship difficulties. During the assessment interview, she revealed that when she was a child her brother had sexually abused her, a fact that she had never been able to disclose to her parents. This childhood event shaped her ability to form close relationships, as she developed an ‘internal working model’ (Bowlby, 1988) of being a victim in her relationships with significant others. When she came to therapy, Ms. Brown reported
having lost trust in her ability to make judgements about other people and feeling very wary of relationships. This is consistent with research findings that suggest that one of the common effects of older brother-younger sister incest is that the victims develop mistrust of men and women (Laviola, 1992). This reluctance to trust people was inevitably re-enacted in the context of the therapeutic relationship. In the beginning of therapy, Ms. Brown was openly doubtful about the potential value of psychological therapy and reluctant to explore her experiences with me, particularly as she viewed me as too young and inexperienced. Working from a psychodynamic perspective, I could have interpreted her reluctance as a fear to invest in the therapeutic relationship in case she was let down. However, at the time, it was more significant to acknowledge the reality of her concerns about engaging in therapy and about my qualifications as a therapist. By acknowledging her concerns through the use of empathy and unconditional positive regard, Ms. Brown gradually felt secure in my ability to understand her and engaged in therapy.

Through the course of time and as my formulation of Ms. Brown’s difficulties evolved, I gradually became aware of her inability to express negative feelings in the context of loving relationships. It was then that one of the shortcomings of a ‘purely’ humanistic approach became clear to me. Ms. Brown’s difficulty in expressing negative affect in loving relationships originated from her inability to express any negative feelings towards her parents. By offering her unlimited empathy and unconditional positive regard, I was also contributing to her tendency to view me as an ‘idealised parent’ in the transference and thus, be unable to express negative feelings towards me in the therapeutic relationship. This was an issue that I discussed in supervision. Eventually, this insight enabled me to give space for Ms. Brown to express her anger towards me, especially when she felt let down about our contract coming to an end. This in turn provided her with a ‘corrective emotional experience’ (Kahn, 1997) that disconfirmed her belief that loving relationships cannot survive anger. According to Winnicott (1971) positive change in clients comes about through the therapist’s survival of the client’s attacks and the absence of any retaliation for these attacks.

In this case vignette, I have attempted to demonstrate how integration of different approaches was prominent to my practice even from the early days of training, in
that I was called to hold in mind two different approaches that initially seemed rather incompatible. As the placement progressed though, I came to appreciate that both approaches had important contributions to make, depending on the stage of therapy and clients’ individual needs. Hence, my scepticism regarding integration was gradually replaced by a growing curiosity to understand under which circumstances integration of different approaches is appropriate and more effective.

**Year II: Theoretical integration in a psychodynamic placement**

In the second year, I worked in a Psychotherapy Department of a large mental health hospital. The type of intervention offered to clients was insight-orientated, psychodynamic psychotherapy over the course of a year. Applying psychodynamic principles was not particularly problematic, as I had already started to practice using a psychodynamic framework in the first year. However, the impact of context on therapeutic practice soon became apparent to me, as in this placement I was expected to work from a completely ‘pure’ psychodynamic perspective. This felt counterintuitive at the time, in that I had already begun to appreciate the value of a more flexible approach and hence, was sceptical about the effectiveness of working from purist perspectives.

A particular disagreement I had with traditional analytic approaches was their over-reliance on interpretation and the tendency to explain all therapeutic interactions as reflective of the client’s intra-psychic conflicts. My perception of therapeutic interactions is more holistic, in that I view them as a combination of reality factors and a repetition of intra-psychic conflicts. Reflecting on my current way of working integratively, the second year has nonetheless greatly influenced my practice. Despite the fact that I worked from a purely psychodynamic standpoint then, I was still integrative in that I was integrating different psychodynamic theories. Supervision was key in assisting me with this process. Within the department I worked I was fortunate to attend both individual and group supervision. This contributed to a growing ability to integrate different psychodynamic theories, as in the different forms of supervision clients were conceptualised from a multiplicity of approaches. In order to further demonstrate how this happened in practice, I will now discuss Ms. Winger, a client I saw during the second year.
Ms. Winger presented with symptoms of depression such as low mood and lack of energy, as well as a difficulty in interpersonal relationships and chronic low self-esteem. The client described her upbringing as particularly strict. She did not have a close relationship with either of her parents. Her mother was depressed throughout her childhood and the client experienced her as rather critical. Goodman et al. (1994) concluded that mothers with a history of depression express more critical attitudes towards their children. These attitudes were found to actively contribute to their children's lower self-esteem. This finding could potentially explain Ms. Winger's chronic low self-esteem. The client described having felt closer to her father. However, she felt as though her father's love was conditional on her conforming to his standards and expectations. One of the main issues explored in therapy was her difficulty in interpersonal relationships. Ms. Winger identified a pattern in her relationships whereby she either let others have complete control over her or had complete control over them, which resulted in her constantly feeling frustrated and alone.

Having discussed Ms. Winger in individual and group supervision, I was able to formulate her difficulties integrating different psychodynamic theories. Hence I gradually came to understand her difficulty in interpersonal relationships as stemming from not having experienced security in her relationships with her parents as a child, which made the client grow up feeling unlovable and helpless especially in her ability to form and maintain affectionate relationships. Thus, in all her relationships she either let the other person control her and this resulted in her feeling frustrated and unable to satisfy the other's demands and expectations of her, or she ended up having complete control which left her feeling unsatisfied and alone. In both cases, she interpreted her difficulty in maintaining close relationships, as a personal inadequacy as she felt intrinsically unlovable. This pattern is consistent with Bowlby's (1981) definition of 'avoidant' pattern of attachment. According to Bowlby (1981), individuals who have an avoidant pattern of attachment to others feel uncomfortable in close relationships and although they want to be closer they experience a strong sense of shame and find intimacy frightening, as they are sensitive to being controlled in relationships. This was consistent with Ms. Winger's description of herself as somebody who longed for interpersonal relationships but felt unable to maintain them. According to Levitt et al. (1996), a history of poor
attachment relations may compromise later relationships. In addition, the client’s low self-esteem and depressive symptomatology were explained by taking Kohut (1977) into consideration. According to Kohut, when parents repeatedly put their child down, like the client’s parents did, the child ends up experiencing herself as bad, shameful and ineffective and cannot achieve the ideals necessary to achieve self-esteem. It was Kohut's position that at this point, depression arises.

In this section, I have attempted to demonstrate how I integrated mainly at a theoretical level during the second year. By theoretical integration, I am referring to the development of the ability to hold in mind and apply different therapeutic models (Norcross & Arkowitz, 1992). I also attempted to illustrate how broader psychological literature was integrated into my practice as an aid to a more holistic and comprehensive understanding of the client’s difficulties.

**Year III: Working as an integrative practitioner in an alcohol service**

In the third year, I worked in an alcohol service, which is part of a larger substance misuse service that operates using a multidisciplinary team approach. My role within the team involved conducting generic assessments, seeing clients for alcohol-specific work and also, offering specialist cognitive-behavioural interventions.

Evaluating my experience of working in this context, it would be fair to say that this placement turned out to be the most appropriate arena for my development as an integrative practitioner. The ways in which I integrated during the third year went beyond a theoretical integration of different approaches. I started integrating within the therapeutic relationship, taking into consideration what clients needed at given moments in time. This was guided by Clarkson’s (1990) model of the five therapeutic relationships, namely the working alliance, the transference/counter-transference relationship, the developmentally needed reparative relationship, the real relationship and the transpersonal relationship. Using this approach to integration was particularly relevant in the specific context, as the clients of the service came at different stages in terms of their motivation for change (Prochaska, et al., 1992) and hence, needed different interventions.
Most of the clients, who presented at the alcohol service, were at a *contemplative* stage with regards to their addictive behaviour. Hence, whereas they were willing to examine the problems associated with their alcohol use, they were still ambivalent about taking any constructive action. My role as an integrative psychologist was to assist them to move into a *preparation* stage, meaning a stage in which they were willing to make actual changes to their alcohol use. In order to help them achieve this shift, I used ‘motivational interviewing’ (Miller & Rollnick, 1991). Motivational interviewing is a therapeutic approach that raises a client’s self-esteem and awareness of problems by eliciting self-motivational statements and pinpointing motivated behaviour. As every other cognitive-behavioural intervention, motivational interviewing calls for a collaborative relationship between client and therapist. In Clarkson’s (1990) model of the five therapeutic relationships this corresponds to the working alliance.

To demonstrate this further I will briefly discuss Mr. Carter. When he self-referred to the alcohol service the client drank in the range of 140 units of alcohol per week. He reported having been dependent on alcohol for the past ten years. Mr. Carter also had a long history of psychiatric hospitalisations and had been diagnosed with paranoid schizophrenia. The main focus of the sessions with the client was to help him achieve controlled drinking, as he had reached a stage in which he acknowledged how debilitating his alcohol consumption was. Despite this realisation, Mr. Carter was rather ambivalent about taking action to reduce his drinking. Building a solid working alliance was key in assisting the client move from a contemplative stage to one of action. This was a challenging task, as the client due to his experience as an inpatient was rather wary of mental health professionals. It took a number of sessions before basic issues of trust were worked through in order for the working alliance to be established. Again, the humanistic values of empathy, congruence and unconditional positive regard were key in conveying to the client that the therapeutic relationship was a place where he would be valued and respected. Once the working alliance was built and through the use of motivational interviewing, Mr. Carter managed to achieve significant changes to his drinking by reducing his weekly consumption to 50 units per week.
Another important aspect of my work in this setting was to address other concurrent psychological difficulties clients presented with. This is evident in the case of Ms. Holmes. The client presented at the alcohol service, as she was increasingly concerned about her alcohol consumption. The aim of therapy was to achieve controlled drinking and work on her long-standing symptoms of depression and low self-esteem. In the beginning of therapy, the sessions focused more on the client keeping drink diaries with the aim of managing to control her drinking. This, as in the case of Mr. Carter, required building a good working alliance. As the sessions progressed the focus shifted and we looked at the patterns in Ms. Holmes' relationships and how her schemas (Young, 1999) about herself and others maintained these patterns and contributed to her depressive symptoms.

It was the client’s account that she never experienced any empathy or warmth from her parents during her formative years. Her mother was physically abusive towards her and her sisters and only maintained a close and loving relationship with her brother. It would seem that this lack of emotional connectedness that is so critical during a child’s formative years could account for the client’s development of a self-schema of unlovability (Young, 1999). Ms. Holmes had no trust in her ability to maintain close relationships, as she felt unwanted and inadequate and feared rejection when she exposed herself to other people.

Providing Ms. Holmes with a corrective emotional experience through working in the developmentally reparative relationship (Clarkson, 1990) was crucial in her treatment. The client had never experienced herself as somebody who had value or was worthy of other people’s attention. The consistency of the therapeutic relationship and the gradual growth in her ability to trust me was one of the main agents of change, as it provided her with alternative experience that constituted evidence against her schema of unlovability.

In this section, I have attempted to demonstrate how I worked as an integrative practitioner in the three years of the training and how my approach to integration was shaped by the context I worked in. I will now discuss the current trend for evidence-based practice and how evaluation of practice constitutes an integral aspect of my work.
Evaluation of practice versus evidence-based practice

Barkham (1990) argued that the ability to use research-based evidence and to engage in ongoing research is crucial to the credibility of counselling psychology. This is in accordance with the scientist-practitioner model under which the discipline operates. However, adopting a scientist-practitioner model can be rather problematic at times. Counselling psychologists' approach to practice is phenomenological in that as therapists we are concerned with validating the individual experiences of our clients. This could potentially come in epistemological opposition with the traditional scientific focus on measuring objective reality.

Outcome research in psychotherapy is concerned with comparing different therapeutic approaches and evaluating which therapy works best for which client. One of the main criticisms of outcome research is that the applicability of its findings into clinical settings is questionable. This holds particularly true for the outcome studies that are strictly carried out using quantitative research methods such as randomised experimental and control groups. Findings from such studies are usually theoretical, as the participants can by no means be mapped against individuals who seek therapeutic help. At the heart of counselling psychology lies the need to validate clients' individuality. Persons have an innate will to be different, to live and understand their lives in individual ways. Therefore to assume that two psychotherapeutic interventions could be the same is not to acknowledge the nature of human beings (Rustin, 2001).

This is not to argue that as counselling psychologists we should oppose evidence-based practice. However, there needs to be recognition that its scope is rather limited. Woolfe (1996) suggests that one way of resolving this conflict is by the adoption of methodological diversity. Qualitative research, such as grounded theory, discourse analysis and interpretative phenomenological analysis (IPA), is concerned with the subjective experiences of the individual. My own research into the decision-making of lesbian couples about parenting and the role of therapy in facilitating this process focused on the subjective experiences of individual couples. For therapeutic professionals working with lesbian women and/or with lesbian couples and their
children, the findings from this study extend the evidence base from which informed practice can draw.

I view evaluation of practice as a phenomenological process. In that respect, what I attend to is the client's perception of what they gained from therapy. This evaluation takes place both in the course of each session but also at the end of therapy with each individual client. Evaluation of practice at an individual level also depends on the practitioner's capacity for self-reflection. Two experiences that have been instrumental in my developing capacity for self-reflection are supervision and personal therapy.

**The internal supervisor**

Throughout the three years of the training, supervision has been invaluable in my development as a counselling psychologist and an integrative practitioner. Supervision has not only been essential in furthering my understanding of different clients but has also enabled me to engage in a continuous process of self-reflection. According to Casement (1985) 'internal supervision' involves the ability of the therapist to 'be' with the client and at the same time, maintain enough distance to observe and function as a therapist. It is Casement's view that novice therapists initially depend significantly on their supervisors for guidance and advice. Through the course of time and further experience they begin to develop a capacity for self-reflection, in other words, an 'internal supervisor'. Indeed looking back on the training and my experiences in supervision, I remember relying heavily on my supervisor's suggestions especially in the early days of my therapeutic practice. However, as the training progressed, I gradually started to act as my own supervisor by paying close attention to clients' narratives and using different theories to inform my practice.

As I began to feel more confident in my abilities as a therapist, I became more able to 'listen' from multiple perspectives (Frederickson, 1999). Working as an integrative practitioner, I focus my attention on clients' communications at a multiplicity of levels. Listening at a 'humanistic' level, I attend to the ways in which they make meaning of their experiences (Rogers, 1951). Listening at a 'psychodynamic' level, I
am in tune with the clients' 'unconscious communications' (Smith, 1991) and listen for narratives that reflect the transference relationship (Kahn, 1997). Listening at a cognitive level, I am actively identifying clients' 'negative automatic thoughts' (Beck et al., 1979) and maladaptive schemata (Young, 1999). This developing ability to listen from a multiplicity of different perspectives has been greatly facilitated by the experience of working and being supervised in different models and constitutes a main ingredient of my integrative practice.

The value of personal therapy

Personal therapy has been another crucial factor that has contributed to my evolving ability for self-reflection. Exploring my own conflicts and becoming aware of them has been invaluable in my ability to work effectively with clients. In Corey's (1996) words:

Therapists cannot open doors for their clients that they have not opened for themselves (p.21).

In addition, personal therapy has provided me with the experience of being a client. Sometimes during the early days of my work, I felt frustrated when clients did not change the patterns of their behaviour, even after having recognised how maladaptive these were for their lives. Being a client in my own therapy helped me appreciate how difficult and threatening change can feel and taught me to be more patient with my clients. It also made me more attentive of potential power inequalities in the therapeutic relationship.

Personal therapy was key in my development both as a person and as a professional. Finally, my development as a counselling psychologist has been greatly influenced by my personal view of the world, which in essence allowed me to arrive at my own personal integrative position.
Integrating the personal and the professional self

Fear and Woolfe (2000) described the process of integration as a journey in which the practitioner's personal and professional selves move into some sort of harmony and congruence. It is their understanding that in order for this integration to take place, each individual therapist should operate within a theoretical orientation that encompasses the same underlying assumptions as their own vision of the world.

Four visions of the world have been identified in the literature: romantic, tragic, comic and ironic. The 'romantic' vision sees people as free and in control of their own destinies. Humanistic therapies are consistent with this vision. The 'tragic vision' focuses on the notion of inevitability and describes a process of repetitious compulsion as reflected by the assumptions made by psychodynamic therapies. The 'comic vision' focuses upon the way in which an individual develops an increased capacity to understand what is needed to fulfil social roles and adapt in the world. Cognitive therapies are consistent with this vision.

Thinking about my own personal vision of the world and how it has shaped my position on integration, I mostly identified with the 'ironic' vision. Unlike the three others, the ironic vision sees 'good' and 'bad' as co-existing. The essence of this vision lies in its ability to hold contradictions together and tolerate the tension created by the attempts to accommodate them.

Psychodynamic, behavioural and humanistic theories have been viewed as antithetical and contradictory throughout the history of psychology. I agree with Clarkson's (1996) view that these three philosophical traditions could be seen as complementary and mutually enriching. It is my position that human development is too complex and psychological problems are too multidimensional to be explained by a single theory. In practice, this means that no approach can be considered to contain the 'absolute' truth. Instead, it is through the use of different approaches that a more rounded picture of human beings can be construed.

This paper has attempted to discuss my own development as an integrative practitioner. Various influences that shaped my personal way of integrating theory
and research into practice have been discussed. However, this process has by no means come to a conclusion, as being an integrative counselling psychologist involves a continuous process of personal and professional development. In Clarkson's (1996) words:

"Any good, competent and growing counselling psychologist is always integrating themselves, whether between or within schools, their professional and life experiences or between themselves and the learning they forge in the relationship with their clients" (p.260).
References


RESEARCH DOSSIER
The Research Dossier contains three research reports: a literature review and two empirical studies using qualitative and quantitative methods of data analysis. The literature review critically evaluates the psychological implications of lesbian and gay parenting both for lesbian and gay parents as well as for their children's emotional, social and sexual development. Specific emphasis is given to the different challenges, which lesbian and gay couples face upon deciding to become parents. The first empirical study investigates the processes by which lesbian couples make various decisions associated with parenting, using interpretative phenomenological analysis. The second empirical study examines clinical and counselling psychologists' attitudes towards lesbian parenting and their beliefs about sexual orientation, using a factor-analytic approach. All three pieces of research constitute a single research programme that also considers the ways in which therapeutic practice with lesbian families can be enhanced.
Abstract

In recent years, there is a whole generation of children who grow up as part of planned lesbian and gay families. In this review, there is an attempt to consider the psychological implications that lesbian and gay parenting has both for lesbian and gay parents as well as for their children's emotional, social and sexual development. Specific emphasis is given to the different challenges, which lesbian and gay couples have to face upon deciding to become parents. The role of the counselling psychologist in assisting these couples is discussed and guidelines for research and therapeutic practice are provided.
Abstract

In recent years, there is a whole generation of children who grow up as part of planned lesbian and gay families. In this review, there is an attempt to consider the psychological implications that lesbian and gay parenting has both for lesbian and gay parents as well as for their children's emotional, social and sexual development. Specific emphasis is given to the different challenges, which lesbian and gay couples have to face upon deciding to become parents. The role of the counselling psychologist in assisting these couples is discussed and guidelines for research and therapeutic practice are provided.

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Short title: Lesbian and gay parenting
Introduction

Research in the area of lesbian and gay psychology was first undertaken by psychologists in the mid-1970s. Up to that time, psychological research had mainly focused on the origins of homosexuality, as the explicit assumption was that same-sex orientations are yet another form of pathology. With the emergence of the feminist tradition and Gay Liberation movement, homosexuality was removed as a diagnostic category from the Diagnostic and Statistical Manual of Mental Disorders in 1973 (Greene, 1994). At the present time, quite a large amount of research in the area of lesbian and gay psychology exists both in the United States and increasingly so in the United Kingdom.

Within lesbian and gay psychology, one of the issues that has received great attention is that of lesbian and gay families. Although families with a lesbian or gay parent have always existed, it was not until the 1970s that they started being visible and gaining public attention (Golombok & Tasker, 1994). This shift occurred when lesbian women started to fight for the custody of their children following divorce. For the past two decades, researchers in the field have provided evidence on the children of lesbian and gay parents in an attempt to inform both public consciousness and court decisions regarding custody. At the present time, although chances that a lesbian mother is going to be assigned custody of her children are higher compared to the 1970s (Rivera, 1991), it is still the case that there are lesbian mothers who are denied custody of their children on the grounds of their sexual orientation and lifestyle. Thus, it seems quite reasonable that research in the area of lesbian and gay parenting has mostly focused on attempts to compare lesbian and gay families to heterosexual families always with the aim of challenging the myths and prejudices regarding lesbian and gay parenting (Parks, 1998).

In recent years, there is also a new generation of children who are growing up as part of planned lesbian families (Tasker, 1999). As the options for lesbian couples increased, many lesbian mothers decide to have children through adoption or donor insemination. Thus, as lesbian couples have started to create their own families, research has started to shift its focus to the processes of lesbian family formation as well as the unique challenges these families might face (Patterson, 1995). However,
the amount of research that has been conducted with planned lesbian and gay families, as its focus, is still rather limited compared to that which has lesbian and gay parents who come from previous heterosexual marriages as its focus.

In this paper, there will be an attempt to review the psychological implications that lesbian and gay parenting might have both for the lesbian or gay couples who decide to undertake such an endeavour and for their children. When one undertakes such a complicated task such as to provide the potential reader with a comprehensive review of literature conducted in such a rapidly expanding area, there are certain choices to be made. In this specific instance, one of the most essential choices made in the writing of this paper, was that of focusing on a specific group of lesbian and gay parents. Up to recently, research in the area of lesbian and gay parenting had adopted a rather defensive stance. As mentioned above, this can be justified in light of the need to come up with valid scientific evidence that would inform both the formal and informal judges and juries of our society about the actual consequences that growing up in lesbian or gay families has for children's development. This very important task has to a certain extent been accomplished. What still remains largely unknown though, are the everyday personal and familial experiences of lesbian and gay parents and their children (Laird, 1996). Also, with regards to therapeutic implications, the concerns that lesbians and gay men face upon making the decision to become parents are very different to those of gay and lesbian parents who were previously engaged in a heterosexual marriage. It would seem that examining the unique challenges that this particular group faces could provide us with rich information both about the strengths and resilience of lesbian and gay families. Since the existence of lesbian and gay led families has altered the definition of 'family' itself, it seems imperative to examine both its contribution to the deconstruction of gendered parenting as well as to the revising of family theory and therapy in general.

In such a way, a brief overview of the research findings with regards to children's emotional, social and sexual development when growing up in a lesbian or gay family will be provided. The main focus of this paper though will be on lesbians and gay men and the different dilemmas and challenges that they face upon deciding to become parents. Finally, the role of the counselling psychologist in assisting this process will be highlighted.
What about the children?

Brief overview of children’s development in lesbian/gay families

The research to date regarding children born to or adopted by lesbian mothers is quite limited (Patterson, 1995). At the same time, research on children adopted by gay fathers or born through surrogacy in the context of a gay relationship is absent. In this section, there will be an attempt to review the findings regarding the emotional, social and sexual development of children born or adopted by lesbian led families.

Emotional development

In one of the first studies of children born in planned lesbian families, Steckel (1987) compared the progress of individuation-separation among pre-school children born via donor insemination to lesbian couples with that among same-age children of heterosexual couples. He also compared ego functions and object relations amongst two groups of children. His results suggested that there was a great similarity in the development of the children in the two groups. Similar findings have been reported by McCandlish (1987), who conducted an uncontrolled clinical study. He found that children formed secure attachments to both mothers and showed no evidence of psychological difficulties. Moreover, Flaks et. al. (1995) compared the cognitive functioning and behavioural adjustment of children of lesbian mothers who were born through donor insemination to those of heterosexual mothers and found that there were no differences between the two groups of children. Golombok, Tasker and Murray (1995) who compared children born in the context of lesbian relationships with those of heterosexual mothers, found that children had similar high levels of psychological adjustment and that children in lesbian families were no more likely to have emotional or behavioural problems than children in father-present households. On the other hand, Steckel (1987) reported some differences between children born in heterosexual and lesbian families. He found that children of heterosexual parents saw themselves as more aggressive, bossy and domineering, whereas children of lesbians saw themselves as more lovable and were described both by teachers and parents as more affectionate, responsive and protective toward younger children.
Social development

The first study to examine psychosocial development among pre-school and school-aged children born to or adopted by lesbian mothers was conducted by Patterson (1994). What she found was that children scored in the normal range on a variety of standardised measures, including the Achenbach and Edelbrock Child Behaviour Checklist, which is a measure of behaviour and social problems and the Eder Children's Self-View Questionnaire, which is a measure of self-concept. However, on two subscales on the self-concept measure, children of lesbian mothers reported feeling more reactions to stress but a greater sense of well-being than did children of heterosexual mothers. Patterson (1994) provided alternative interpretations for this finding, such as the possibility that children of lesbian mothers reported greater reactivity to stress because they experienced more stress in their daily lives. Golombok, Tasker and Murray (1997) found no differences in ratings of maternal or peer acceptance in children born to lesbian compared to heterosexual couples.

Sexual development

One of the major concerns that courts have had in assigning custody of children to lesbian and gay parents, was the 'fear' that children growing up in lesbian or gay families, would themselves grow up to become gay or lesbian as well. This was for many years, one of the strongest arguments courts used in order to justify their denial of custody to lesbian and gay parents (McLeod & Crawford, 1998). Of course, behind this argument there is the implicit assumption that lesbian and gay sexualities are an undesirable pattern of behaviour. Despite the lack of any validity of this argument, researchers have tried to examine whether the children of lesbian or gay couples were more likely to engage themselves in same-sex sexual activities. All studies conducted in this area reported consistently that children of lesbian or gay parents were no more likely to engage in same-sex sexual activities than children of heterosexual parents (eg., Patterson, 1992; Golombok & Tasker, 1996). However, most of the studies that have examined the development of sexual identity in the children of lesbian and gay parents have used children that came from heterosexual marriages as their sample. In a study that was conducted by Patterson (1994), it was found that children reported preferences for sex relationships that were considered to be normative for their age.
Currently, there is a growing interest in research in the area of planned lesbian families. Still, the amount of research that has been generated at the present time is rather limited. Nevertheless, from the research mentioned above, one can conclude that no major differences seem to be evident in the emotional, social and sexual development of the children being born in lesbian families as compared to those born into heterosexual families. At the same time, research in the area of planned gay families seems to be absent. Even more so, there seems to be a growing need to go a step backwards from considering the potential implications lesbian and gay parenting might have for children's development to consider the implications of parenting for the lesbian and gay couples themselves. The rest of this paper will focus on lesbian and gay parents in an attempt to review the literature on the challenges they might face as well as the implications for therapeutic practice with this population.

What about the parents?

Preparation for parenthood: Dilemmas and decisions

The transition to parenthood is a very significant process in the lives of lesbian and gay couples as in the lives of heterosexual couples. Although there is a substantial body of research regarding the transition to parenthood for heterosexual couples (Cowan & Cowan, 1992), very limited attempts have been made to conduct research on the additional issues faced by lesbian and gay couples who decide to become parents (Patterson, 1998). Gartrell et al. (1996) interviewed both biological mothers and co-mothers of children who were conceived by donor insemination. One of the aims of their study was to identify the pregnancy motivations of lesbian mothers. The analysis of the data indicated that among 39 first-time prospective mothers, the desire to have a child was recent in some and long-standing in others. Lesbian mothers described their decision to become parents as related to their love of children, belief in their ability to be good parents, and the desire for stability in their lives.

At this point, it should be mentioned that perhaps attempting to come up with different factors that might contribute to lesbian or gay couples' decision to become parents might be indicative of an implicit assumption that lesbian or gay couples
should be able to come up with different sets of reasons for becoming parents than heterosexual couples. Whereas making this assumption would undermine the significance of recognising the similarities that exist between lesbian and gay and heterosexual couples, it is still important to consider the possibility of differences as well. As Kitzinger & Coyle (1995) have pointed out, placing emphasis on the similarities between heterosexual and same-sex behaviours is a phenomenon frequently observed in research conducted in the area of lesbian and gay relationships as well. However, as they explain this emphasis originates from a 'liberal humanistic' framework and has the inevitable shortcoming of failing to examine the specificity and social context of lesbian and gay relationships. Thus, issues such as the potential difficulty that lesbian women or gay men might face in integrating positive identities both as lesbians and gay men and as parents (Bozett, 1981; Levy, 1989) might be dimensions that differentiate the transition to parenthood for this specific group. Crawford (1987) and Pies (1990) have considered the process of choosing parenthood for lesbian couples and identified that one of the concerns of lesbian mothers is that if they chose motherhood they should be prepared to be something more than 'ordinary' mothers. Following the actual decision to have a child, there are certain further decisions and dilemmas that lesbian and gay prospective parents usually face.

Method of conception

One of the major decisions that lesbian and gay couples have to make is that of the method of the child's conception. Out of the latest available options for lesbian couples is that of alternative or artificial insemination by donor (AID). Other options involve adoption, foster care and heterosexual intercourse. As far the option of donor insemination is concerned, one further decision that lesbian and gay couples have to make relates to whether the identity of the donor will be known or not. One of the factors that frequently lead to the choice of an unknown donor through the use of a sperm bank or medical facility is that it is considered to be the safe decision in that it excludes the possibility of future paternity claims on the child (Hare, 1994). On the other hand, there are also lesbian couples who decide that they want the donor to assume some parental role and as a result, choose a known donor. This usually relates to the extent that the lesbian woman or couple feel that they want their child to know about his or her biological origin. One more option available for lesbian
women is self-insemination which involves the donor producing sperm and then delivering it to the receiver who following, puts it into her vagina using a syringe without a needle (Hargaden & Llewellyn, 1996). In a study by Gartrell et. al. (1996), who conducted interviews with prospective lesbian mothers, it was found that 45% of the lesbian mothers chose to use a known donor, whereas 47% chose to use an unknown donor. From the mothers that chose a known donor, the expectancy that he would be involved in the care of the child was evenly divided among lesbian mothers. This is in accordance with Patterson (1998) who found a tremendous amount of variability in the amount of information lesbian mothers had about the donor or the biological father of the child. Adoption is also increasingly becoming a parenting option for lesbian couples. The issue that arises in that case is that depending on the adoption agency the acceptability of lesbian couples might vary. Thus, in many cases only one partner makes the application to adopt a child instead of applying as a same-sex couple (Hare, 1994). Finally, there is the alternative of heterosexual sex. However, the psychological implications of such a choice have not been addressed (Hargaden & Llewellyn, 1996). As Tasker (1999) points out, in the United Kingdom, most lesbian mothers have chosen to avoid fertility clinics exactly because this would mean that they would have to account for their sexuality and to present a 'case' for the validity of their decision. Instead, self-insemination is considered to be the most popular way of conceiving a child through the help of a volunteer donor. Sometimes the donor may be a gay man who is involved in co-parenting the child (Tasker, 1998). This is one of the ways in which gay men become fathers.

Other than co-parenting a child with a lesbian couple or a lesbian friend, there are some other paths that gay men can follow in order to become parents. For one thing, there is the possibility of an arrangement with a lesbian friend that she bears a child to be raised solely by a gay couple. In addition, there is also the option of adoption but it seems that it is much more likely for gay men to be discriminated against, especially given the fact that men are traditionally not considered to be 'child carers' (Hargaden & Llewellyn, 1996). Still, gay couples have also started creating families through adoption and surrogacy (Martin, 1993), the latter allowing a biological link between father and child. However, only a very small number of studies have been
conducted at the present time focusing on gay planned families and their children (e.g., Sbordone, 1993; McPherson, 1993).

**Biological, social and legal aspects of parenthood**

In traditional nuclear families, one cannot distinguish between the three aspects of parenthood, as these are defined by parents' biological connection to their child, their social duties towards the child, and the laws that protect this relationship. However, even for heterosexual couples the conditions are gradually changing since, on many occasions, children are born outside marital relationships or using alternative forms of donor insemination or even live with adults who are not their legal parents (Patterson, 1998).

A family structure that is by definition reflective of this change is the planned lesbian and gay family. In lesbian and gay 'families of choice' biological, social and legal aspects of parenthood are quite distinct from one another. One fine example of this distinction is that when a lesbian couple decides to have a child through unknown donor insemination, the child grows up knowing only one of his or her biological parents and most likely only one of the two parents has legal custody of the child. Nevertheless, that child grows up having two social parents. The question then arises, about whether this lack of overlap between biological, social and legal aspects of parenting differentiates the roles a lesbian or gay couple chooses to adopt in bringing up their children (Patterson, 1998). In other words, what then becomes the focus of inquiry, is the extent to which the lack of biological or legal connection between the non-biological parent and the child influences their relationship or the amount of responsibility the non-biological parent undertakes in bringing up the child.

Slater (1995) has discussed the difficulties involved in the role of the 'second lesbian parent'. The non-biological mother starts being excluded from forming a close bond with the child even from the stage of her partner's pregnancy. In cases of adoption, often only one member of the lesbian couple makes contact with the agency and is the one who obtains legal custody of the child. The reason behind this choice is the potential discrimination that lesbian couples come up against if they are open to agencies about the nature of their relationship and the family the child will grow up
in. Following the birth of the child, in most cases, the social environment of the non-biological parent is unable to recognise how significant the transition into parenthood for the non-biological mother might be. Crawford (1987) discussed how difficult it can be for the non-biological parent to overcome a sense of being invisible, which is how the school, the families of origin and the society as a whole, makes her feel. Green (1987) has also discussed that the non-biological mother tends not to be viewed as a 'real mother'. Other issues that might arise may involve even the name the child will use for the non-biological parent. It has been suggested that the term 'co-parent' offers some recognition to the role of the non-biological parent but at the same time, fails to acknowledge the lesbian partner's gender. Thus, it becomes evident that since difficulties arise even in considering a name for the non-biological parent, undertaking the task of defining a role might be even more complicated (Muzio, 1993). Apart from the potential lack of acknowledgement of the second parent's relationship with the child, a further difficulty might arise because parenting roles are socially constructed along gender lines. Hence, the lesbian couple is called to 'envision a second, parenting role for a woman' (Slater, 1995, p.97). At the same time, the non-biological parent being legally invisible has no way of ensuring visitation rights to the child, in case the lesbian couple splits up (Benkov, 1998; Rivera, 1991). One would then, expect that this power that the biological parent has in relation to the child, could easily result in a power imbalance in the lesbian couple's relationship.

However, some research findings have indicated that the picture might be slightly different. Despite the validity of the above-mentioned difficulties that the non-biological parent might have to encounter as part of her co-parenting role, research in lesbian-led families has demonstrated that lesbian couples have found ways to overcome these difficulties. Gartrell et al. (1996) interviewed seventy lesbian families, which included both a co-mother and a birth mother whose child was conceived by donor insemination and found that there was no difference in jealousy with regards to bonding in prospective birthmothers and co-mothers. Moreover, both biological and non-biological mothers reported that they were surprised by their work colleagues' support. This finding is contradictory to the notion that only biological mothers are invisible in their social environments. Patterson (1995) conducted a study to assess lesbian couples' division of labour and their children's psychosocial
adjustment. The findings of this study indicated that both parents reported sharing the household tasks equally, however, the biological mothers reported greater involvement in childcare, whereas non-biological mothers reported spending longer hours in paid employment. She also found that parents were more satisfied and the children better adjusted when childcare was more evenly distributed. On the other hand, Sullivan (1996) found that lesbian couples make an equal division of labour including the aspect of childcare. However, he pointed out that economic dependency is likely to determine the inequitable distribution of domestic responsibilities. Mitchell (1996) compared lesbian couples to heterosexual couples and found that the distribution of work, influence and time is more equal for lesbian couples, since heterosexual couples are equally involved in the decision-making but not in the actual parenting tasks. Moreover, she found that in lesbian couples there are very few feelings of competition for the parenting role. Instead the couple is jointly able to discuss all the aspects of parenting. These findings are in agreement with previous research that suggested that equity is an important aspect in lesbian relationships (Kurdek, 1988; Peplau, 1991; Schreurs & Buunk, 1996). Hence, it is potentially the principle of equity, which is valued by most lesbian couples, that might be providing a coping mechanism that enables them to avoid the potential power imbalance that could arise in their relationship because of the biological parent’s legal custody of the child.

Another issue that lesbian led families are called to resolve is that of the child’s surname. Patterson (1998) found that this was an issue that arose for the families who had participated in the Bay Area Families’ Study and that mothers adopted a number of different approaches in an attempt to come up with satisfactory solutions. Most of the mothers chose to give to the children the surname of the biological mother. However, the members of these families, despite the absence of a common surname, were very clear about their family identity. Another popular choice was giving the child a hyphenated surname, which was created from the surnames of both mothers. One family had decided to give the child the surname of the non-biological mother in order to emphasise her inclusion in the parenting role. Other lesbian couples chose to use a word that had a special meaning for them for the child’s surname. Thus, although most couples had chosen the surname of the child
along biological lines, other couples were able to find imaginative ways that assisted them in defining their families' connectedness.

Still, one should keep under consideration Patterson's (1998) findings, which suggest that although there might be an equal distribution of childcare in lesbian couples, biological mothers have reported that they undertake responsibility for more of the childcare than non-biological mothers. The significance of the biological relationship with the child is also evident in other findings (e.g., Hand, 1991; Osterweil, 1991). Hand (1991) concluded that although lesbian couples shared parenting more equally than heterosexual couples, lesbian biological mothers viewed their maternal role as more salient than did any other mothers, lesbian or heterosexual. Osterweil (1991) also reported that according to her study, biological mothers viewed their maternal role as more salient than did non-biological mothers. These findings do not suggest, however, that non-biological mothers do not feel emotionally connected with their children. In one of the first studies conducted with lesbian led families, McCandlish (1987) reported that regardless of their interest in parenting before the birth of the first child, the non-biological mothers in each couple unanimously reported "an unexpected and immediate attachment to the child" (p. 28). However, he also noted that attachment and bonding for the non-biological parent comes especially after early infancy. Thus, one might hypothesise that biological linkages are important in lesbian led families not in terms of family formation but in terms of structuring the relationships within the family, once the latter has been created. This is quite contradictory to the notion that non-biological mothers have difficulty experiencing themselves as 'real' mothers since, despite their reliance on biology, Patterson (1998) found that lesbian families were rather unanimous in regarding both women as 'mothers'.

Finally, one might conclude that despite the difficulties inherent in the role of the 'second parent', lesbian couples are to a certain extent able to deal with these challenges constructively. A good indicator of this ability is the finding that lesbian parents' relationship satisfaction is very high compared to norms for relationship satisfaction among heterosexual couples (Patterson, 1995).
In terms of research on gay men who became fathers after identifying themselves as gay, very limited research has been reported in the literature. McPherson (1993) examined division of labour, satisfaction with division of labour and satisfaction with couple relationships among gay and heterosexual parenting couples. He found that gay couples reported a more equal division of household duties and childcare than heterosexual couples. In addition, gay couples reported greater satisfaction with their division of childcare tasks and greater relationship satisfaction than heterosexual couples. This finding is in accordance both with findings about division of childcare duties in lesbian couples (Hand, 1991; Mitchell, 1996; Osterweil, 1991; Patterson, 1995; Sullivan, 1996) and with findings regarding the importance of equality in gay couples' relationships (Kurdek, 1995; Peplau, 1991). However, in McPherson's (1993) study, the role the biological connection to the child plays in determining parenting tasks and responsibilities was not examined. Thus, the extent to which gay couples face similar dilemmas and challenges regarding the inclusion of the 'second parent' to those of lesbian couples is open to future research.

The lesbian/gay family cycle

Stage and life cycle theories have always been central in developmental theory as well as in family therapy (Laird, 1993). In lesbian and gay psychology, stage models have been also quite prevalent especially taking into consideration the different 'coming out' models that have been developed in an attempt to describe the development of lesbian and gay identities (eg., Altman, 1971; Cass, 1979; Ettore, 1980; Minton & McDonald, 1984; Troiden, 1988). However, these models have been criticised on the basis of their liberal humanistic ideology (Kitzinger, 1989).

In the case of lesbian and gay family cycle models, Slater and Mencher (1991) were the first to draw attention to the fact that family cycle models in the literature were based on entirely heterosexual assumptions and milestones (eg. Carter & McGoldrick, 1980). In recent editions, Carter and McGoldrick's (1989) revised model of the family cycle acknowledges the existence of lesbian led families. However, as Malley and Tasker (1999) have suggested, their view of lesbian relationships appears to emphasise pathological patterns without considering the wider context of lesbian and gay relationships. Slater and Mencher (1991) explain that heterosexual culture,
recognising the power of validation in sustaining family life, has devised different rituals for this purpose. On the contrary, the lesbian family cycle seems to be empty of rituals that move a family through life. In such a way, the issue of lesbian families’ invisibility and lack of social validation was identified and the authors concluded that there was an immediate need for the development of “an accurate articulation of normative life cycle stages of family life” specific to lesbian families (Slater & Mencher, 1991, p. 381).

Slater (1995) has proposed a five-stage model of the family life of lesbian couples based on the changes that progressively occur in the couple’s relationship. The model does not include parenting events, since it is suggested that heterosexual family cycle models are typically child-centred, whereas the lesbian life cycle is typically not. The first stage of the model focuses on the formation of the couple’s relationship. In stage two, the couple has to negotiate the balance in their relationship, and to find ways of dealing both with their similarities and differences. The key element of stage three is commitment to the relationship, together with a deepening in the partner’s understanding of themselves and of each other. Stage four is the stage of generativity and is a time when partners share common involvements with each other, one of which may be parenting. Finally, in stage five issues faced by older couples are discussed such as retirement and even the potential loss of a partner.

In a similar way, McWhirter and Mattison (1984) have attempted to come up with a developmental model of gay relationships. In their model, the six stages are blending, nested, maintaining, collaborating, trusting and repartnering. In the two additional stages of this model, partners may experience a lack of communication and an attitude of taking the relationship for granted but with stage six, renewal of the relationship occurs and at that stage partners assume that they will remain together until separated by death. The possibility of gay couples becoming parents is not included as part of this model.

While these two models might be quite significant and outline some of the developmental milestones of lesbian and gay relationships they have important disadvantages. As Malley and Tasker (1999) have suggested, in lesbian and gay
partnerships there might be a greater mix of pairings between members of different ethnic groups compared to heterosexual couples. As a result, it might not be feasible for both partners to be open about their relationship as different ethnic groups might provide a varying degree of support for lesbian and gay families. With regards to lesbian and gay parenting, Slater’s (1995) model has not incorporated it into the family’s life cycle but has instead discussed it as a separate issue, whereas, McWhirter and Mattison (1984) have not discussed it at all. Thus, both models have failed to consider the changes that take place in both lesbian and gay couples’ relationships, following their potential decision to become parents. Slater (1995) has discussed some of the issues that potentially arise following lesbian couples’ decision to become parents. However, she has not placed the transition to parenthood in the context of the model. This way, the model has failed to consider the different ways in which parenting could affect the lesbian couples’ relationship depending on the actual stage the relationship is at. Finally, the lesbian and gay family cycle models have the drawback inherent in all stage models, namely that they leave very little room for individual differences and fail to describe processes within relationships. Thus, these models might have been more useful had they identified the processes that take place in the development of lesbian and gay relationships, instead of a series of cumulative stages. In a similar fashion, the processes involved in lesbian and gay couples’ decision to become parents could be identified together with the ways in which their relationships are affected by this decision.

**Relationships with families of origin**

The lesbian or gay couples’ decision to become parents influences the couples’ relationship with their families of origin in various ways. Some families of origin may be very supportive of this decision, whereas others might have a rather negative reaction. Slater (1995) discussed how upon hearing of the couple’s intentions to raise a child, members of the family of origin reexperience their reactions to their relative’s lesbianism. She also elaborated on the reactions of ‘intrusive’ or ‘underinvolved’ families of origin, describing how the former might be failing to respect the family’s boundaries after the birth of the children and the latter remain largely unavailable “due to their homophobia toward the lesbian family” (Slater, 1995, p.111). At the same time, she also described how supportive families of origin are genuinely
respectful of their lesbian relative. However, she emphasised the fact that the presence of children offers more potential incentives for the families of origin to want to maintain supportive relationships with their lesbian relative. Overall, Slater (1995) devotes more space discussing all the potential difficulties that might arise following the birth of a child in relation to the families of origin. Thus, she fails to consider the possibility that some lesbian couples might have maintained supportive relationships with their families of origin even prior to the birth of the child.

Throughout the literature on lesbians’ and gay men’s relationships with their families of origin, the prevailing picture that emerges is one of disappointment, rejection and emotional cut-off (Laird, 1996). Parental reaction to disclosure of a lesbian or gay identity by a child is usually perceived as a crisis in the family (Jones, 1978), and research has suggested that most lesbian women do not have contact with their families of origin (e.g., Kurdek & Schmitt, 1987; Weston, 1991). Strommen (1989) discussed how parents in the families of origin might progress at different rates of awareness to integration of the disclosure. Thus, for lesbian parents, these reactions can have far-reaching complications.

On the other hand, Lewin (1993), in her study of lesbian mothers, found that mothers regarded their family members and especially their parents, as the most reliable sources of support when times were bad. In addition, she found that becoming a mother oneself seemed to enhance the need for stronger kinship ties for both the mother and her parents. Moreover, Gartrell et al. (1996) reported that when prospective lesbian mothers were asked how their families of origin feel about the prospective child, 78% of the participants expected some relations at least to accept the child. Also, one quarter of the participants reported that their parents were open about their daughter’s sexuality and that they would be similarly open about a child born to their lesbian daughter. In accordance with these findings, Hare (1994) reported that lesbian couples felt more accepted as a family with their own families of origin and among their associates and friends rather than by the lesbian community. One potential hypothesis for the lack of support that lesbian couples experience from the lesbian community is that by becoming parents, lesbian couples build their lives along more traditional dimensions. Thus, their lifestyle becomes rather different from the lifestyle of other lesbians of the lesbian community. In a
study conducted by West and Turner (1995) some lesbian mothers reported that their families were at that time rather supportive. Other mothers expressed less support but acknowledged that their parents tried. Patterson (1998), in an exploratory study with 37 lesbian-mothers, found that the frequency of children’s contact with adults in their extended family was found to counter stereotypes of children being isolated from their parents’ families of origin. However, she also found that children were more likely to have regular contact with relatives of the biological mother. One of the potential explanations that Patterson (1998) came up with was that possibly the lesbian partner who had a better relationship with her family of origin was the one that decided to become pregnant. On the other hand, an alternative hypothesis might be that families of origin define ‘family’ along more traditional lines and thus, the degree of their biological connectedness to the child determines the nature of their relationship.

With regards to gay parents’ relationships with their families of origin, only two studies have been conducted. West & Turner (1995) reported that in their study, gay fathers expressed satisfaction with their own families of origin. In addition, Sbordone (1993) studied gay men who became parents through adoption and surrogacy arrangements and compared them to gay men who were not fathers. He found that there were no differences between fathers and non-fathers on reports about relationships with the men’s own parents. However, gay fathers reported higher self-esteem and fewer negative attitudes about their sexuality than non-fathers. Overall, research in gay fathers’ relationships with their families is very limited and as it is indicated above does not provide any answers as to the actual nature of the relationships or how gay men’s choice to become parents might impact on their relationships with their families of origin.

**Gender differences between lesbian and gay parents**

Some of the different issues that arise following a lesbian or gay couple’s decision to become parents have been reviewed above. The emphasis, however, has been definitely placed upon research that has been conducted with lesbian led families. Due to the very limited extent of research in the area of planned gay families, one
can only make informed hypotheses about whether the different issues that pertain to lesbian led families might also be relevant to gay led families.

Research on the area of lesbian and gay couple relationships has indicated that there are indeed differences between lesbian and gay couples. One of domains of difference is that of sexual exclusivity in relationships. Although both lesbian and gay couples are overall less sexually exclusive when compared to married heterosexual couples, gay couples are much less exclusive than lesbian couples (Kitzinger & Coyle, 1995). This raises a set of questions with regards to whether gay couples that decide to become parents do so in the context of a sexually exclusive relationship or not necessarily so. In addition, if gay couples become parents in the context of a non-exclusive relationship, there is a question about the extent to which the birth of their child might influence the level of exclusivity of the relationship. With regards to the equal sharing of child-care, research has indicated that both lesbian and gay couples value equity in a relationship and thus, one would expect that the tasks of parenting would be equally shared by gay couples as they are by lesbian couples. McPherson's (1993) study has confirmed this hypothesis.

The extent to which difficulties would arise in defining the role of the 'second parent' in gay parenting couples and the extent to which biological connection would influence the nature of the relationships within the family is open to question. A potential hypothesis is that gay men might feel more insecure than lesbian women in undertaking a primary caregiver role because of gender stereotypes that exclude men from primary caregiver roles (Benkov, 1998). Thus, it is likely that biological connection might not play such a significant role for them as it does for lesbian mothers. Gay fathers, having to create their own 'scripts' about parenting roles, might find it easier to achieve balance in parenting tasks and responsibilities.

Finally, since no study has looked at the differences between the dilemmas and concerns lesbian and gay couples face upon deciding to create families of choice, this issue is open to future research.
The role of the counselling psychologist

Having reviewed the different dilemmas and concerns lesbian and gay couples face following their decision to become parents and also, following the birth of their children, what still needs to be defined is how counselling psychologists can help lesbian and gay clients with their concerns. In this section, there will be a discussion of different implications that the research reviewed has for therapeutic practice with this population.

The reasons for which a lesbian or gay couple may seek therapeutic consultation vary. Starting before the lesbian or gay partners have made the final decision to become parents, a therapist may be approached in order to help both members of the couple assess their ability to adapt to the stresses of parenthood (Martin, 1993). One of the major concerns of lesbian and gay couples is whether the decision to become parents might isolate them from their social environment even further. In a study conducted by Gartrell et. al. (1996), prospective lesbian mothers reported that some of their major concerns were raising a child in a heterosexist and homophobic world, raising a child in a non-traditional family, raising a child conceived by donor insemination and the impact of multiple discriminations imposed on them and their children. All these are very significant concerns that should be explored in therapy with prospective lesbian and gay parents. Martin (1998) suggests that although it is important for the therapist not to minimise these concerns, it is equally important to help lesbian and gay couples believe in their ability to overcome these difficulties and to bring prospective parents into contact with other lesbian led or gay led families.

Following the actual decision to become parents, as it has been reviewed above, lesbian and gay couples are required to do a substantial amount of planning in order to make decisions about the method of conception used as well as the amount of involvement they wish the biological other gendered parent to have in raising the child. Again, all possible alternatives need to be explored (Hargaden & Llewellin, 1996) as well as the implications of these decisions. Thus, the informed counselling psychologist should be able to provide information about all the legal considerations, health issues and insemination options involved. In addition, it is the therapist's responsibility to ensure that lesbian and gay couples have carefully thought out the
consequences of their choices. For example in choosing an unknown donor for the conception of their child, lesbian and gay couples should have carefully examined what potential effect this might have on their child's emotional development. On the other hand, in choosing a known donor lesbian and gay couples should make decisions regarding the role they wish the donor to have in bringing up their child (Martin, 1998). After they have made a decision, it is important for the therapist to help the couples to discuss their decisions with the donor, so that everybody is clear on their roles and responsibilities.

Overall, in assisting a lesbian or gay couple with the decision making and the transition into parenthood, Martin (1998) has suggested that the therapist should be prepared to take on a much more active role in the negotiating process. Thus, he has suggested that the therapist should assist both optimistic couples to become more aware of the potential difficulties involved in their decisions as well as help pessimistic couples see some of the strengths and solutions they have overlooked.

In the case of adoption, again the counselling psychologist should have up to date information concerning different adoption services that might be open to considering lesbian and gay couples. Providing this information could save the couple a lot of time and potential disappointment, since some agencies might be openly discriminating against lesbian and gay couples.

In the case where lesbian or gay couples seek therapeutic support following the birth of their child, it is important to clarify whether their newly developed family structure is related to their decision to seek therapy at the specific moment in time. However, Parks (1998) emphasises how this should not be taken for granted as there might be other issues that might have brought the couple to therapy. Thus, the therapist should always keep an open mind, taking into consideration the special issues that these families have to face but also allow space for individual variation.

Overall, as Laird (1996) has argued when seeing lesbian and gay couples in therapy, it is preferable to work under a social constructionist framework. In the specific context of therapeutic practice, this would mean that the lesbian and gay families would be called to co-create new narratives about their problems that would help
them “open up their possibilities for unique outcomes” (Laird, 1996, p. 567). Malley and Tasker (1999) has also reviewed the usefulness of an open agenda for therapy with lesbian and gay parents, with the therapist assuming the position of ‘not-knowing’ in order to create space for the client to generate new meanings for events. Thus, the ultimate task of therapy with lesbian and gay parents would be to enable them to create alternative stories and ways of viewing their lives, also through examining the ways in which social injustices may have constrained them from creating these stories (Laird, 1996). (For a discussion of exemplary practice with lesbian and gay clients, see, Garnets, et al. 1991; Milton & Coyle, 1998).

Guidelines for future research and therapeutic practice

Lesbian and gay families are different than other families and are diverse within themselves. Lesbians and gay men become parents through a variety of different pathways, including a previous heterosexual marriage or the context of a lesbian or gay relationship. A brief review of the effects of growing up in lesbian or gay families on the children’s development has been provided. Research on the issues that lesbian and gay parents might face in their transition to parenthood has been rather limited. This paper was written in an attempt to review the dilemmas and decisions lesbian and gay parents are faced with. Due to the limited amount of research on gay planned families, there was an attempt to consider possible gender differences between lesbian mothers and gay fathers and how these might differentiate their dilemmas and concerns about parenting. Finally, the role of the counselling psychologist in assisting planned lesbian and gay families with their concerns has been reviewed and guidelines for therapeutic practice have been offered.

What then are possible directions for future research? From the review of the literature, there are certain questions that remain to be answered. First of all, we have limited knowledge about the processes that lead lesbian and gay couples into parenthood. Although there is the implicit assumption that lesbian and gay couples’ relationships change following parenthood, we have limited information about the nature of this change. In addition, although there is some awareness of the different issues involved in dilemmas lesbian and gay couples face regarding method of conception, surname and inclusion of both the non-biological parent and potentially
the biological other-gendered parent in the parenting role, future research could potentially identify the psychological processes that are involved in this decision-making. Future research could also attempt to identify the possible strengths and resilience of these families and how counselling psychologists can help them activate these strengths in order to overcome the obstacles that are inherent in their social environment.

Finally, one should also consider how lesbian and gay families are generating new ideas about the formation and structure of families and about how couples and families may operate. Thus, it is our responsibility as counselling psychologists and psychotherapists to develop new ways of thinking and working that will incorporate the narratives and everyday concerns of this special population into our practice.
References


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Decision-Making in Planned Lesbian Parenting: An Interpretative Phenomenological Analysis

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ABSTRACT

Although lesbian parenting has attracted much research attention within psychology in the USA and the UK, the processes by which lesbian couples make the various decisions associated with parenting have been largely overlooked as an explicit research focus. This article presents findings from a qualitative study with nine lesbian couples in England who had had children within their current relationships. Interviews were subjected to interpretative phenomenological analysis. Resultant themes focused on factors internal and external to the partners and the couple which led them to decide to have children; decision-making about using known or anonymous sperm donors (including reflections on experiences of negotiating the nature and extent of the biological father’s involvement with the child); the perceived impact of biological links with the child on decisions about parenting roles (including reflections on the relationship between the non-biological lesbian parent and the child); and the role of therapy in facilitating decision-making. The study may be seen as expanding the knowledge base on lesbian parenting (specifically by adding new English, qualitative data that are attentive to decision processes) and informing professionals who might assist lesbian couples in decision-making about parenthood.

Key words: lesbian parenting; decision-making; donor insemination; qualitative
Decision-Making in Planned Lesbian Parenting: An Interpretative Phenomenological Analysis

INTRODUCTION

Lesbian and gay parenting has received considerable attention within social, developmental and lesbian and gay psychology in recent years, with the majority of research and writing emanating from the USA (for example, Baum, 1996; Chan et al., 1998; Crawford, 1987; Flaks et al., 1995; Gartrell et al., 1996, 1999; Hand, 1991; Hare, 1994; Harris & Turner, 1986; Laird, 1993; Lewin, 1993; McCandlish, 1987; McLeod & Crawford, 1998; McNeill et al., 1998; Mitchell, 1996; Muzio, 1993; Patterson, 1992, 1995, 1998; Pies, 1990; Steckel, 1987; West & Turner, 1995). A smaller European (mostly British) literature exists which explores similar concerns (for example, Brewaeys et al., 1997; Golombok & Tasker, 1994, 1996; Golombok et al., 1983, 1995, 1997; Tasker, 1999; Tasker & Golombok, 1995, 1997, 1998); other useful material also exists that is not located within an explicitly psychological framework (for example, Dunne, 2000; Griffin & Mulholland, 1997). Most of this research (especially in the UK) has centred on the psychological, social and sexual development of children who grow up in lesbian and – to a lesser extent – gay-parented families. More recently, research has also begun to focus on the generation of children growing up as part of planned lesbian families, i.e., where children are planned and conceived within the context of a lesbian couple relationship (through donor insemination, for example) (Tasker, 1999). However, other issues relevant to planned lesbian parenting remain under-researched within (social) psychology, especially in the UK.
Among these is the process by which lesbian couples decide to become parents and the subsequent decision-making which flows from this. These issues have been addressed by studies in the USA (Baum, 1996; Crawford, 1987; Gartrell et al., 1996, 1999; Hare, 1994; Leiblum et al., 1995; Mitchell, 1996; Patterson, 1995, 1996; Pies, 1990) but seldom in the UK and Europe (although some studies have examined similar issues but not from an explicitly decision-making perspective: see Tasker & Golombok, 1998). For example, Gartrell et al. (1996) found that lesbian couples decided to become parents because of their love for children, a belief in their ability to be good parents and a desire for stability in their lives — motivations that overlap with those of heterosexual parents (Cowan & Cowan, 1992). However, some research has also identified specific concerns harboured by lesbian couples, which shaped their decision-making. In the studies by Gartrell et al. (1996) and Hare (1994), the main concerns voiced by lesbian couples focused on the possible implications of raising a child in a non-traditional family in a heterosexist and homophobic world and the effects of multiple discriminations on their children. In addition, Harris and Turner’s (1986) participants pointed to the lack of informal support systems for lesbian (and gay) parents that are typically available to heterosexual-parented families.

Having made the decision to have a child, lesbian couples face a range of subsequent decisions concerning, for example, how conception will occur, the nature and extent of the biological father’s involvement with the child (if they decide to use a sperm donor who is known to them), the role of the non-biological mother, the division of parenting responsibilities within the lesbian couple (and implications for the couple’s relationship) and the negotiation of relationships with the couple’s families of origin. Some psychological studies have addressed some of these issues. For example, with
regard to method of conception, Patterson (1998) found that 27% of the lesbian
couples in her study had chosen a known sperm donor, whereas 46% had chosen an
anonymous donor (other couples had conceived through heterosexual intercourse,
had adopted or had had children in other/undisclosed circumstances). In Gartrell et
al.'s (1996) study of motivations and preferences in lesbian parenting, 45% of
couples expressed a preference for a known donor and 47% preferred an
anonymous donor; 8% did not express a preference (see also Griffin & Mulholland,
1997, on conception options for lesbian parents in European countries). Research has
also reported couples' concerns about how a child conceived through anonymous
donor insemination might respond to not knowing the identity of their biological
father and/or not having a relationship with him (Gartrell et al., 1996; Leiblum et al.,
1995). In relation to negotiating the role of the non-biological parent, McCandlish
(1987) discussed lesbian couples' concerns about whether their children would bond
with the non-biological parent as closely as with the biological mother. Slater (1995)
also examined the difficulties that can be associated with the non-biological parent
role, including a sense of exclusion and a lack of recognition and affirmation of her
parental status from the woman's social environment.

These and other studies of planned lesbian parenting have not adopted an explicit
decision-making focus but have examined decision-making on these issues as one
consideration among many. Consequently they have often sacrificed depth and detail
for breadth of coverage. The study reported in this article examined decision-making
in planned lesbian parenting in a detailed, contextualised way, focusing on the
phenomenology of decision-making through a qualitative examination of accounts
provided by lesbian couples in England who had become parents within the context
of their current relationships. This also represents a departure from traditional
approaches to studying decision-making which tend to be theory-driven, individualistic and quantitative (Chase et al., 1996; Gilhooly, 1996; Ingham et al., 1992 – but see Tversky & Kahneman, 1981, for a contextually-attuned perspective). It was hoped that viewing decision-making from a thoroughly contextualised perspective and attending to the implications of social context at individual, interpersonal and macro-social levels would produce a truly social and psychological analysis.

**METHOD**

*Participants*

Attempts were made to recruit lesbian couples who were expecting a child or already had a child/children within the context of their current relationship (i.e., excluding couples whose children who had been conceived within previous heterosexual relationships). Appeals for research participants were made in the lesbian and gay press and a lesbian community newsletter and through lesbian parenting support groups and social networks; further attempts to recruit participants were made by ‘snowballing’ from those who volunteered through these channels. Although it proved unexpectedly difficult to recruit participants, nine couples were ultimately interviewed. All interviews took place in the couples’ homes, with the interviewer posing questions to the couple rather than to each individual partner in turn.

*Interview schedule*

The interview schedule began with demographic and background questions, followed by questions on the couple’s motivations to become parents; decision-making about conception, the role of the non-biological parent and child-rearing responsibilities
within the couple; and the role of professional services in their decision-making (see Appendices A and B). Other decision-making issues and related concerns were also addressed but are not reported in this article due to space constraints. The interviews lasted between one hour and one hour and forty-five minutes. All were audio-recorded and transcribed verbatim.

**Analytic strategy**

The data were analysed using Interpretative phenomenological analysis (IPA) (Smith, 1996a; Smith et al., 1997, 1999). This procedure arose from the domain of health psychology but has now been used to analyse qualitative data to explore experiences, cognitions and meaning-making on diverse topics in health, social, clinical and counselling psychology (for example, see Coyle & Rafalin, 2000; Flowers et al., 1997, 1998; Jarman et al., 1997; Macran et al., 1999; Osborn & Smith, 1998; Turner & Coyle, 2000). IPA’s recognition that the outcome of any qualitative analysis represents an interaction between participants’ accounts and the researcher’s framework of meaning means that the analytic process is both phenomenological and interpretative.

The first step in the analysis involved repeated reading of the transcripts, which resulted in notes being made on each transcript regarding key phrases and processes. These notes included summaries of content, connections between different aspects of the transcript and initial interpretations. Within each transcript, these notes were condensed to produce initial themes, with care being taken to ensure that these themes were consistent with and could be illustrated by the data. When this process had been repeated with each transcript, the resulting sets of initial themes were examined to identify recurrent patterns across the transcripts,
producing a final set of superordinate themes. The links between these themes and the data set were checked again at this stage. Themes were then ordered in such a way as to produce a logical and coherent research narrative.

Inevitably such an analysis involves a high degree of subjectivity as it is shaped by the researcher's interpretative framework. In this study, the researcher was a female, trainee counselling psychologist who had previously studied the subject of lesbian parenting. Thus, there was a potential tendency to focus on participants' accounts that had particular resonance for therapeutic practice. The researcher was also a heterosexual woman who does not have children herself but who engaged in the research holding the belief that the lesbian family is an equally valid form of family to its heterosexual counterpart. This subjectivity means that traditional criteria for evaluating research quality (such as reliability), which are based on an assumption of researcher objectivity and disengagement from the analytic process, are inappropriate in assessing this study (Henwood & Pidgeon, 1992). Among the alternative criteria which qualitative researchers have suggested is the criterion of persuasiveness by 'grounding in examples', which is applied through an inspection of interpretations and data (Elliott et al., 1999; Smith, 1996b). In this article, interpretations are illustrated by extracts from the data set (to the extent that space permits) to allow readers to assess the persuasiveness of the analysis. In these quotations, empty brackets indicate where material has been omitted; clarificatory information appears within square brackets; and ellipsis points (…) indicate a pause in the flow of participants' speech. Pseudonyms have been used to indicate the varied sources of the quotations.
ANALYSIS

Background information
Sixteen participants (88.9%) identified as lesbian; one (5.6%) identified as both lesbian and bisexual; one (5.6%) claimed a 'public' lesbian identity and a 'biological' bisexual identity. Participants' mean age was 38.9 years (range 30-47; SD 4.5). All described themselves as 'white'. Fifteen participants were British whereas one participant was Australian. In terms of educational qualifications, nine (50.0%) had a postgraduate degree/diploma, four (22.2%) had a degree, two (11.1%) had a national diploma or equivalent, two (11.1%) had qualifications equivalent to GCSEs/O-levels and one (5.6%) had no educational qualifications. Using the International Standard Classification of Occupations (International Labour Office, 1990), 11 (61.1%) were classified as holding professional jobs, four (22.2%) were senior managers or officials and three (16.7%) fell into the category of service, shop and sales workers. The mean duration of participants' current relationships was 10.8 years (range 1.8-15.2; SD 4.6). All participants described their current relationships as sexually exclusive. All nine couples lived together and had done so for a mean duration of 10.0 years (range 1-15; SD 4.4). The mean number of children the participants had was 1.4 (range 1-2; SD 0.52); one couple was expecting a child at the time of the interview.

The analysis of the data revealed a variety of themes, five of which will be presented here – internal factors in decision-making about having children, external factors, decision-making about using known or anonymous sperm donors, the perceived impact of biological links on parenting roles and the role of therapy in facilitating decision-making. Themes and subthemes which offer new insights or which are
important in contextualising participants' experiences are reported in greater detail than themes and subthemes which reflect common motifs in the literature.

**Internal factors in decision-making about having children**

The first theme concerned factors internal to the partners and to the couple which led them to decide to have children. It encompassed two subthemes of desire to parent and appropriate stage of life and relationship.

**Desire to parent:** When asked about their feelings about parenthood, as in other studies, many participants spoke of a lifelong wish and commitment to become parents. Some described their decision to become parents as reflecting a consistent picture that they and/or their partner had held about themselves and their future throughout their lives:

>[Addressing her partner, Lorna] You've always wanted children. You've known like [ ] God, haven't you? For all your life I think, you've said and I say...[addressing the interviewer] It wasn't a burning thing for me in the same way it was for Lorna. She's always wanted children and that's that.

(Julia)

The desire to become a parent had been such a salient feature of some participants' identity that they had required any prospective partner at least to be open to parenthood and preferably to be committed to this as part of a life plan:

>I had previously been involved in a relationship with another woman who was really saying that she didn't want children so I sort of ended that
relationship. It wasn’t going to last and I was clear that the next relationship that I found that it was something that I wanted to be clear that was what I wanted to do. (Kate)

*Appropriate stage of life and relationship:* Most participants talked about having made their decision to become parents because they felt they had reached a stage in their lives and in their relationships where it would be appropriate to have children. Many also pointed out that their age was a pragmatic factor that had driven them towards making plans to implement their decision, with the metaphor of the ‘biological clock’ being frequently invoked. For example, Lisa said:

I think one [of the factors that disposed me towards deciding to have children] was age. I’m not that old – I’m only 36 and I had her [our daughter] when I was 36 so I think I thought my biological clock was ticking...So I think it was that and I suppose it’s also about being in a certain stage in life. We’d been together for quite a number of years. We thought we’d sorted out our relationship. [] It sort of felt like the right time somehow in a way.

*External factors in decision-making about having children*
Most participants spoke of external factors shaping their decision-making. These (which are presented in more detail because of their contextualising function) are discussed under the subthemes of the impact of social context, perceived inconsistency between parenting and lesbian identity and the impact of an ‘unconventional’ family structure.
Impact of social context: The significance of changes in the social and political context in opening up and raising the profile of the possibility of lesbian parenthood was a consistent feature of participants' accounts (see also Griffin & Mulholland, 1997). Most couples reported feeling that, despite the difficulties involved in lesbian parenting and the resistance that was sometimes encountered, a change in social outlook had occurred which had now made it much easier for lesbian couples to consider parenthood:

When Pam and I got together and, you know, when we starting thinking seriously about it [having children], I think at that point culturally and politically it seemed to become a possibility whereas ten years before it wasn't. (Fiona)

For some, this was seen as significant in normalising lesbian parenting or at least in relieving fears about lesbian parents and their children feeling socially isolated:

I don't think it's something I would have gone for if I didn't feel that – if I felt that our children would have been the only children in the world with gay parents, I'm not so sure I would, so that would have influenced me but I already knew by then that wasn't the case. (Lorna)

Chief among the contextual factors that had made participants feel wary or ambivalent about becoming parents was the negative way in which their families of origin viewed their lesbian identity:
My parents are very very religious so that was big deal. [ ] They think lesbians and gay men are evil so it's kind of difficult. I worried about how they would respond – how they would deal with it. You know, would they ostracise me completely? (Pam)

Some participants also talked about the lack of role models for lesbian parenting among their peers and in the lesbian community. Many felt that they had been and still were pioneers in lesbian parenting. Although such a representation can instil pride, some participants felt that often they were ‘trekking in uncharted territory’ in raising their children and were having to create their own ‘maps’ and contribute to building a body of experience that others might subsequently draw upon but which had not been readily available for them. This was said to have presented a host of difficulties to those couples who had first considered parenting some time ago. For example, Joan reflected on how lesbian parenting had usually been structured in the lesbian community in which she and her partner had been involved:

Maybe a woman that had been married to a man had had a child and then had broken up and gone into a lesbian relationship and then you saw the child but certainly not lesbian couples with children. You see it more and more [now]

[ ] but when we first decided we wanted a child – well it was a bit difficult to find lesbian couples [who had had a child within a lesbian relationship] to sit and talk to.

In the absence of relevant peer experience and expertise, many participants said they familiarised themselves with the practicalities, challenges and rewards of lesbian
parenting through reading relevant literature, although a common observation was that most books on the topic were American and so their relevance to the British social context was felt to be questionable.

**Perceived inconsistency between parenting and lesbian identity:** Linking to comments cited earlier, many participants reported that, whereas the desire to have children had been prevalent throughout their lives, when they came out as lesbian they initially saw their wish to become parents as inconsistent with their lesbian identity. For example:

I think – yes – I always wanted to become a parent but I think coming out as a lesbian – I actually think that for years I’ve felt that I wasn’t meant to become a parent because I was a lesbian. (Sophie)

Yeah, I knew that I wanted to have children. I think that it didn’t really occur to me for a long time that it would be possible – being a lesbian. (Pam)

These remarks echo what is often described in the literature on lesbian parenting, namely that for a long time the term ‘lesbian mother’ was considered contradictory in itself, as it was thought – on the basis of social representations of ‘lesbians’ and ‘mothers’ – that ‘lesbians’ and ‘mothers’ were mutually exclusive groups (Griffin & Mulholland, 1997; Muzio, 1993).

**Impact of ‘unconventional’ family structure:** It was earlier noted that the main concerns about having a child voiced by lesbian couples in other research related to
the possible implications of raising a child in a non-traditional family in a heterosexist and homophobic world (Gartrell et al., 1996; Hare, 1994; Harris & Turner, 1986).

Similar concerns were expressed by the couples in the present study. It has already been pointed that one participant expressed concern that 'our children would have been the only children in the world with gay parents' (Lorna). More specifically, when asked whether there was anything that made them wary of deciding to have children, participants said:

I think for me it's being in a lesbian relationship. It wasn't about – I don't think I had any hesitation of bringing a child into the world...It was more about [ ] you know, for him to deal with homophobia or anything like that. [ ] I think that was my main concern. (Mary)

I think we did worry a bit. We did discuss how it might be for the children...I think in a way that has prevented us from moving forward but yeah – thinking about how the children would be affected by homophobia, how the children would be affected by, you know, a lesbian couple, you know – two women bringing them up. (Pam)

Research conducted with young people who grew up in lesbian mother families in the UK has suggested that such fears may not be realised. Tasker and Golombok (1997) found that these young people were no more likely than those from heterosexual backgrounds to report having been bullied or teased about their mother or family background at school. This should not be interpreted as indicating that the fears expressed by the women in the present study were groundless or even paranoid. Tasker and Golombok (1997) reported that lesbian mothers had taught their children
to estimate when it was safe to talk about having a lesbian mother, which may have helped minimise experiences of prejudice.

To conclude the examination of this theme, it may be worth including a general observation on the reported process of deciding to have children (but one that is difficult to substantiate by pointing to the data). Reflecting on the couples’ interactions within the interviews and the ways in which they talked about this decision-making process (see Kitzinger, 1994, on interaction data in other qualitative work), the interviewer obtained the impression that, in most cases, one partner had been the ‘driving force’ in deciding to have a child and this partner had persuaded the other partner, who had not objected strongly to the proposal. Only in one couple did it seem that the decision-making had arisen from a mutually intense desire to have children.

**Decision-making about using known or anonymous sperm donors**

Most of the couples reported that they had contemplated the conception options available to them and reached their final decision at an early stage. Six couples (66.7%) had had a child through self-insemination using a sperm donor who was personally known to them; the other three couples (33.3%) had opted for an anonymous donor through a fertility clinic. The present study therefore differs from some larger-scale studies of lesbian parenting – such as those of Gartrell et al. (1996) and Patterson (1998) which were examined earlier – in that a larger proportion of this sample opted for a known donor.

**Opting for a known donor:** Those couples who chose to conceive through self-insemination with a known donor explained their decision in terms of considerations...
about their child’s psychological well-being (specifically in terms of the desirability of
the child knowing who their father was), their own desire to exert control over the
conception process and the perceived desirability of having the father actively
involved in the child’s upbringing.

i) The child’s psychological well-being. Couples who opted for a known donor did not
believe that they had the right to deprive their child of the possibility of knowing their
biological father or at least knowing who he was. They felt that depriving their
children of (the possibility of) this information could undermine their identity and,
more generally, their psychological well-being. These concerns are reflected in the
following quotations:

I mean [ ] you’re bringing a person into the world [ ] who’s going to want to
be independent but will look back on their roots and hopefully feel a sense
of confidence and pride [ ] and I didn’t have the confidence to bring
children into the world who didn’t have a clue who their father was. (Claire)

I thought [I would opt for a known donor] for their psychological sort of
well-being as well as to know that they had a father and were wanted by
the father. (Pam)

These experiences accord with concerns expressed about the implications of
using an anonymous donor by lesbian couples in other studies (for example,
Leiblum et al., 1995).
ii) *Desire for control over the process of conception*: Some couples explained that they had chosen to conceive through a personal arrangement with a known donor because they felt they could exert greater control over the process if they avoided using official agencies such as fertility clinics:

I think partly for me the motivation to do it ourselves was it’s nobody else’s business. [ ] If you quietly arrange it with a friend, it’s just completely private really. (Julia)

It’s a very simple process. There’s no medicalisation. You can do it on your own and in your own home, you know – on your own terms really. (Christine)

This wish for privacy and control was linked to the disapproval that many couples were aware of or had faced from their social environment following the decision to become parents. For example, Lisa referred to:

All this stuff that is happening in the press about, you know, oooh, lesbian mothers – ‘Oh it’s outrageous’, ‘Oh it should be illegal’. I thought ‘They can’t control us’. [ ] You know – we can do this.

This is consistent with the picture presented by Tasker (1999), who explained that most of the new generation of lesbian mothers in the UK do not use fertility clinics partly to avoid having to justify their desire to conceive (see also Alldred, 1996). Furthermore, in the UK, clinics are obliged to take account of the welfare of the child – including the need for a father – when providing insemination services, which leads
to differences in policy and practice across clinics and may make lesbian couples less inclined to use clinic services (Griffin & Mulholland, 1997).

iii) Perceived desirability of having the father involved in the child's upbringing: Some couples explained their decision to use a known donor in terms of the desirability of having a significant male presence in the child's upbringing. These couples had wished for the donor to have a consistent involvement with the child and to fulfil a significant fathering role:

We wanted a father that wasn't just a sperm donor. We wanted a father that would come round and have a relationship with the girls. We definitely wanted somebody involved. (Pam)

I feel it's important that they [the children] at least know one man so that they don't learn to fear men. [ ] It was just validating that, you know, men have an important role to play in our lives and in children's lives. (Claire)

Experiences of negotiating the father's involvement with the child: The couples who wished for the donor to undertake an active parenting role reported varied experiences of negotiating the father's involvement. Some couples had thoroughly discussed their wishes and expectations with prospective fathers before trying to conceive, whereas others had allowed negotiations to evolve over time. Most couples provided accounts in which they and the donors had managed to work out roles and responsibilities in a generally satisfactory way. However, at the time of the interviews, two couples were still experiencing difficulties in negotiating roles and responsibilities with the biological fathers and
had begun to question whether they had made the right decision in choosing a known donor. This is illustrated by the following comment from Sophie:

How to ruin a friendship? Have a child with your best friend. I mean basically it's nothing like we pictured it would be and I feel – knowing what I know now, I would never have never done it. I think I would probably prefer to do it with a clinic.

Most couples felt that what made these negotiations difficult was that they found themselves having to make very personal decisions with the donor, sometimes without there being a pre-existing close relationship within which such discussions could be contextualised:

I think when you love somebody and they're your partner you've got a completely different set of ground rules about negotiating [ ] and actually a third party – having to negotiate with them can be even harder. (Eve)

I feel that it's involved us having to have the kinds of conversations with him that you would only normally have with your lover because we've done something with him that you would only normally do with your lover.

(Sophie)

Within Sophie's account, there was a sense in which the negotiations were experienced as an intrusion into life domains previously reserved for partners. Difficulties in negotiating with prospective biological fathers have also been reported in other research (Baum, 1996).
Opting for an anonymous donor: The couples who decided to have children through insemination in a clinic with sperm from an anonymous donor identified three factors which shaped their decision-making – the desire to avoid disputes with the biological father, fears about the biological father undermining the non-biological mother and the belief that the potential costs of using a known donor outweighed any benefits. These factors were all concerned with a desire to have control and autonomy as a couple over how they raised their child.

i) The desire to avoid disputes with the biological father. All these couples had decided against using a known donor because of concerns about the potential emotional and legal implications of involving a third party in their family life. As Zoe said:

We came to agree that the legal position with known donors is dodgy and difficult and that it would be cleaner in the longer term emotionally and legally if we were to have an anonymous donor.

As has been found in other studies (Gartrell et al., 1996; Hare, 1994), it seemed that, for these couples, the need to protect their family unit from possibly difficult legal and other disputes outweighed concerns about the potential implications of their child not knowing the identity of the biological father. As Sophie said:

I felt more able to deal with that – with how he [her son] felt about not knowing his father – and live with that for myself than I felt willing to or
able to deal with a known donor who might contest, might want parental rights or might not be as involved as we wanted to.

**ii) Fears about the biological father undermining the non-biological mother.** As in some other studies (for example, Morningstar, 1999), using a known donor was seen as potentially threatening the couple’s family unit because of the possibility that the donor might undermine the role of the non-biological lesbian mother and her relationship with the child. This threat was also conceptualised in legal terms because the non-biological mother was perceived to have no custodial rights over the children. These concerns were reflected in the following quotations:

I remember [ ] – and certainly for me – [the decision about using a known or anonymous donor] hinged around what role would I have [as the non-biological parent]? How would it be different if we had a known donor? Would I be marginalised? The potential legal problems if there was some conflict. (Kate)

The father would have more rights than Lucy [the non-biological parent]. If it went to court, his name would be on the birth certificate and Lucy's wouldn't. (Nadia)

**iii) The belief that these costs outweighed any benefits:** The couples who had used an anonymous donor seemed ultimately to have made this decision on the basis of a cost-benefit analysis: the potential costs of using a known donor were seen as outweighing the benefits of the child knowing the identity of the biological father and having him involved in the child's upbringing. Another factor in this analysis seemed
to have been the couple’s confidence that they would be able to overcome any
difficulties that their child experienced as a result of not knowing who their biological
father was and not having him in their life (seen in Sophie’s quotation earlier):

I felt more able to deal with the consequences of Jack not having a father
and to deal with that than I felt willing to enter into a relationship with
somebody I know who would become the donor. It felt terribly complicated
so it just felt like the better decision [to use an anonymous donor]. (Mary)

The risk that we had to take is [ ] like children getting very hooked up by
the fact they don’t know who their father is and I suppose we will have that
problem but I hope that we will bring her up in such a way that that she
won’t have a problem. (Kelly)

These findings accord with those of other studies. For example, Leiblum et al. (1995)
compared single heterosexual and lesbian women and lesbian couples in terms of
how they felt about conceiving via donor insemination. They found that, whereas
participants in all three groups were concerned about the absence of a biological
father, lesbian couples felt they could meet their children’s needs for love and
security. In a study conducted in Belgium and the Netherlands, Brewaeys et
al. (1997) compared lesbian-parented families with heterosexual-parented families in
which children had been conceived via donor insemination and found that children in
heterosexual-parented families had greater problems with behavioural and emotional
adjustment. This may be explicable in terms of lesbian parents’ (necessarily) greater
openness with their children about their origins.
Perceived impact of biological links on parenting roles

Participants were asked how they made decisions about the division of parenting responsibilities. However, this area was not regarded as being open to negotiation to the same extent as other domains of decision-making because some matters were represented as largely pre-determined by biological factors and – to a lesser extent – personality factors (which are not reported here).

Inevitability of the biological mother having a particular relationship with the child:

Participants felt that the biological mother and the non-biological parent inevitably have different relationships with the child. In explaining this difference, participants drew upon discourses of attachment and bonding, with the biological bond between the birth mother and the child being represented as preceding and being inevitably stronger and more fundamental than the social bond between the non-biological parent and the child:

I think that biology is really important and it was interesting because the culture that was about in our [lesbian] community at that time was really in denial of that. Like, you know, ‘You’re interchangeable mothers’ and I mean I had an expectation that that wouldn’t be the case and certainly because of the mother’s bond and through the pregnancy and then with the breast-feeding, it is a completely different relationship. (Fiona)

Well, talking about parenting roles, when Elaine [our child] was a very small baby I was breast-feeding. Zoe [my partner] was very much there and supportive but I think I was a mummy – I was the source of food and comfort and all that but I think that’s what we expected. (Kelly)
The perceived significance of the biological relationship is consistent with findings from other studies. Hand (1991) found that, although lesbian couples shared parenting more equally than heterosexual couples, lesbian biological mothers viewed their maternal role as more salient than did any other mothers, lesbian or heterosexual.

Defining the relationship with the non-biological parent: Participants spoke of the importance of the non-biological parent actively deciding to create her own bond with the child and finding meaningful and rewarding ways of doing so. Mary provided an example of how she did this in one particular context:

Looking back on the early days for me, sometimes it was difficult when Michael [our child] was hungry and Kate [Michael’s biological mother] could feed him at his meals and I was very excited when I found that if he sucked my little finger that would comfort him because then I had a way that was mine of being with him and comforting him.

One of the ways in which the child’s relationship with the non-biological parent is defined is through the use of names. Muzio (1993) discussed the constraints imposed by language when one tries to represent the role of the non-biological lesbian parent. In the present study, some participants talked about having experienced difficulty in deciding how to refer to the non-biological parent and worrying about the impact their decision would have on the child. This was usually resolved by allowing the child to develop their own way of referring to the non-biological parent. For example, Lorna said:
We couldn't make our minds up about it... We just kind of worried about what we'd be putting on a child by forcing this kind of unfamiliar framework [referring to both of us as 'mummy'] on them. We...weren't convinced that it was the right thing to do so we actually left it until Ted [our son] made up his own name for me.

Some non-biological parents talked about their wish to have a clearly defined identity in relation to their child as they felt that the term 'mother' did not accurately reflect their relationship with the child. These participants felt that there was a need to define clearly the different nature of their relationship with the child and to distinguish this from the biological mother's relationship with them:

I mean, yes, I did feel quite clear that I didn't want to be called his mother or his co-mother. I was happy to be called a co-parent but there was something about the word 'mother' that I didn't want. (Vicky)

I wanted to have my own identity. I didn't want her [our daughter] confused. I wanted to be Joan and that's who I am and I love her and will do everything for her and I wanted her to know who I was...She says she's got her Joan. She tells her friends that she's got a mummy and a daddy and she's got a Joan. I'm a new label. (Joan)

The role of therapy in facilitating decision-making
Martin (1993) suggested that therapists might be approached by lesbian couples to help them assess their ability to adapt to the demands of parenthood and assist them in decision-making. Of the four couples who had obtained therapeutic input during
the initial decision-making process, all reported that therapy had helped them deal with feelings of ambivalence about becoming parents and had also promoted more open communication between them. For example, Christine said:

We were struggling with the decisions and having lots of rows. [ ] I think it [going to therapy] was the best decision we'd made. [ ] We had a space to air our — you know, the things that we had kind of got to a point where we really couldn't talk about them. [ ] It was helpful in terms of my feelings of ambivalence. It helped me to see we were able to manage this [parenting].

Most participants who had received therapy reported that being accepted and affirmed in their decision-making by their therapist had helped to compensate for the lack of validation experienced in their social environment:

It's more validating. Maybe it's also about approval, you know — that this great person thinks we're OK, therefore we must be OK, you know. You don't wanna be like that [in need of approval] but there's a bit of, you know, there's so much disapproval around that it's quite nice. (Lorna)

This exemplifies the importance of Faria's (1994) contention that a fundamental requirement of good therapeutic practice with lesbian couples and their children is a belief in the viability and value of the lesbian family unit. Those couples who had not received therapy felt that it would have helped them in their decision-making if they had had the opportunity to talk with professionals who had knowledge and experience of working with other lesbian couples.
Need for therapeutic services for lesbian parents

All the couples expressed the view that therapeutic and counselling services that were fully informed about the issues that lesbian couples may face in deciding to become parents and that were capable of exploring these in an appropriate manner with lesbian clients were needed. As Demi explained:

I think perhaps just to have an avenue where you can talk about it, your problems, the plus points, the bad points.

At the same time, many couples acknowledged that there is a need for services specific to lesbian couples who want to have children, as most of the services that already exist are designed for heterosexual couples and their families. This is reflected in what Zoe said:

All of the literature and all of the information, everything about infertility is about straight people so that's part of being lesbian, the whole world is straight anyway you just have to sort of read between the lines or come and take the bits that are relevant to you. [] But you know it's like if services are available then you can make your own decisions but if no services are there then it's pretty hard to go out and try and find them anyway.

OVERVIEW

In this section, the limitations of the study are considered and some findings and their implications are examined in a more general way. Although the sample may appear small, it conforms to the recommended sample size for IPA work (i.e., ten) if
each couple's account is regarded as one unit (Smith et al., 1999). The sample cannot be seen as representative of lesbian parents, partly because the parameters of this population are unknown. However, achieving a representative sample is not the aim of most approaches to qualitative research. Instead, the aim is to produce an in-depth analysis of the accounts of a small number of participants; any conclusions are specific to that group and any move beyond the group must be undertaken tentatively. This should be borne in mind when considering the conclusions that will be drawn, especially in the light of the relative homogeneity of the sample.

The research reported here can claim originality on the basis of its examination of key issues within lesbian parenting from an explicitly decision-making perspective; the fact that it presents decision-making research within a qualitative, phenomenological framework; and its focus upon an English sample. Yet many of the substantive issues that it covers have been addressed by other researchers, mostly in the USA. The process by which qualitative research advances knowledge through a series of detailed, small-scale, complementary studies needs to be borne in mind, however. The present study may be seen as adding new English data to a growing body of knowledge about the challenges faced by lesbian parents and their responses to these challenges. The consideration of the findings within the context of largely US literature allows for the conclusion that these women's experiences did not differ significantly from the experiences of lesbian parents who have been studied in the USA – which may be seen as pointing to common areas of experience – except for the fact that a higher proportion of couples in this study conceived with a known donor than in US studies. By providing a full description of those who took part, it is hoped that other researchers can in the future obtain data from women whose experiences and perspectives have not been represented here or in previous
research, with the aim of building up an increasingly complete picture of lesbian parenting.

Turning to the study's substantive findings, it was apparent that the issues examined here had been accorded substantial and careful consideration by the couples. Alldred (1998) and Clarke (1999) have noted that, in some media coverage, lesbian (and gay) parenting has been represented as selfish and immoral. Yet, drawing upon the classic work of Gilligan (1982) who regards moral decision-making as involving a careful weighing of options, taking account of implications for the welfare and well-being of all concerned, what these women reported could be regarded as a moral and ethical process: it is clear that these decisions were not taken lightly or without due regard for others, especially for the welfare of the children conceived.

Some of the factors that were implicated in the women's decision-making about having children overlapped with factors that have been identified as influencing decision-making about parenthood among heterosexual couples. For example, Cowan and Cowan (1992) found that some heterosexual couples cited the quality of their marriage as the main factor that led them to decide to have a baby, just as some of the lesbian couples in the present study pointed to the dynamics and quality of their relationship as an influential factor. Also, the invocation of the idea of being in a certain life stage – including an acknowledgement of the role of the 'biological clock' – was evident in Cowan and Cowan's (1992) findings as well as in the lesbian couples' accounts. However, in the present study, the life stage consideration may have been rendered salient by factors specific to lesbian parenting. For example, as some participants pointed out, lesbian parenting has only moved centre stage in lesbian life scripts and become a 'thinkable' option in relatively recent years and so
lesbians who might not have considered parenthood earlier in life are now deciding to embark on the parenting process. It is advisable to be mindful that similar outcomes across lesbian (gay) and heterosexual samples may be underpinned by different processes in this research area.

One overarching theme that characterised the data on decision-making about using anonymous or known sperm donors related to a concern with control and autonomy. This was an especially salient concern for those couples who had decided to conceive though an anonymous donor. These couples represented the parenting process as fundamentally involving only themselves and their child, without interference from the biological father who was consistently positioned as a potentially threatening and disruptive ‘outsider’ in their accounts. Some couples who had chosen to conceive through a known donor also invoked the issue of control when explaining their decision, although their concern was with control over the conception process and avoiding what they saw as interference from fertility clinics. Given the negative social attitudes towards lesbian sexuality that some participants spoke of having encountered from family members and given the negative social representation of lesbian parenting that one participant noted, this concern with control is not surprising. Limiting the involvement of potentially troublesome outsiders (whether those outsiders are seen as fertility clinics or sperm donors) can be viewed as a strategy for protecting the couple (and, in the case of couples who conceived with a known donor, the biological father too) from social and legal threat. It may also serve the psychologically beneficial purpose of enhancing couples’ sense of self-efficacy.

In explaining how their relationships with their children developed, participants displayed a resistance to representing this process in terms of conscious decision-
making. Instead, they drew upon discourses of maternal bonding and attachment (and, in unreported data, personality factors) and used these to construct a version of events in which the outcome of these decisions was pre-determined and in which there was little opportunity for choosing one type of relationship over another. In using these discourses, the couples narrowed the life terrain relevant to their decision-making. The necessity and implications of doing so (for example, in terms of limiting the possibility of developing new forms of parent-child relationships and developing these relationships through new processes to individually- and socially-beneficial ends) may need to be explored in other writing (for an example, see Clarke, 2001), in community and other discussion groups on lesbian parenting and in therapeutic practice with lesbian parents.

For therapeutic professionals working with individual lesbian women and/or with lesbian couples and their children, the findings arising from this study are relevant for two reasons. Firstly, they help to inform practitioners about some of the decision-making dilemmas that clients may be confronted with and so extend the evidence base from which informed practice can draw. Secondly, it is notable that all the couples who had experienced therapeutic services had found them beneficial in decision-making about parenthood and affirmative of their decisions; those who had not sought or received therapeutic input felt that it would have been beneficial to them. Although lesbian couples who are considering having children may now find it easier to contact other couples who have been through this process and to learn from their experiences than did some of the ‘pioneering’ couples in this study, informed therapeutic services may help to meet the needs of couples who do not have access to peer support. However, research undertaken in the UK which has identified ill-informed, suboptimal therapeutic practice with lesbian (and gay) clients
(for example, Golding, 1997; McFarlane, 1998; Milton & Coyle, 1998, 1999; Proctor, 1994) – especially on the matter of lesbian parenting (Annesley & Coyle, 1998) – suggests that lesbian women who seek therapeutic help in decision-making about parenting may first have to assess the therapist’s outlook and knowledge base on this issue. Informed and affirmative therapy may provide couples with a supportive context in which to reflect upon and develop workable solutions to some of the dilemmas identified in this study. For example, those couples who are considering using a known donor may find it useful to negotiate responsibilities with the prospective donor (and perhaps with his partner too, where relevant) with a therapist who works within a systemic framework (Dallos & Draper, 2000). This approach may also be useful when revisiting these responsibilities in the light of experience.

Finally, it is appreciated that this study has examined an issue that is embedded within a changing social context and that this will impact upon some of the concerns that have been explored here. Indeed, some participants acknowledged that the visibility of lesbian parenting and the availability of peer experience and expertise on the subject have changed over time. This may necessitate a regular reconsideration of the issues covered here to ensure that the empirical knowledge base on lesbian parenting remains up-to-date and reflective of current concerns.

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Appendix A

INTERVIEW SCHEDULE

INTRODUCTORY QUESTIONS ABOUT THE RELATIONSHIP

☐ To begin with, I would like you to tell me a little bit about your relationship. How long have you been together? Do you live together? [If yes: when did you start living together?] Could you tell me a little bit about the rules of the relationship? [eg. Is it a closed or an open sexually relationship?]

MOTIVATION FOR PARENTING

☐ In the past, what were your thoughts about becoming a parent? Have you always thought you wanted to have children?

☐ Have your feelings about parenthood changed over time? [If yes: In what ways? At which point did you change your mind about having children? What do you think contributed to that decision?]

☐ What were the main factors that moved you towards deciding to have children?

☐ Were there any factors that made you feel wary about deciding to have children? What were they?

☐ How did you reach the point where the factors pushing you towards this decision outweighed the factors pulling you away from it?

☐ Was it a case of making a definite decision at one point in time or was it a process that evolved over time? Could you tell me more about that?
Once you made the decision did you change your minds afterwards? Could you tell me more about that?

How did you feel once you had made your decision?

I'd like you to think about the contribution that each of you made towards making this decision. If we think of the final decision as representing a 100% contribution from both of you, what percentage did each of you contribute to that? What makes you say that?

Were there any other people involved in the decision-making process or was it just the two of you? [If others:] What role did they play in helping you make your decision?

**CHOICE OF METHOD OF CONCEPTION**

Once you decided you wanted to have children together, how did you choose the way in which you would go about having children?

Were there any disagreements about the choice of method of conception? Was it a joint decision?

What made you choose (this method/ use specific name)? What made you prefer this method over other alternative ones? How do you feel now about having chosen this method?

What difficulties did you encounter in putting your decision into practice? How did you overcome these difficulties?
[If they had difficulties with their original decision and they had to choose alternative method]

☐ How did you go about selecting an alternative method of having a child?

[If they chose artificial donor insemination/self-insemination:]

☐ How did you choose who of the two of you would give birth to the child? Did you both want to give birth to the child? Was it a joint decision? Did you have any difficulties in making that decision?

☐ What were your thoughts about the identity of the donor? How did you end up choosing a (known/unknown/friend) donor?

☐ What specific characteristics/qualities did you look for in the donor?

☐ What additional information did you want to have about the donor?

☐ Did you want to meet/did you meet the donor?

☐ [If known donor:] What did you consider the advantages/disadvantages of choosing a known donor? What contributed to your choice of a known donor?

☐ Do you plan to involve the donor in the raising of the child? OR: Have you involved the donor in the raising of the child? (if child is older) How did you make this decision? What factors did you take into account?
☐ (If not) Do you plan in the future to inform your child about the identity of the donor?

☐ [If unknown donor:] What did you consider the advantages/disadvantages of choosing an unknown donor? What contributed to your choice of an unknown donor?

[If they chose adoption:]

☐ Did you encounter any difficulties in arranging for the adoption of the child?

☐ Are you both legal guardians of the child? If not, how did you decide which one of you would be the legal guardian? Was it a joint decision? Did you have any difficulties in making that decision?

[If they chose conception through sexual intercourse:]

☐ From an outsider’s perspective, this may seem an unusual route to take, given your identity as lesbian women and the fact that you decided to try to conceive through sex outside your relationship. How did you feel about this decision? Did it raise any concerns for you? [if yes:] How did you deal with them?

☐ How did you chose which one of you would give birth to the child? Was it a joint decision?

☐ Did you have sex with someone you know? Does that person have any involvement with the raising of the child? Will you/have you disclosed his identity to the child? How did you make these decisions?
ROLE OF NON-BIOLOGICAL PARENT

☐ How did you decide on the roles that each of you would fulfil when bringing up your child? Was it something that you worked out before the birth or were these decisions made as you went along?

☐ How much do you think the fact that one of you is the biological mother of the child contributed to the parenting roles each one of decided to take? [how do they share household tasks, child care-giving activities and how did they decide about the current division of labour]

☐ How do you make different decisions with regards to raising the child? Do you see yourselves as equals in raising the child? Has that changed over time?

☐ What does the child call the non-biological mother? How did you decide about that?

FAMILY IDENTITY

☐ Who do you consider to be part of your family? Who is included in the primary family unit? How did you go about deciding that?

☐ How did you go about choosing a surname for the child?

FAMILIES OF ORIGIN

☐ At what point did you tell your families about your decision to have a child? Who did you tell? How did you tell them? Why did you tell them?
What sort of reaction did you receive - at first? Subsequently?

How did that make you feel?

How do your families feel about this now?

[If family reactions have changed: What do you think contributed to this change?]

**THERAPEUTIC ISSUES**

Did you receive therapy at any point during the time you were contemplating parenthood? Did you have any therapy after you became parents? [If yes:] Was that individual therapy or couple therapy? What factors contributed to your decision to go for individual/couple therapy?

Did therapy help you reaching your decision to become parents? To what extent did you find it helpful?

To what extent did you think it was not helpful?

To what extent did you think your experience as a lesbian parent/or lesbian parents was understood by the therapist?

How do you think your experience of therapy as a lesbian parent might have been made more valuable?

[If no (no therapy):] Was that because you felt you did not need any therapy or is it because there's something about therapy that makes you feel wary or was it for some other reason?
▪ If either of latter, could you say some more about that?

▪ If you had decided to seek some kind of therapeutic help, which do you think would be your therapy needs as a lesbian parent?

**Prompts and Probes**

Could you tell me more about that?

What makes you say that?

What happened then/after that?

Why do you think that happened?

How did that make you feel? How do/did you feel about that?

What factors contributed to this decision? Was it a joint decision?
Appendix B

DECISION-MAKING IN PLANNED LESBIAN PARENTING

Background Information

To begin, we'd like to get some basic information about you (such as your age, ethnicity, education and occupation), as well as about your sexuality. The reason that we'd like this information is so that we can show those who read our research report that we managed to obtain the views of a cross-section of lesbian couples who have decided to become parents. The information that you give will never be used to identify you in any way because this research is entirely confidential. However, if you don't want to answer some of these questions, please don't feel that you have to.

1. How old are you? [ ] years

2. Which of the following ethnic groups would you say you belong to?

(tick the appropriate answer)

- Black-African
- Black-Caribbean
- Black-Other
- Chinese
- Bangladeshi
- Indian
- Pakistani
- White
- Other (please specify:)

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3. What is your highest educational qualification?

(tick the appropriate answer)

None
GCSE(s)/O-level(s)/CSE(s)
A-level(s)
Diploma (HND, SRN, etc.)
Degree
Postgraduate degree/diploma

4. What is your current occupation (or, if you are no longer working, what was your last occupation?)

5. How long have you and your partner been together?

_____ years _____ months

6. a) Do you live together?

Yes _____ (go to part b) No _____ (go to question 7)

b) How long have you lived together?

_____ years _____ months
7. How would you currently define your sexual orientation?
(tick or write the appropriate answer)
Lesbian ____
Bisexual ____
Heterosexual ____
Other: (please specify: )

8. How many children do you have together with your partner?

[  ]

9. a) Do you have any children from previous relationships?
Yes _____ (go to part b) No _____ (go to question 10)

b) How many children do you have from previous relationships?

[  ]

10. How would you describe your current lesbian relationship status?
(tick the appropriate answer)
One regular partner only _____
One regular partner with casual partners also _____
More than one regular partner _____
More than one regular partner with casual partners also _____
Other (please specify: )
Appendix C

DECISION-MAKING IN PLANNED LESBIAN PARENTING

I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study, which looks at the decision-making processes of lesbian couples who have decided to become parents.

Following their decision to become parents lesbian couples are usually faced with a number of different dilemmas such as choosing a method of conception, negotiating parenting roles, dividing labour, defining their family unit and their relationships with their families of origin. The aim of this study is to look at how decisions about these issues are negotiated and finally reached by the couple. Although this is a research area that has gained considerable attention over the past decade, there have been very few studies addressing the issues lesbian couples face following their decision to become parents and none of them have been conducted in the UK. Another question that has not been answered is how counselling psychologists might potentially help lesbian couples in the decision-making process. That is why I am undertaking this research.

I am seeking lesbian couples who have decided to become parents and are either at the stage of expecting a child or already have children. Those couples who volunteer to take part in the research are going to be interviewed together for approximately one hour. Interviews will take place at a location convenient for you. The interview will be recorded on audio-tape so that, in writing up the research, I can cite people's experiences directly. Naturally, to protect confidentiality, I will not quote on any identifying information such as names and locations. In making transcriptions your name will be replaced by a letter, and I will not record the names of other people or
places that might arise in the interview. Once transcribed, the audio-tape recordings will be destroyed. If at any point in the interview you feel the need to withdraw this will be perfectly acceptable and you will not need to justify your decision.

I hope that this research will help counsellors, psychologists and psychotherapists who work with lesbian couples, become aware of the issues that lesbian couples are called to deal with when they decide to become parents. I hope then that this will enable them to be more effective when offering therapeutic services to these couples. I also hope that those who take part in the research will find it helpful to talk about their experiences.

If you would like to take part in this research or find out more about it, please ring me on 01483 259176.

Elena Touroni
Counselling Psychologist in Training
Department of Psychology
University of Surrey
Guildford GU2 5XH
Appendix D

CONSENT FORM

I the undersigned voluntarily agree to take part in the study on decision-making about children in planned lesbian families.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible negative effects on my psychological well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my psychological well-being, or experience any distress.

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

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I understand that in the event of my suffering any significant deterioration in psychological well-being caused directly by my participation in the study,
compensation will be paid to me by the University of Surrey. The amount of such compensation shall be calculated by reference to the amount of damages commonly awarded for similar injuries by an English court if liability is admitted, provided that such compensation may be reduced to the extent that I, by reason of contributory fault, am partly responsible for the injury. I understand that this offer of compensation does not prevent me from alternatively pursuing a claim on the basis of negligence or strict liability.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

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

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

NOTES FOR CONTRIBUTORS

Initial manuscript submission. Submit three copies of the manuscript (including copies of tables and illustrations) to: Geoffrey Stephenson, JCASp, 46 West St, Faversham, Kent, ME13 7JG, U.K.

Authors must also supply:
- an electronic copy of the final version (should normally apply, see section below);
- a Copyright Transfer Agreement with original signature — without this, we are unable to accept the submission; and
- permission letters — if the manuscript contains extracts (including illustrations) from, or is based in whole or in part on, other copyright works (including, for the avoidance of doubt, material from online or print sources), the Author, at the Author’s expense and in the form specified by the Publisher, will obtain from the owners of the respective copyrights written permission to reproduce those extracts in the article in all territories and editions and in all media of expression and language; all necessary permission forms must be submitted to the Publisher on delivery of the manuscript.

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

Electronic submission. The electronic copy of the final, revised manuscript should be sent to the Editor together with the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect [and TeX or one of its derivatives].

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or PowerPoint.

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

The title page must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page, as the Journal of Community & Applied Social Psychology operates a ‘blind’ reviewing system.

- Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).
- Supply an abstract of up to 200 words for all articles, except book reviews. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- Include up to ten key words that describe your paper for indexing purposes.
- Short Papers of no more than 2,000 words in length (or equivalent in text, references and tables) are encouraged. Research papers, Innovations in practice and Communication and commentary are all welcome in the Short Paper section. Submissions will be reviewed in the usual way but it is anticipated that the reviewing and publication process will be of shorter than average duration than for longer papers.

Abstracts for Short Papers should be of around 50 words.

Reference style. References should be quoted in the text as name and year within brackets and listed at the end of the paper alphabetically. Where reference is made to more than one work by the same author published in the same year, identify each citation in the text as follows: (Collins, 1998a), (Collins, 1998b). Where three or more authors are listed in the reference list, please cite in the text as (Collins et al., 1998). All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list.

References should be listed in the following style:


Illustrations. Supply each illustration on a separate sheet, with the lead author’s name and the figure number, with the top of the figure indicated, on the reverse. Supply original photographs; photocopies or previously printed material will not be used. Line artwork must be high-quality laser output (not photocopies). Tints are not acceptable; lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing, which should not exceed 208 mm x 135 mm. Please submit the figure legends on a separate sheet.

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Further information. Proofs will be sent to the author for checking. This stage is to be used only to correct errors that may have been introduced during the production process. Prompt return of the corrected proofs, preferably within two days of receipt, will minimise the risk of the paper being held over to a later issue. 25 complimentary offprints will be provided to the author who checked the proofs, unless otherwise indicated. Further offprints and copies of the journal may be ordered. There is no page charge to authors.
Dear Ms Touroni

Decision-making about children in planned lesbian families: experiences of lesbian couples and implication for therapeutic practice (ACE/2000/4/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/2000/4/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 08 March 2000
Date of expiry of Advisory Committee on Ethics approval: 07 March 2005

Please inform me when the research has been completed.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics
Registry

cc: Professor L J King, Chairman, ACE
    Dr Adrian Coyle, Principal Investigator, Dept of Psychology

Enc
Clinical and Counselling Psychologists’ Attitudes Towards Lesbian Parenting

ABSTRACT

A study was conducted to measure British clinical and counselling psychologists’ attitudes towards lesbian parenting and their beliefs about sexual orientation. Two questionnaires were used to that effect. The first questionnaire consisted of items that were derived from the Attitudes Towards Lesbians and Gay Men (ATLG) scale (Herek, 1994) which were adjusted to measure attitudes towards lesbian parenting as well as some additional items. The second questionnaire measured the belief dimensions of immutability and fundamentality of sexual orientation. Exploratory factor analysis on the responses of 165 participants indicated three factors on the questionnaire measuring attitudes about lesbian parenting: condemnation-tolerance, normality and therapeutic practice. Two factors were derived from the questionnaire measuring beliefs about sexual orientation: immutability and fundamentality. The results showed that the psychologists held generally positive attitudes towards lesbian parenting and endorsed immutability beliefs about sexual orientation. Immutability beliefs were not related to more tolerant attitudes, whereas fundamentality beliefs were related to more condemning attitudes. Males held more fundamentalist beliefs about sexual orientation. Social contact with lesbians was related to holding more positive attitudes about lesbian parenting, whereas religious affiliation was related to more negative attitudes. Counselling psychologists and systemic practitioners were found to be more sensitive to therapeutic issues with lesbian families. It is suggested that these findings have important training and practice implications for professionals working with lesbian families.

Key words: lesbian parenting; psychologists’ attitudes; sexual orientation beliefs; factor analysis
Clinical and Counselling Psychologists' Attitudes Towards Lesbian Parenting

INTRODUCTION

It has been almost three decades since the board of trustees of the American Psychiatric Association voted for the removal of homosexuality as a category from the Diagnostic and Statistical Manual of Mental Disorders in 1973 (Greene, 1994). At the time, this event marked the recognition that homosexual orientations do not indicate psychological disturbance and psychologists were urged to remove the stigma of mental illness from lesbian and gay sexualities. Almost three decades later, lesbian and gay psychology has come a long way. Understanding the lives of lesbians and gay men has become the focus of scientific enquiry and a significant amount of literature exploring non-traditional sexual orientations from affirmative (i.e. non-pathologising) perspectives has emerged (Greene, 2000).

Within lesbian and gay psychology, one of the issues that has received considerable attention is lesbian and gay parenting. Lesbians and gay men have always been parents. Until about the 1980s, most lesbian and gay parents had children in the context of heterosexual relationships prior to 'coming out'. As a result of the need to inform both public consciousness and court decisions regarding custody cases, most research in the area focused on the psychological, social and sexual development of children who grew up in lesbian and gay-parented families (Parks, 1998). This research has generally revealed that children of divorced lesbian mothers grow up in ways that are very similar to children of divorced heterosexual mothers (for a review see Falk, 1989; Green & Bozett, 1991; Patterson, 1992, 1995; Tasker, 1999; Tasker & Golombok, 1991, 1997).
In the 1990s, the number of planned lesbian families increased (Patterson, 1995). The subsequent increase in births by women who were 'out' as lesbians has been referred to as a lesbian 'baby boom'. As lesbian couples started to create their own families, research started to shift its focus towards identifying the different dilemmas and challenges lesbian couples face upon deciding to become parents (see Baum, 1996; Crawford, 1987; Gartrell et al., 1996; 1999; Hare, 1994; Leiblum et al., 1995; Mitchell, 1996; Patterson, 1995; 1996; Pies, 1990; Tasker & Golombok, 1998; Touroni, this volume).

In a similar fashion, British publications related to therapeutic practice with lesbians and gay men have started to appear in recent years (Milton & Coyle, 1998; 1999). This development in Britain has been marked both by the commissioning of a study by the Standing Committee for Professional Affairs of the British Psychological Society's Division of Counselling Psychology (DCoP) to develop guidelines for professional practice with lesbian and gay clients and also, by the emergence of British texts on lesbian and gay affirmative therapy (Davies & Neal, 1996).

Nevertheless, psychologists working in psychotherapeutic contexts in Britain have only recently started to conceptualise lesbian and gay sexualities from an affirmative perspective. It also seems that, at present, most training courses address issues of working with lesbian and gay clients very briefly, if at all (Milton & Coyle, 1998). Hence, there seems to be a question as to whether psychotherapeutic psychologists have managed to incorporate the literature on lesbian and gay psychology and lesbian and gay affirmative therapy into their practice and thus, are able to offer appropriate psychotherapeutic services to lesbian and gay clients and their families.
Several studies attempting to measure mental health professionals' attitudes towards lesbian and gay clients have been conducted (Annesley & Coyle, 1995; Crawford et al., 1999; Hardman, 1997; Jordan & Deluty, 1995; Palma, 1996; Schwanberg, 1997). These studies mainly aimed to investigate the extent to which mental health professionals still hold prejudicial attitudes towards this population and also to assess their competence in working with lesbian and gay clients.

Palma (1996) looked at counsellor trainees in order to determine their attitudes toward ethnic and non-ethnic minorities. He found that counselling students still hold somewhat negative attitudes towards lesbians and gay men. In a similar way, Jordan and Deluty (1995) conducted a study to assess clinical psychologists' methods of intervention and attitudes toward lesbians and gay men. Although they found that none of these psychologists used aversion techniques to change sexual orientation, 11% reported the use of alternative psychotherapeutic methods for that purpose.

Hardman (1997) conducted a study to ascertain social workers' attitudes to lesbians, which highlighted a predominance of liberal humanistic attitudes amongst social workers. It should be noted that a liberal humanistic framework places emphasis upon the similarities between heterosexuals and lesbians and gay men and hence has the inevitable shortcoming of failing to examine the specificity and social context of lesbian and gay sexualities and relationships (Kitzinger & Coyle, 1995). When translating these attitudes into practice, it was indeed confirmed that social workers with liberal humanistic attitudes failed to acknowledge the lesbian context in their assessments, formulations and interventions.
Annesley and Coyle (1995) looked at clinical psychologists' competence in dealing with lesbian clients by examining their attitudes towards lesbians and lesbianism. They found that the participants displayed generally positive attitudes. The only area in which participants' attitudes were more ambivalent related to lesbian parenting. This finding is interesting in that it seems that although psychologists have moved significantly in the attitudes they hold about lesbians in a general sense, they still hold reservations and negative stereotypes about lesbian parenting. Crawford et al. (1999) conducted a study specifically to explore psychologists' attitudes towards lesbian parenting. They used six vignettes describing a couple interested in adopting a five-year old child. The vignettes were identical except that the couples' sexual orientation was depicted as lesbian, gay or heterosexual and the child was a boy or girl. The results indicated that participants who rated the lesbian and gay couples with a female child were less likely to recommend custody for these couples than participants who rated the heterosexual couples. The rationale behind that decision was that psychologists were concerned about the level of stigmatisation and bias lesbian and gay families encounter in our society. These findings are in accordance with previous findings on students' attitudes to lesbian parenting. In two previous studies (Crawford & Solliday, 1996; Fraser et al., 1995) participants were less likely to favour a lesbian or gay parent winning custody when compared to a heterosexual parent and were most likely to view lesbian or gay parents as creating an unstable environment for the child.

To date no study in Britain has looked at counselling psychologists' attitudes towards lesbian parenting. If one considers that the development of counselling psychology reflects a move away from the medical model and a move towards a belief in therapy as a collaborative endeavour (Woolfe, 1996), then there might be reasons to believe
that counselling psychologists’ attitudes to lesbian parenting might differ to those of clinical psychologists. Due to the underlying philosophy of the discipline that seeks to validate individual’s personal experiences, counselling psychologists might be more able to offer more sensitive psychotherapeutic services to lesbian families.

**Correlates of attitudes towards lesbians and gay men**

No single variable has emerged as the best predictor of attitudes towards lesbians and gay men (Herek, 1994). Analyses of differences in attitudes among members of sub-groups have shown that males (e.g. Donnelly *et al.*, 1997; Herek, 1994; Kerns & Fine, 1994; Klamen *et al.*, 1999; Seltzer, 1992; Simon, 1995), those with religious affiliations (e.g. Crawford & Solliday, 1996; Herek, 1994; Seltzer, 1992) and those with fewer lesbian and gay acquaintances (Herek, 1994; Herek & Glunt, 1993; Kerns & Fine, 1994; Klamen *et al.*, 1999; Simon, 1995) hold significantly more negative attitudes towards lesbians and gay men. Some studies have also indicated that attitudes towards gay men are significantly more negative than attitudes towards lesbians (Berkman & Zinberg, 1997; Schellenberg *et al.*, 1999).

Another interesting finding is that whereas several studies (e.g. Kerns & Fine, 1994; Simon, 1995) have indicated that males tend to hold more negative attitudes about gay men than females, there are no gender differences in attitudes towards lesbians.

**Existing instruments measuring attitudes towards lesbians and gay men**

In the early 1970s most of the scales attempting to measure attitudes to lesbians and gay men centred on the concept of ‘homophobia’. Weinberger (1972) defined homophobia as the ‘dread of being in close quarters with homosexuals’ (p.4). Many
studies conducted at the time aimed to measure heterosexuals' attitudes towards lesbians and gay men by measuring their degree of 'homophobia' (see Hansen, 1982; Henley & Pincus, 1978; Hudson & Ricketts, 1980; Smith, 1971).

Most of the shortcomings of these studies originate from the use of the term 'homophobia' to refer to and define attitudes towards lesbians and gay men. Characterising hostility towards lesbians and gay men as a 'phobia' implies that those attitudes are based on an irrational fear. Hence, the term 'homophobia' fails to take into consideration the social and political context in which attitudes are formed and maintained. Kitzinger and Perkins (1993) offer a comprehensive discussion of the term 'homophobia' and the implications of using it to describe negative attitudes towards lesbians and gay men. Specifically, they explain how the suggestion that people who hold negative attitudes about lesbians and gay men suffer from a form of phobia removes the argument from the political arena and relocates it in the domain of psychology. The implication then is that the oppression that lesbians and gay men have suffered can become justified as originating from the personal inadequacy of particular individuals who suffer from a diagnosable phobia. Furthermore, to suggest that only individuals with psychological problems would find lesbians and gay men as threatening and objectionable is to ignore the challenges that lesbian and gay sexualities may pose to standard ways of thinking about relationships, parenting and families which, in turn, is to deprive them of their revolutionary potential.

However, the shortcomings of the term 'homophobia' are not only of a political nature. From a methodological standpoint, the term 'homophobia' focuses only on negative attitudes and hence, when used as an attitudinal measure, it fails to explain the broad range of both positive and negative attitudes. In addition, scales that
attempted to measure participants' 'homophobia' did not assess attitudes toward lesbians and gay men separately but instead referred to 'homosexuals' in general. This was unfortunate since an unknown proportion of respondents most likely equated homosexuality with gay men (Herek, 1994).

Taking into consideration all the shortcomings of previous scales, Herek (1984, 1986, 1988, 1994) developed a standardised scale assessing attitudes towards lesbians and gay men (ATLG). The ATLG uses a 9-point Likert response format that is comprised of two subscales—one measuring attitudes towards lesbians and one attitudes towards gay men. A review of empirical studies using the ATLG establishes this scale as a reliable and valid instrument for assessing heterosexuals' attitudes towards lesbians and gay men (Herek, 1994).

To date, no standardised scales measuring attitudes towards lesbian parenting exist. Hence, it would be advisable for any study attempting to measure attitudes towards lesbian parenting to draw upon the ATLG as a frame of reference.

**Theoretical Framework**

*Defining the attitude concept*

The framework from which this study was conducted comes from contemporary theorising in the social psychology of attitudes. Two different approaches to the definition of attitudes exist. The first approach is the 'three-component model' of attitudes. According to this model, an attitude is a combination of three conceptually distinguishable reactions to a certain object (e.g., Eagly & Chaiken, 1993; Zanna & Rempel, 1988). These reactions are specified as affective, cognitive and behavioural.
Affective reactions refer to feelings or emotions associated with an attitude object; cognitive reactions refer to beliefs or thoughts about an attitude object and behavioural reactions refer to past behaviours or behavioural intentions with respect to an attitude object. The three-component model claims that the three defined components of attitudes are moderately correlated. The second approach to the study of attitudes can be described as 'unidimensional' as it suggests that the term 'attitude' should only be used to refer to "a general, enduring positive or negative feeling about some person, object or issue" (Petty & Cacioppo, 1981, p.7). For the purposes of this study, the three-component model of attitudes was endorsed, as this model was deemed to offer a more comprehensive and all-encompassing theory of attitudes.

Beliefs about sexual orientation

The theoretical framework employed in this study was also based on the dimensions of 'immutability' and 'fundamentality' of sexual orientation. A belief in the 'immutability' of sexual orientation is defined as a belief that sexual orientation is immutable, beyond one's choosing or 'not a person's fault'. A belief in the 'fundamentality' of sexual orientation is defined as a belief that the categories 'homosexual' and 'heterosexual' are distinct, exclusive and fundamental.

Social psychologists have conducted research looking at the relationship between beliefs about sexual orientation and attitudes towards lesbians and gay men. Previous research (Crawford et al., 1999; Herek & Capitanio, 1995; Schmalz, 1993; Whitley, 1990) has indicated that people who hold 'immutability' beliefs hold more tolerant attitudes towards lesbians and gay men. Social psychologists explain these
findings by referring to attribution theory (e.g. Anderson et al., 1996; Crocker et al., 1998; Whitley, 1990). According to attribution theory, beliefs about the controllability of a stigmatised trait shape the emotional and behavioural responses of non-stigmatised persons towards stigmatised persons. Stigmata understood to be under personal control elicit more hostility, less pity and less willingness to help than stigmata understood to be beyond personal control (Weiner et al., 1988). Thus, attribution theory claims that belief in the notion that sexual orientation is biologically based and hence, beyond a person’s control, could account for heterosexual people’s more tolerant attitudes. However, Hegarty (2000) argues that immutability beliefs might be correlated with attitudes about lesbians and gay men only when they are recognised by those holding them as expressive of tolerance and that it is this construction that accounts for the relationship between attitudes and immutability beliefs. In a similar way, he proposes that people who endorse ‘fundamentality’ beliefs tend to hold more condemning attitudes. This is justified in light of the ‘self expressive’ function of attitudes, as it is suggested that fundamentality beliefs usually serve as vehicles for the expression of broader self-relevant ideologies such as fundamentalist Christianity (Hegarty, 2000). In this study, the participants’ beliefs in the immutability/fundamentality of sexual orientation were considered as potentially predictive of their attitudes.

Research aims

The purpose of this study is to measure British clinical and counselling psychologists’ attitudes towards lesbian parenting. Since attitudes towards lesbian parenting have not been measured before in any depth in Britain, this is an exploratory study.
Specifically, the main aim is to investigate whether clinical and counselling psychologists hold positive or negative attitudes towards lesbian parenting and to consider how their attitudes might impact on their therapeutic practice with this population.

**Research hypotheses**

It is hypothesised that:

1. Psychologists who hold strong beliefs about the immutability of sexual orientation will hold more positive attitudes towards lesbian parenting.

2. Psychologists who hold strong beliefs about the fundamentality of sexual orientation will hold more negative attitudes towards lesbian parenting.

3. No differences will be found in attitudes about lesbian parenting between male and female psychologists.

4. Psychologists with no/limited social contact with lesbians will hold more negative attitudes towards lesbian parenting.

5. Psychologists with religious affiliations will hold more negative attitudes about lesbian families.

6. Counselling psychologists will hold more positive attitudes towards lesbian families than clinical psychologists.

**METHOD**

*Participants*
Five hundred clinical and counselling psychologists were identified using the British Psychological Society's Register of Chartered Psychologists (BPS, 1998/99) using a random sampling strategy (e.g., Fife-Schaw, 1995). Specifically, a sampling interval approach was used to select 500 potential participants from a population of 2674 chartered counselling and clinical psychologists listed in the Register. The participants did not have to meet any other criteria apart from being chartered, since the study aimed to measure the attitudes of the average clinical and counselling psychologist. Therefore, specialised knowledge and experience with this population was not an inclusion criterion for this study. A sampling interval for the selection process was derived by choosing the first digit between 1-5 from a table of random numbers (de Vaus, 1996). One hundred and sixty five participants returned the complete questionnaire (33% response rate). Due to the lack of additional funds as well as time limitations no follow up letters or additional questionnaires were sent out.

**Questionnaire design**

A questionnaire was developed, drawing upon the ATLG scale (Herek, 1994). Ten items were adjusted in order to measure attitudes specifically towards lesbian parenting. An additional twenty-six items were included in the questionnaire. These items were derived from a previous qualitative study that investigated the decision-making processes and therapeutic experiences of 9 lesbian couples who had had children within the context of a lesbian relationship (Touroni, this volume). Participants in this study were asked to discuss: (a) the extent to which therapy contributed to their parenting decision (b) the extent to which their experience as lesbian parents was understood by the therapist and (c) their therapy needs as
lesbian parents. Their responses to these questions formed the basis for the development of the additional items of the questionnaire. Thirty-six items in total were initially included in the questionnaire. The items attempted to measure all three components of attitudes towards lesbian parenting.

A second shorter questionnaire was also used, which consisted of six items assessing beliefs about sexual orientation. The six beliefs' items were drawn from Hegarty and Pratto's (in press) research on sexual orientation beliefs. Each of the three items in the questionnaire measured each of two belief dimensions; namely, immutability and fundamentality.

Demographic questions were included at the end (de Vaus, 1996). All forty-two items from the two questionnaires were presented to respondents in Likert format with a 7-point scale ranging from 'strongly agree' to 'strongly disagree'. A Likert scale is the most popular scaling procedure in use today (Oppenheim, 1998) and is particularly useful when it comes to the measurement of attitudes (Anastasi & Urbina, 1997).

Every single item on the scale, the instructions and the layout were piloted at the researcher's clinical placement. The questionnaire was administered to seven clinical psychologists who following its completion offered feedback both on its content and layout. The participants in the pilot study considered four items as vague and open to multiple interpretations. Hence, these four items were eliminated completely and a number of items were slightly rephrased. The questionnaire was then piloted again and no further corrections were considered to be necessary.
Procedure

All the participants received a covering letter explaining the purpose of the study and providing specific instructions about taking part (see Appendix A), a questionnaire (see Appendix B), a background information sheet (see Appendix C) and a pre-paid self-addressed envelope.

Data Analysis

Pearson's correlations were carried out to explore the relationships between participants' percentage of close lesbian friends, attitudes towards lesbian parenting and beliefs about sexual orientation. Independent-samples t-tests were carried out to investigate the effect of the participants' gender, professional affiliation, religious affiliation and social contact with lesbian women on their attitudes about lesbian parenting and their beliefs about sexual orientation. Pearson's correlations were also used to investigate the relationships among the different attitude measures and beliefs about sexual orientation.

Finally, exploratory factor analysis was used to explore the variable areas (attitudes towards lesbian parenting and beliefs about sexual orientation) and identify the factors underlying the variables. Making the assumption that the factors that influence attitudes on lesbian parenting and beliefs about sexual orientation are correlated, oblique rotation was used as it allows for the factors to be correlated (Kerlinger, 1992). In addition, principal component analysis was employed, in order to look at the factors that explain as much of the variance as possible (Loewenthal, 1996).
RESULTS

Sample Characteristics

A sample of 165 participants returned the completed questionnaire (33% response rate). Out of all the respondents, 142 were female (61.8%) and 62 male (37.6%). The participants' age ranged from 26-80 with a mean age of 46.1 (SD: 9.4). One hundred and fifty six participants (94.5%) described themselves as white and 10 (5.5%) as non-white. In terms of sexual orientation, 145 participants (87.9%) were heterosexual, 9 (5.5%) were bisexual, 7 (4.2%) were gay and 3 (1.8%) were lesbian.

There were 144 clinical psychologists (87.3%) and 21 counselling psychologists (12.7%). The participants' years of practice ranged from 2-46 with a mean of 17.04 (SD: 9.06). Regarding their preferred model of working with clients, several participants selected more than one model. Specifically, 79 (47.9%) were cognitive-behavioural, 43 (26.1%) were integrative, 37 (22.4%) were systemic, 31 (18.8%) were psychodynamic, 25 (15.2%) were humanistic, 13 (7.9%) ticked the 'other' category and 8 participants (4.8%) were cognitive-analytic. Some of the 'other' orientations that were specified were existential and TA (transactional analysis).

The participants had varying degrees of experience working with lesbian clients. Eight participants (4.8%) had never worked with a lesbian client, 25 (15.2%) had worked with one or two lesbian clients, 69 (41.8%) had worked with more than two and less than ten lesbian clients, 41 (24.8%) had worked with more than ten and less than twenty-five lesbian clients, 14 (8.5%) had worked with more than twenty-
five and less than fifty lesbian clients, 6 (3.6%) had worked with more than fifty and less than one hundred lesbian clients and 2 (1.2%) did not respond to this question.

Out of all the respondents 153 (92.7%) had never received any training in working with lesbian clients and 12 (7.3%) had received some form of training. When asked whether they wanted to receive training/further training on working with lesbian clients, 22 participants (13.3%) answered 'yes, definitely', 74 (44.8%) said 'possibly', 46 said 'not sure' (27.9%) and 23 (13.9%) replied 'definitely not'.

When asked whether they had any social contact with lesbian women outside work contexts, 105 participants (63.6%) said 'yes' and 60 (36.4%) said 'no'. The percentage of the participants' close lesbian friends ranged from 0-50% with mean: 4.3 (SD: 8.51).

In terms of religiosity, 6 participants (3.6%) described themselves as 'very religious', 25 (15.2%) as 'quite religious', 45 (27.3%) as 'not very religious' and 87 (52.7%) as 'not at all religious'. Ninety-six participants (58.2%) did not belong to a religious denomination whereas 69 (41.8%) did. Out of the 69 participants that belonged to a religious denomination, 15 (9.1%) belonged to the Church of England, 10 (6.1%) were Baptist, 2 (1.2%) were Roman Catholics, 5 (3%) were Muslim, 4 (2.4%) belonged to Buddhism, 2 (1.2%) were Jewish and 30 (18.2%) belonged to other non-Christian denominations. (see Table 1 for a summary of the participants background information)
## Table 1: Summary of Participants' Background Information

<table>
<thead>
<tr>
<th>Description</th>
<th>No. of Participants</th>
<th>Number of Participants</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td>Female</td>
<td>142 (61.8%)</td>
<td>62 (37.6%)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>156 (94.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td>Mean age (years)</td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Range (years)</td>
<td>26-60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD (years)</td>
<td>9.4</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td>White</td>
<td>156 (94.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-white</td>
<td>10 (5.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Profession:</strong></td>
<td>Clinical Psychologists</td>
<td>144 (87.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counseling Psychologists</td>
<td>21 (12.7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Years of Practice:</strong></td>
<td>Mean (years)</td>
<td>17.04</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Range (years)</td>
<td>2-46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD (years)</td>
<td>9.06</td>
<td></td>
</tr>
<tr>
<td><strong>Theoretical Orientation:</strong></td>
<td>Cognitive-analytic</td>
<td>8 (4.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive-behaviour</td>
<td>79 (47.9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Humanistic</td>
<td>25 (15.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrative</td>
<td>43 (26.1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychodynamic</td>
<td>31 (18.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Systemic</td>
<td>37 (22.4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>13 (7.9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Experience with Lesbian Clients:</strong></td>
<td>None</td>
<td>8 (4.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One or two</td>
<td>25 (15.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than two and less than ten</td>
<td>69 (41.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than ten and less than twenty-five</td>
<td>41 (24.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than twenty-five and less than fifty</td>
<td>14 (8.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than fifty and less than one hundred</td>
<td>6 (3.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did not respond</td>
<td>2 (1.2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Training with Lesbian Clients:</strong></td>
<td>No</td>
<td>153 (92.7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>17 (7.3%)</td>
<td></td>
</tr>
<tr>
<td><strong>Wish for Training with Lesbian Clients:</strong></td>
<td>Participants' responses</td>
<td>22 (13.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, definitely</td>
<td>22 (13.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Possibly</td>
<td>74 (44.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure</td>
<td>46 (27.9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Definitely not</td>
<td>23 (13.9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation:</strong></td>
<td>Heterosexual</td>
<td>145 (87.9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>9 (5.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gay</td>
<td>7 (4.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lesbian</td>
<td>3 (1.9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Religiosity:</strong></td>
<td>Very religious</td>
<td>6 (3.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quite religious</td>
<td>25 (15.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not very religious</td>
<td>45 (27.3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religious</td>
<td>87 (52.7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Religious denomination:</strong></td>
<td>No</td>
<td>96 (58.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>69 (41.8%)</td>
<td></td>
</tr>
</tbody>
</table>

1SD= Standard Deviation

2Several participants selected more than one preferred model of working with clients.
Three separate factor analyses were conducted. The ten items that had been derived from the ATLG scale and adapted in order to measure attitudes towards lesbian parenting were analysed first. The remaining twenty-two items that had been developed by the researcher were included in the second analysis. The six items that measured participants' beliefs about sexual orientation were included in the third analysis. The pre-analysis checks were the same for all three analyses. It was ensured that the number of participants was adequate for the analysis (Ferguson & Cox, 1993). The participants-to-variables ratio was estimated to be 4.34:1, which meets the recommendation of 2:1 to 10:1 participant/variable ratio (see Gorsuch, 1983). The sampling adequacy has been checked using the KMO measurement (KMO=0.79).

Exploratory factor analysis was performed using principal component analysis (PCA) in SPSS (v.10). According to Ferguson and Cox (1993), PCA is recommended as the first step in exploratory factor analysis. In addition, PCA was selected as it gives the most robust results (Fife-Shaw, 1997).

Factor analysis of the ATLG items

The principal components analysis indicated one factor that accounted for 60% of the variance (eigenvalues greater than one). Given that only one factor was extracted, the solution could not be rotated. This finding is consistent with previous studies using the ATLG scale, which found that throughout the analyses, a stable general factor consistently emerged that accounted for most of the explained variance in responses. Herek (1994) who developed the ATLG scale labelled this the condemnation-tolerance factor. The present study has yielded the same results, despite the fact that the items of the ATLG scale had been rephrased specifically to
measure attitudes towards lesbian parenting. The factor loadings for the condemnation-tolerance factor were between 0.65-0.9 (see Table 2 below for the loadings of the items on the factor).

**Table 2: Factor Loadings on the Condemnation-Tolerance Factor**

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian families are an inferior form of family</td>
<td>.83</td>
</tr>
<tr>
<td>Lesbian families just can’t fit into our society</td>
<td>.71</td>
</tr>
<tr>
<td>Lesbian couples should be allowed to adopt the same as heterosexual couples</td>
<td>.76</td>
</tr>
<tr>
<td>For a lesbian couple to have children is just plain wrong</td>
<td>.90</td>
</tr>
<tr>
<td>Having children in a lesbian relationship is a sin</td>
<td>.69</td>
</tr>
<tr>
<td>The idea of lesbian families seems ridiculous to me</td>
<td>.84</td>
</tr>
<tr>
<td>Lesbian families are a threat to our basic social institutions</td>
<td>.74</td>
</tr>
<tr>
<td>The growing number of lesbian families indicates a decline in society’s morals</td>
<td>.76</td>
</tr>
<tr>
<td>A lesbian family should not be discriminated against in any situation</td>
<td>.65</td>
</tr>
<tr>
<td>Lesbian families are merely a different kind of family that should not be condemned</td>
<td>.85</td>
</tr>
</tbody>
</table>

*Factor analysis of new scale on attitudes towards lesbian parenting*

The principal components analysis initially indicated three factors that accounted for 61% of the variance (eigenvalues greater than one). Given that the third factor mainly comprised of cross-loadings with factors 1 and 2 and that the solution was not easy to interpret, three selection criteria were used to decide on the number of factors to be extracted. These were the scree test (Cattell, 1966), the Kaiser 1 (K1) rule and factor interpretability (Ferguson & Cox, 1993).
The scree test (Cattell, 1966) indicated a two-factor model (see Figure 1). Following the guidelines set by Ferguson and Cox (1993) an independent rater was used to verify the extraction of two factors. Moreover, the percentage of variance explained by the two-factor model and the Kaiser 1 rule (eigenvalues greater than one) (Ferguson & Cox, 1993) supported the decision to extract two factors. The eigenvalues for the two factors were 11.06 and 1.31 accounting for 50.27% and 5.95% of the variance.

The two-factor model was preferred to the three-factor model because it had a simpler structure and represented the best interpretable solution (see Ferguson & Cox, 1993).

![Scree Plot](image)

**Figure 1. Scree Plot of eigenvalues for each factor.**
An oblique rotation was performed and produced the rotated factor matrix in six iterations. The oblique rotation was selected because it assumes that the rotated factors are correlated. According to the literature on the social psychology of attitudes, the three defined components of attitudes (namely, affective, cognitive and behavioural) are moderately correlated, thus appearing separate but not unrelated (Stahlberg & Frey, 1996). Hence, the theoretical framework of this study justifies the decision to perform oblique rotation.

A loading of above 0.3 as a cut-off point for a variable to define a factor has been chosen (Fife-Schaw, 1997). The factor loadings for factor I were between 0.48-0.93 and for factor II between 0.32-0.94. (see Table 3 for the loadings of the items on each factor).
Table 3: Factor Loadings on the Two-Factor Model Using Oblique Rotation

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel comfortable to offer therapy to a lesbian parent</td>
<td>.94</td>
<td>.41</td>
</tr>
<tr>
<td>Having children in a lesbian relationship is not fair on the children</td>
<td>.93</td>
<td>--</td>
</tr>
<tr>
<td>Lesbian families need psychological treatment</td>
<td>.63</td>
<td>--</td>
</tr>
<tr>
<td>Lesbian families are as stable as heterosexual families</td>
<td>.36</td>
<td>.45</td>
</tr>
<tr>
<td>It is selfish for lesbian couples to have children</td>
<td>.88</td>
<td>--</td>
</tr>
<tr>
<td>Lesbian families represent a valid form of family unit</td>
<td>.87</td>
<td>--</td>
</tr>
<tr>
<td>I would feel comfortable to work therapeutically with a lesbian family</td>
<td>.41</td>
<td>.45</td>
</tr>
<tr>
<td>Lesbian parents are not able to provide a stable environment for their children</td>
<td>.80</td>
<td>--</td>
</tr>
<tr>
<td>It is appropriate for a therapist to assist lesbian couples with the decision-making to have children</td>
<td>--</td>
<td>.40</td>
</tr>
<tr>
<td>I would feel comfortable to discuss parenting issues with lesbian clients</td>
<td>.30</td>
<td>.61</td>
</tr>
<tr>
<td>Lesbianism and motherhood are incompatible</td>
<td>.87</td>
<td>--</td>
</tr>
<tr>
<td>Lesbians should have the same access to artificial insemination as heterosexual women</td>
<td>.70</td>
<td>--</td>
</tr>
<tr>
<td>If a lesbian client decided to have children, I would validate her decision</td>
<td>.58</td>
<td>--</td>
</tr>
<tr>
<td>Lesbian couples should not have children because a child needs a male and female parent</td>
<td>.90</td>
<td>--</td>
</tr>
<tr>
<td>Children in lesbian families are as emotionally stable as children in heterosexual families</td>
<td>.55</td>
<td>.32</td>
</tr>
<tr>
<td>Lesbian families in themselves are not a problem but what society makes of them can be a problem</td>
<td>.56</td>
<td>--</td>
</tr>
<tr>
<td>A lesbian couple can provide a child with a facilitating environment</td>
<td>.76</td>
<td>--</td>
</tr>
<tr>
<td>It is more likely for children of lesbian parents to become lesbian or gay themselves</td>
<td>.48</td>
<td>--</td>
</tr>
<tr>
<td>Laws enabling both lesbian partners to have legal custody of their children should be implemented</td>
<td>.71</td>
<td>--</td>
</tr>
<tr>
<td>I would feel anxious if a lesbian client disclosed that she wanted to have children</td>
<td>.50</td>
<td>--</td>
</tr>
<tr>
<td>If a lesbian client wanted to have children I would be able to offer her information about possible methods of conception</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Lesbian families are psychologically unhealthy</td>
<td>.92</td>
<td>--</td>
</tr>
</tbody>
</table>

\(^1\)Dashes indicate the loading was below 0.3.
Two items were eliminated from the analysis because they were considered factorially complex (Hammond, 1995). The first item ('Lesbian families are as stable as heterosexual families') cross-loaded with loadings higher than 0.3 (Ferguson & Cox, 1993) on both factors and there was a relatively small difference between the loadings (Kline, 1997). The second item ('If a lesbian client wanted to have children I would be able to offer her information about possible methods of conception') did not load on either factor. In addition, during data entry, it was revealed that the specific item was accompanied by the participants' comments due to its ambivalent nature. Hence, theoretical and statistical considerations allowed the elimination of both items from further analysis. Another item ('I would feel comfortable to work therapeutically with a lesbian family') also cross-loaded on both factors. However, theoretically and conceptually the item fitted better in Factor 2, and, since it loaded higher on that factor it was retained.

After the elimination of the two problematic items, 16 items loaded on the first factor. The first factor is related to the normality of lesbian families. All the items that loaded on this factor asked the participants about the extent to which they regarded lesbian families to be a healthy, valid and functioning form of family unit. Specifically, some items intended to measure the participants' assessment of lesbian families along a health-pathology continuum, others related to participants' views on the extent to which children develop normally in lesbian families, whereas some other items asked whether lesbianism and motherhood were compatible and enquired about the rights of lesbian mothers. The fact that all 16 items loaded on a general factor suggests that all items tapped into the same underlying variable, ie, the perceived normality of lesbian families.
The second factor related to therapeutic practice. Four items loaded on the second factor. All the items that loaded on this factor asked the participants about their practice with lesbian families and more specifically, what they would consider their role to be if they worked with a lesbian couple that wanted to have children or with a lesbian family. (see Table 4 for the items that constituted the factors).
Table 4: Factor Loadings of the Remaining Items on the Two-Factor Model

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel comfortable to offer therapy to a lesbian parent</td>
<td></td>
<td>.93</td>
</tr>
<tr>
<td>Having children in a lesbian relationship is not fair on the children</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>Lesbian families need psychological treatment</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>It is selfish for lesbian couples to have children</td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>Lesbian families represent a valid form of family unit</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>I would feel comfortable to work therapeutically with a lesbian family</td>
<td>.38</td>
<td>.52</td>
</tr>
<tr>
<td>Lesbian parents are not able to provide a stable environment for their children</td>
<td>.82</td>
<td></td>
</tr>
<tr>
<td>It is appropriate for a therapist to assist lesbian couples with the decision-making to have children</td>
<td></td>
<td>.42</td>
</tr>
<tr>
<td>I would feel comfortable to discuss parenting issues with lesbian clients</td>
<td></td>
<td>.65</td>
</tr>
<tr>
<td>Lesbianism and motherhood are incompatible</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>Lesbians should have the same access to artificial insemination as heterosexual women</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>If a lesbian client decided to have children, I would validate her decision</td>
<td>.58</td>
<td></td>
</tr>
<tr>
<td>Lesbian couples should not have children because a child needs a male and female parent</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td>Children in lesbian families are as emotionally stable as children in heterosexual families</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>Lesbian families in themselves are not a problem but what society makes of them can be a problem</td>
<td>.55</td>
<td></td>
</tr>
<tr>
<td>A lesbian couple can provide a child with a facilitating environment</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>It is more likely for children of lesbian parents to become lesbian or gay themselves</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>Laws enabling both lesbian partners to have legal custody of their children should be implemented</td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>I would feel anxious if a lesbian client disclosed that she wanted to have children</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>Lesbian families are psychologically unhealthy</td>
<td>.93</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\text{Dashes indicate the loading was below 0.3.}\)
Factors analysis of scale on beliefs about sexual orientation

The principal components analysis indicated two factors that accounted for 61.1% of the variance (eigenvalues greater than one). An oblique rotation was performed and produced the rotated matrix in three iterations. Again, the oblique rotation was selected for both theoretical and statistical reasons. It was assumed that beliefs about sexual orientation would be correlated.

The eigenvalues for the two factors were 2.01 and 1.66 accounting for 33.5% and 27.6% of the variance. As in the previous analysis, a loading of above 0.3 has been chosen as a cut-off point for a variable to define a factor. The factor loadings for factor 1 were between 0.67-0.88 and for factor 2 between 0.67-0.77.

The first factor related to immutability of sexual orientation. Three items loaded on the first factor. The first factor included all the items that asked the participants whether they believed that sexual orientation is immutable, ‘beyond a person’s choosing’ and hence, ultimately ‘not a person’s fault’.

The second factor concerned fundamentality of sexual orientation. Three items loaded on the second factor. This factor included all the items that asked the participants whether they believed that the categories ‘homosexual’ and ‘heterosexual’ are distinct, exclusive and fundamental. (See Table 5 for the loadings of the items on each factor).
Table 5: Factor loadings on the Immutability-Fundamentality Factors Using Oblique Rotation

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor I</th>
<th>Factor II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual orientation is caused by biological factors such as genes and hormones</td>
<td>.67</td>
<td>--</td>
</tr>
<tr>
<td>Whether a person is homosexual or heterosexual is pretty much set on early on in childhood</td>
<td>.88</td>
<td>--</td>
</tr>
<tr>
<td>If someone comes out as gay or lesbian they were probably attracted to the same sex all along</td>
<td>.84</td>
<td>--</td>
</tr>
<tr>
<td>Homosexual relationships are fundamentally different from heterosexual relationships</td>
<td></td>
<td>.77</td>
</tr>
<tr>
<td>Doctors and psychologists can help people change their sexual orientation</td>
<td></td>
<td>.67</td>
</tr>
<tr>
<td>Bisexual people are fooling themselves and should make up their minds</td>
<td></td>
<td>.77</td>
</tr>
</tbody>
</table>

*Dashes indicate the loading was below 0.3.*

Out of the three factor-analyses, five subscales have been calculated from the items in each of the factors. Subsequently, the internal consistency reliabilities (Cronbach’s alphas) for all five scales were estimated. These were calculated for the Condemnation-Tolerance (CT) factor α=.92; for the Normality (NO) factor α=.95; for the Therapeutic Practice (TP) factor α=.74; for the Immutability (I) factor α=.73 and for the Fundamentality (F) factor α=.59. As evident, all the scales have good internal reliability apart from the Fundamentality scale. According to Fife-Schaw (1997) α=0.6 is the barest minimum for purposes other than scale construction. Since this was an exploratory study and .59 approximates .60, this scale’s reliability was considered acceptable.

The total scores for the items from each of the five scales that derived from the factor analysis were obtained to produce the main variables for all subsequent analyses in this study. Prior to the analyses, normality of variance was examined and
all the main variables (CT, NO, TP, I, F) met the necessary criteria for the analyses that follow. For the variables that were not normally distributed (gender, sexual orientation, religiosity, theoretical orientation, social contact and professional affiliation) the equivalent non-parametric tests were used.

**Descriptive Analyses**

One of the main aims of the present study was to measure the attitudes of clinical and counselling psychologists towards lesbian parenting. In the three scales that constitute attitudinal measures (CT, NO, TP) the means indicate that psychologists endorse positive attitudes towards lesbian families. Specifically, the mean on the Condemnation-Tolerance factor was 57.7 (SD: 11), on the Normality factor 86.9 (SD: 17.7) and on the Therapeutic Practice factor 23.1 (SD: 3.8).

In terms of immutability and fundamentality beliefs, the means of the scores indicate that most of the participants endorsed immutability as opposed to fundamentality beliefs about sexual orientation. The mean on the Immutability factor was 11.2 (SD: 3.4) and on the Fundamentality factor 16 (SD: 3.1). (See Table 6 for means and standard deviations of main variables).
Table 6: Means and standard deviations of main variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Minimum/Maximum</th>
<th>Possible Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condemnation-Tolerance</td>
<td>57.7 (11)</td>
<td>21-70</td>
<td>10-70(^1)</td>
</tr>
<tr>
<td>Normality</td>
<td>86.9 (17.7)</td>
<td>32-112</td>
<td>16-112(^1)</td>
</tr>
<tr>
<td>Therapeutic Practice</td>
<td>23.1 (3.8)</td>
<td>4-28</td>
<td>4-28(^1)</td>
</tr>
<tr>
<td>Immutability</td>
<td>11.2 (3.4)</td>
<td>3-20</td>
<td>3-21(^2)</td>
</tr>
<tr>
<td>Fundamentality</td>
<td>16 (3.1)</td>
<td>4-21</td>
<td>3-21(^2)</td>
</tr>
</tbody>
</table>

\(^1\)Higher scores indicate positive attitudes.

\(^2\) Higher scores indicate low immutability/fundamentality beliefs.

To provide a more holistic picture of the participants' attitudes, 7.9% held negative attitudes as measured by the Condemnation-Tolerance scale, 12.1% held negative attitudes as measured by the Normality scale and 3.6% held negative attitudes as measured by the Therapeutic Practice scale. As far as the participants' beliefs about sexual orientation are concerned, 57% of the participants held immutability beliefs whereas only 7.3% held fundamentality beliefs. (See Table 7 for scores of participants' attitudes to lesbian parenting and beliefs about sexual orientation).
Table 7: Percentages of Participants’ Attitudes towards Lesbian Parenting and Beliefs about Sexual Orientation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scores</th>
<th>Number of Participants (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condemnation-Tolerance</td>
<td>21-39 (negative)</td>
<td>13 (7.9%)</td>
</tr>
<tr>
<td></td>
<td>40-50 (ambivalent)</td>
<td>23 (13.9%)</td>
</tr>
<tr>
<td></td>
<td>51-70 (positive)</td>
<td>129 (78.2%)</td>
</tr>
<tr>
<td>Normality</td>
<td>32-63 (negative)</td>
<td>21 (12.1%)</td>
</tr>
<tr>
<td></td>
<td>65–79 (ambivalent)</td>
<td>28 (17.6%)</td>
</tr>
<tr>
<td></td>
<td>81-112 (positive)</td>
<td>116 (70.3%)</td>
</tr>
<tr>
<td>Therapeutic Practice</td>
<td>4-15 (negative)</td>
<td>6 (3.6%)</td>
</tr>
<tr>
<td></td>
<td>16-19 (ambivalent)</td>
<td>18 (10.9%)</td>
</tr>
<tr>
<td></td>
<td>20-28 (positive)</td>
<td>141 (85.5%)</td>
</tr>
<tr>
<td>Immutability</td>
<td>3-11 (high)</td>
<td>94 (57%)</td>
</tr>
<tr>
<td></td>
<td>12-14 (ambivalent)</td>
<td>51 (25.4%)</td>
</tr>
<tr>
<td></td>
<td>15-21 (low)</td>
<td>20 (17.6%)</td>
</tr>
<tr>
<td>Fundamentality</td>
<td>4-11 (high)</td>
<td>12 (7.3%)</td>
</tr>
<tr>
<td></td>
<td>12-14 (ambivalent)</td>
<td>30 (18.2%)</td>
</tr>
<tr>
<td></td>
<td>15-21 (low)</td>
<td>123 (74.5%)</td>
</tr>
</tbody>
</table>

Relationship between demographics, attitudes towards lesbian parenting and beliefs about sexual orientation

A Mann-Whitney test was conducted to examine whether there were any significant differences in the participants’ attitudes about lesbian parenting and their beliefs about sexual orientation depending on gender. A significant difference was found (z=-2.68, p<.05) between males and females on the Fundamentality scale. Specifically, the mean score for females was 16.4 (SD: 3.1) and for males 15.2 (SD: 3). This indicates that male participants endorsed fundamentality beliefs to a greater
extent than female participants. No differences in attitudes towards lesbian parenting were found across gender.

Social contact with lesbian women was another variable that produced significant results. Significant differences were found on all three attitudinal scales and on the Immutability/Fundamentality scales between psychologists who had contact with lesbian women outside work contexts and those that did not have any contact. Specifically, a significant difference was found on the Normality scale \( z = -3.69, p < .001 \), on the Therapy Practice scale \( z = -2.32, p < .001 \), on the Condemnation-Tolerance scale \( z = -3.16, p < .05 \), on the Immutability scale \( z = -2.22, p < .05 \) and on the Fundamentality scale \( z = -2.65, p < .05 \). These findings indicate that the psychologists who had social contact with lesbian women outside work contexts endorsed more positive attitudes about lesbian parenting and held less immutability and fundamentality beliefs about sexual orientation. A positive correlation \( r = .27, N = 165, p < .001 \) was also found between the Normality scale and the percentage of close lesbian friends the participants have as well as the Condemnation-Tolerance scale and the percentage of close lesbian friends \( r = .23, N = 165, p < .001 \). Thus, it is suggested that the higher the percentage of close lesbian friends the participants had, the more positive their attitudes were about lesbian parenting as measured by the NO and CT scales.

To determine whether theoretical orientation played any role in the participants’ responses, Mann-Whitney tests were carried out. Significant differences were only found between systemic and non-systemic practitioners on the Normality scale \( z = -3.6, p < .001 \), the Therapeutic Practice scale \( z = -3.1, p < .001, p < .01 \), the Condemnation-Tolerance scale \( z = -3.2, p < .001 \) and the Fundamentality scale \( z = -
Specifically, the mean scores were 95.70 (SD: 13.1) on Normality, 24.65 (SD: 3) on Therapeutic Practice, 62.84 (SD: 6.8) on Condemnation-Tolerance, 17.76 (SD: 2.5) on Fundamentality for systemic practitioners and 84.39 (SD: 18) on Normality, 22.57 (SD: 3.9) on Therapeutic Practice, 56.26 (SD: 11.6) on Condemnation-Tolerance, 15.46 (SD: 3.1) on Fundamentality for non-systemic practitioners. These findings clearly suggest that systemic practitioners held more positive attitudes about lesbian parenting as measured by all three attitudinal scales and also, were less fundamental in their beliefs about sexual orientation.

A Mann-Whitney was also conducted to examine the effect of professional affiliation on attitudes and beliefs. A significant difference was found between clinical and counselling psychologists (z=-2.64, p<.05) on the Therapeutic Practice scale. Specifically, the mean scores were 22.78 (SD: 3.9) on Therapeutic Practice for clinical psychologists and 24.95 (SD: 2.6) for counselling psychologists. This finding suggests that counselling psychologists were more aware of potential therapeutic issues with lesbian parents and their families as measured by the Therapeutic Practice scale.

Finally, a Mann-Whitney test was carried out to investigate the effect of religious membership on attitudes and beliefs. A significant difference was found on the Condemnation-Tolerance scale between those participants who had a religious affiliation and those who did not (z=-1.99, p<.05). Specifically, the mean scores were 55.56 (SD: 11.6) on Condemnation-Tolerance for participants who had a religious affiliation and 58.97 (SD: 10.6) for those who did not. This finding indicates that participants who belonged to a religious group held more negatives attitudes about lesbian parents as measured by the Condemnation-Tolerance scale.
Relationships among attitude and beliefs’ measures

Pearson’s correlations were conducted to investigate the relationships among the main variables. Several positive correlations were found between the different attitude measures. Specifically, there was a positive correlation between the Normality scale and Therapeutic Practice ($r=.67$, $N=165$, $p<.001$), the Normality scale and the Condemnation-Tolerance scale ($r=.925$, $N=165$, $p<.001$) and the Condemnation-Tolerance Scale and Therapeutic Practice scale ($r=.65$, $N=165$, $p<.001$). These positive correlations suggest that as expected, all three attitude measures tapped into the same concept and hence, the higher a participant scored on one of the measures, the higher she/he would score on the other measures as well.

Positive correlations were also found between the Fundamentality scale and the Normality scale ($r=.67$, $N=165$, $p<.001$), the Fundamentality scale and the Therapeutic Practice scale ($r=.42$, $N=165$, $p<.001$) as well as the Fundamentality scale and the Condemnation-Tolerance scale ($r=.64$, $N=165$, $p<.001$). Due to scoring methodology, these findings suggest that the more positive attitudes a participant held about lesbian parenting as measured by all three attitudinal scales, the less fundamental her/his beliefs were about sexual orientation. No significant correlations were found between the Immutability scale and the three attitude measures. (see Table 8)
**Table 8: Relationships between Attitudes towards Lesbian Parenting Measures and Beliefs about Sexual Orientation measure**

<table>
<thead>
<tr>
<th></th>
<th>Immutability</th>
<th>Fundamentality</th>
<th>Condemnation-Tolerance</th>
<th>Normality</th>
<th>Therapeutic Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immutability</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Fundamentality</td>
<td>--</td>
<td>1</td>
<td>.64**</td>
<td>.67**</td>
<td>.42**</td>
</tr>
<tr>
<td>Condemnation-Tolerance</td>
<td>--</td>
<td>.64**</td>
<td>1</td>
<td>.93**</td>
<td>.65**</td>
</tr>
<tr>
<td>Normality</td>
<td>--</td>
<td>.67**</td>
<td>.93**</td>
<td>1</td>
<td>.66**</td>
</tr>
<tr>
<td>Therapeutic Practice</td>
<td>--</td>
<td>.42**</td>
<td>.65**</td>
<td>.66**</td>
<td>1</td>
</tr>
</tbody>
</table>

1 Dashes indicate the correlation was not significant.

** Stars indicate that correlation is significant at the 0.01 level (2-tailed).

**DISCUSSION**

The purpose of this study was to measure clinical and counselling psychologists' attitudes to lesbian parenting and to examine how their attitudes related to their beliefs about sexual orientation. Furthermore, the relationships between demographic characteristics, attitudes about lesbian families and beliefs about sexual orientation were investigated. Several important findings emerged.

**Attitudes towards lesbian parenting and beliefs about sexual orientation**

Through exploratory factor analysis, three underlying dimensions relevant to attitudinal measures emerged: condemnation-tolerance, normality, and therapeutic practice. In all three dimensions, participants' scores indicated that they generally held positive attitudes towards lesbian parenting. These findings are inconsistent with previous research that suggested that mental health professionals still hold negative
attitudes towards lesbians and gay men (Hardman, 1997; Jordan & Deluty, 1995; Palma 1996; Schwanberg, 1997) and specifically towards lesbian parenting (Annesley & Coyle, 1995; Crawford et al., 1999). There are several possible explanations for the differences in this study’s findings.

The response rate in this study was 33%. Although this constitutes an average response rate, a question emerges around the psychologists who decided not to take part in this study. It is likely that those who held more negative attitudes did not return the questionnaire, whereas those who held positive attitudes were more inclined to participate. Thus, these findings might not reflect psychologists’ attitudes in general but only the attitudes of those who are more accepting of lesbian parenting.

Moreover, even for the psychologists who participated in this study, several considerations need to be borne in mind when interpreting the data. If one takes a closer look at participants’ scores, it becomes evident their attitudes seem more positive when measured by the Therapeutic Practice and Condemnation-Tolerance factors and less so when measured by the Normality factor. This suggests that whereas psychologists are more tolerant in their attitudes about lesbian families in general, they are somewhat more negative when it comes to questions of function, normality and rights of lesbian families. This is consistent with the findings of Crawford et al. (1999) which showed that the main rationale for psychologists not recommending custody for lesbian and gay couples was concern about the level of stigmatisation and bias lesbian and gay families may encounter in society. In a similar manner, in the present study, psychologists were more willing to express more ambivalent or negative attitudes in questions that regarded the well-being of
children in lesbian families. Hence, whilst the present study indicates that psychologists have become more tolerant in their attitudes towards lesbian parenting, it still raises concerns, as its findings might be indicative of a more socially acceptable way of discriminating against lesbian parents.

Another interesting finding was that participants scored excessively highly (meaning they held extremely positive attitudes) in the Therapeutic Practice scale. This finding might seem promising if considered in isolation. However, if one compares the percentages of participants who scored highly on the two other attitudinal measures (see Table 7) it becomes evident that even psychologists who were more ambivalent as measured by the Condemnation-Tolerance and Normality scales, scored very highly on the Therapeutic Practice scale. This finding again raises some concerns, as it suggests that even psychologists who were relatively ambivalent about lesbian parenting felt they would be able to offer their therapeutic services to lesbian families. Hence, it seems that psychologists do not believe that their personal attitudes might limit their competence to work with certain populations.

In terms of immutability and fundamentality beliefs about sexual orientation, psychologists were found to hold immutability as opposed to fundamentality beliefs. This is a rather interesting finding, in that despite the fact that a vast amount of research in the biology of human sexual orientation has been conducted in the past decade in the United States, there still exists controversy as to the validity of this research on methodological and theoretical grounds (Byne & Parsons, 1993; McGuire, 1995; Rice et al., 1999). The finding that a large proportion of the psychologists in this study endorsed immutability beliefs perhaps suggests that they are not familiar with the breadth of literature on the biology of sexual orientation. On the other hand,
the finding that very few psychologists endorsed fundamentality beliefs is rather hopeful in that it suggests that psychologists view same-sex orientations as different qualities in the continuum of human sexuality.

**Correlates of attitudes towards lesbian parenting and beliefs about sexual orientation**

No differences were found in psychologists’ attitudes about lesbian parenting across gender. This replicates previous findings that have suggested that whereas males are more negative in their attitudes about gay men than females, there are no gender differences in attitudes towards lesbians (Kerns & Fine, 1994; Simon, 1995). However, a significant difference was found between males and females on the Fundamentality scale, with males holding more fundamental beliefs about sexual orientation. This finding could be explained if one considers that the items on the questionnaire measuring immutability and fundamentality beliefs referred to ‘homosexuals’ in general –thus, making no distinction between lesbians and gay men. Hence, one potential explanation is that the current findings reflect the need of heterosexual men to distinguish themselves from gay men by endorsing the belief that the categories heterosexual and homosexual are distinct and exclusive. Kite and Whitley (1998) suggest that heterosexual men’s negativity in their attitudes towards gay men but not towards lesbians reflects society’s different response to men’s and women’s gender role non-conformity. Men have more to lose by overstepping their gender role boundaries and engaging in or endorsing homosexual behaviour, whereas the cultural gender script allows more flexibility for the female gender role. Thus, previous findings regarding attitudes towards gay men being significantly more negative than attitudes towards lesbians (Berkman & Zinberg, 1997; Schellenberg et
might suggest that if women’s roles are viewed as lower status, then prejudice towards lesbians is not as culturally sanctioned. The present study’s finding that men hold more fundamentalist beliefs about sexual orientation, in a similar manner, suggests that heterosexual men, due to the higher status of their gender roles, make greater investment in separating themselves from gay men.

Another hypothesis of this study was that psychologists with limited or no social contact with lesbian women would hold more negative attitudes towards lesbian families. Indeed psychologists who had social contact with lesbians endorsed more positive attitudes. This is consistent with previous findings, which have suggested that social contact with lesbians or gay men is a powerful predictor of heterosexuals’ attitudes (see Herek, 1994; Herek & Glunt, 1993; Kerns & Fine, 1994; Klamen et al., 1999; Simon, 1995). As the present study’s findings merely suggested the existence of a relationship between social contact and attitudes, it does not permit conclusions about causality. As Herek and Glunt (1993) argue, these findings most likely suggest the existence of a reciprocal relationship between contact and attitudes in that not only does contact foster greater acceptance of lesbians but also, heterosexuals who already have more positive attitudes are more likely to experience contact.

The other hypothesis of this study was that psychologists with religious affiliations would hold more negative attitudes about lesbian families. This hypothesis was confirmed as psychologists with religious affiliations held more negative beliefs as measured by the Condemnation-Tolerance factor. This replicates previous findings (see Crawford & Sollday, 1996; Seltzer, 1992). According to Herek (1994), people who are religious primarily to enjoy social acceptance and integration as well as a sense of security and status are often prejudiced, as prejudice provides them with
similar benefits. This could account for the relationship between religious affiliation and negative attitudes towards lesbian families in the present study.

Further, it was hypothesised that due to the underlying philosophy of the discipline, counselling psychologists might be more positive in their attitudes than clinical psychologists. This hypothesis was confirmed as counselling psychologists were found to be more aware of potential therapeutic issues with lesbian families as measured by the Therapeutic Practice factor. This finding suggests that indeed the counselling psychologists of this study might have been better equipped to offer more sensitive and unbiased psychotherapeutic services to lesbian families.

Exploratory analyses were conducted between the other demographic variables and the participants' attitudes and beliefs. One significant finding was that systemic practitioners held more positive attitudes and less fundamental beliefs than non-systemic practitioners. Malley and Tasker (1999) have pointed out that fewer than a quarter of family therapists had spent more than two hours in their entire family training specifically addressing working with lesbians and gay clients. Similarly in this study, 92.7% of all the psychologists who took part had never received any training in working with lesbian clients. What could then account for this finding? A potential explanation might be that despite the fact that family therapy in general has been slow to consider sexuality as an influence on family life, it might still be one of the therapeutic approaches that have great potential for working with lesbian families, since it is more sensitive to issues related to difference and context.
Relationships between attitudes about lesbian parenting and beliefs about sexual orientation

As expected, all the attitudinal measures correlated with each other. This finding supports the 'three-component model' of attitudes in that the Condemnation-Tolerance scale can be conceptualised as an affective attitude component, the Normality scale as a cognitive attitude component and the Therapeutic Practice scale as a behavioural attitude component. Specifically, the data support the hypothesis that all three components influence the formation of an attitude.

The two principal hypotheses in this study were that psychologists who held immutability beliefs about sexual orientation would hold more positive attitudes about lesbian parenting, whereas those who endorsed fundamentality beliefs would hold more negative attitudes. Whilst the latter hypothesis was verified, no relationship was found between immutability beliefs and attitudes towards lesbian parenting. This finding is inconsistent with previous studies (Crawford et al., 1999; Herek & Capitanio, 1995; Schmalz, 1993; Whitley, 1990), which had indicated that people who hold immutability beliefs hold more tolerant attitudes towards lesbians and gay men. One potential explanation for the present study’s finding relates to Hegarty’s (2000) hypothesis about the link between immutability beliefs and attitudes towards lesbians and gay men. Hegarty suggests that immutability beliefs are only correlated with attitudes towards lesbians and gay men when they are recognised by those holding them as expressive of tolerance and that it is this construction that accounts for the relationship. It is possible that some heterosexual people might be able to detect the implicit heterosexism of the biological arguments. It then follows that if the participants in this study did not view immutability beliefs as expressive of a pro-
lesbian position, this could account for the lack of relationship between positive attitudes and immutability beliefs.

Overall, the findings of this study suggest that fundamentality beliefs might be a better predictor of attitudes towards lesbians/gay men. Emphasis on the distinction between heterosexual and homosexual orientations by heterosexual people might be reflective of a value judgement about normality and pathology of same-sex orientations. In that respect, it follows that those who perceive the categories homosexual and heterosexual as exclusive and fundamental would be more likely to hold negative attitudes towards lesbian families.

**Implications for training and practice**

Although the present study indicates that psychologists' attitudes towards lesbian parenting are positive overall, some of the findings that emerged have important implications for the training and practice of psychotherapeutic psychologists. The majority of the psychologists in this study (92.7%) had never received any training in working with lesbian clients. However, 41% had seen more than two and less than ten lesbian clients during their career. This finding raises concerns, as even for psychologists who hold positive attitudes towards this population, training in lesbian issues is needed in order to ensure affirmative practice. The present study has identified a need for the further training of psychologists on lesbian and gay identities and relationships. This should be done both by integrating more coverage of lesbian and gay sexualities in clinical and counselling psychology curricula but also, by attendance at more specialised post-qualification courses.
Counselling psychologists in this study were shown to have more awareness of therapeutic issues with lesbian families. This finding is rather promising as it might suggest that the relatively new discipline of counselling psychology has managed to incorporate issues of power and difference into its training courses to a greater extent than other disciplines. The important implication for therapeutic practice is that counselling psychologists might be better equipped to work with this population, provided that they acquire further specialised training. Moreover, another implication of the present study is that training in systemic approaches might be conducive when working with lesbian families, as systemic theories elevate issues of context and difference into the heart of therapeutic practice.

Limitations of the present study and suggestions for future research

This was the first British study aiming to examine psychologists' attitudes specifically towards lesbian parenting. However, there are limitations to this study, which need consideration for future research purposes.

All measures that are based on self-descriptions, such as the questionnaire in this study, start from the assumption that the person who responds is motivated to disclose her/his true attitudes. However, there is substantial evidence that people are often motivated to misrepresent their attitude in order to give socially desirable responses (Stahberg & Frey, 1996). Hence, one of the main limitations of the present study is related to the potential social desirability of the responses provided by the participants. 'Social desirability' is a term used to describe the fact that participants in any study are usually keen to be seen in a positive light, and may therefore be reluctant to provide honest reports of fears, anxieties, feelings of hostility or
prejudice if they think they would be regarded negatively (Manstead & Semin, 1996). In the present study, the participants were professional psychologists, who might have felt inclined to provide ‘politically correct’ responses on the controversial topic of lesbian parenting, even though their true feelings might have been different. Hence, there is a question of how reflective the present study is of psychologists’ true attitudes.

There is also a question as to whether a questionnaire was the appropriate measure to assess attitudes towards lesbian parenting. The potential use of vignettes might have allowed for more subtle differences in attitudes to emerge, especially if there was a comparison of the perception of normality-pathology in heterosexual and lesbian families. It seems likely that such a comparison would have yielded a more accurate picture about the attitudes of psychologists towards lesbian families.

The present study only concentrated on attitudes towards lesbian parenting. Another suggestion for future research relates to previous findings that showed that attitudes towards gay men are more negative than towards lesbians. Therefore, it might be important to compare attitudes towards lesbian and gay-parented families.

Finally, the present study only reflects the attitudes of the 165 psychologists who took part in this study. Further research should seek to verify the present findings and examine in more detail whether indeed psychologists have developed more positive attitudes towards lesbian families. Only then might the potential for truly sensitive and affirmative practice with this population flourish.
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APPENDIX A: COVERING LETTER

Dear colleague

Re: Clinical and Counselling Psychologists’ Attitudes towards Lesbian Parenting

I am a Trainee Counselling Psychologist conducting a survey, which looks at psychologists’ attitudes about lesbian parenting. This study is being carried out as a partial fulfilment for the PsychD in Psychotherapeutic & Counselling Psychology at the University of Surrey.

In recent years, within lesbian and gay psychology, one of the issues that have received considerable attention is lesbian parenting. The aim of the present survey is to explore clinical and counselling psychologists’ attitudes towards lesbian parenting. This is a particularly pertinent issue as a previous British study aiming to explore clinical psychologists’ attitudes about lesbians, found that lesbian parenting was the only matter about which the respondents expressed ambivalence. Hence, the aim of the present study is to explore this issue in more detail and examine our professional responses in a subject that has in the past proven to be rather controversial. Whilst I appreciate that this is a rather sensitive subject, I would be grateful if you could be as honest as possible in your responses.

Whilst I know how valuable your time is, I hope that you will fill out the questionnaire. If you decide to participate you will be presented with a set of statements. You will be asked to indicate the degree to which you agree/disagree with these statements. There are no right or wrong answers as I am only interested in your views. At the end you will be asked to provide a little bit of background information about yourself and your professional experience. The survey should not take you more than 15 minutes to complete. If you wish, you can withdraw from the study at any stage and without any explanation. If you are willing to take part in this research I would be very grateful if you would return the questionnaire in the pre-paid envelope as soon as
possible. If you require any additional information about the questionnaire or the results of this survey, please do not hesitate to contact me at the above address or telephone number.

Your participation is entirely voluntary and anonymous. If you wish to decline answering particular questions, please feel free to do so. All responses will be treated in the strictest confidence. No individual will be identified in the write up of the results.

If you wish to receive a copy of the abstract of the study once it is developed, please contact me at the above address and I will be more than happy to send you a copy. A consent form is not provided for taking part in this survey so as not to compromise anonymity.

Thank you for your time and help with this study.

Yours faithfully

Elena Touroni
Counselling Psychologist in Training
NOTES FOR CONTRIBUTORS

Initial manuscript submission. Submit three copies of the manuscript (including copies of tables and illustrations) to: Geoffrey Stephenson, JCASP, 46 West St, Faversham, Kent, ME13 7JG, U.K.

Authors must also supply:
• an electronic copy of the final version (should normally apply, see section below);
• a Copyright Transfer Agreement with original signature — without this, we are unable to accept the submission; and
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Electronic submission. The electronic copy of the final, revised manuscript should be sent to the Editor together with the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect [and TeX or one of its derivatives]. Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

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

• The title page must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page, as the Journal of Community & Applied Social Psychology operates a 'blind' reviewing system.

• Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).

• Supply an abstract of up to 200 words for all articles, except book reviews. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

• Include up to ten key words that describe your paper for indexing purposes.

References should be quoted in the text as name and year within brackets and listed at the end of the paper alphabetically. Where reference is made to more than one work by the same author published in the same year, identify each citation in the text as follows: (Collins, 1998a), (Collins, 1998b). Where three or more authors are listed in the reference list, please cite in the text as (Collins et al., 1998).

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:


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Dear Ms Touroni

Clinical and counselling psychologists’ attitudes towards lesbian parenting
(ACE/2001/33/Psych)

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

This letter of approval relates only to the study specified in your research protocol (ACE/2001/33/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 06 June 2001
Date of expiry of approval by the Advisory Committee on Ethics: 05 June 2006

Please inform me when the research has been completed.

Yours sincerely

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

cc: Professor LJ King, Chairman, ACE
    Dr A Coyle, Supervisor, Dept of Psychology