A Portfolio of Academic, Therapeutic Practice
and Research Work including:

‘A Qualitative Analysis of Clients’ Accounts of their Eating Disorders: If and How Treatment Experiences provide an Insight into and Aid Recovery from Eating Disorders.’

Harriet L.S. Willis BSc, Department of Psychology, University of Surrey, Guildford, Surrey GU2 5XH. Telephone: 01483 259176.

Submitted in partial fulfilment of the Psych D Practitioner Doctorate Degree in Psychotherapeutic and Counselling Psychology.
Acknowledgements

I would like to thank my parents for their belief in my abilities and their support without which I would not have been able to undertake this course. Thanks also go to Adrian Coyle, Jill Wilkinson and all the other academic staff and supervisors who were involved in my training for their invaluable help and advice. I would also like to thank all the people who participated in my research projects, without whose honest and important contributions needless to say, I could not have done without.

I also thank my friends whose company gave me some much needed distraction from my studies and my cats, Vladimir and Pandora who kept me company during the many hours I spent at my PC. Finally, my deepest thanks are owed to Adam whose constant reassurance, support and love kept me motivated and determined to succeed for our futures together.
Table of Contents

Introduction to the Portfolio 1

Academic Dossier

Introduction to the chapter 2

Theoretical Models of Therapy Essay 3
Describe the major themes of the oral or dependency stage of the infant's development. How can the therapist help clients who have difficulties associated with this stage?

Advanced Theory and Therapy Essay 15
Discuss psychoanalytic contributions to an understanding of homosexuality

Year 3 Options Essay 27
The effects of maternal mental health problems on children

Issues in Counselling Psychology Essay 38
A discussion of the appropriateness of codes of personal conduct for counselling psychologists regarding sexual contact between therapists and clients

Issues in Counselling Psychology Report 49
Individual therapy for people diagnosed with schizophrenia: A counselling psychology perspective
Therapeutic Practice Dossier

Introduction to the chapter 60

1st Year Placement Summary 61

2nd Year Specialist Placement Summary 64

3rd Year Specialist Placement Summary I 67

3rd Year Specialist Placement Summary II 70

Therapeutic Practice
An overview of three years of placement experiences 73

Client Study Summaries
Summary of Client Study I - Mr L 81

Summary of Client Study II - Miss S 85

Summary of Client Study III - Master A 89

Summary of Client Study IV - Mr C 93

Process Issues
A discussion of process issues derived from process reports written during years two and three 97
Research Dossier

Year I Literature Review 106

Cross-generational coalitions: Theoretical explanations and therapeutic implications

Year II Empirical Study 132

A qualitative analysis of the experiences of parents of children with a mental illness with reference to theories of social representations and identity

Year III Empirical Study 185

A qualitative analysis of clients' accounts of their eating disorders: If and how treatment experiences provide an insight into and aid recovery from eating disorders
Copyright

No part of this portfolio may be reproduced in any form, without the written permission of the author, except by the University of Surrey librarian for legitimate academic purposes.

Introduction to the Portfolio

This portfolio is divided into three chapters - an Academic Dossier, a Therapeutic Practice Dossier and a Research Dossier. Each dossier comprises work done over the three years of the Psych D in Psychotherapeutic and Counselling Psychology and covers a broad range of subjects which are of specific interest to the author. The work presented here hopefully reflects the way in this course promotes the linking of theory and practice and encourages a reciprocal relationship between research and practice.

Separate Appendices

Appendices referred to in the Therapeutic Practice Dossier may be viewed in the separate appendices presented in a box file. All appendices referred to in the Research Dossier are contained within this portfolio except for those containing transcripts of research interviews which are included in the separate appendices.

Confidentiality

The names of all clients and research participants referred to in all three chapters have been omitted in order to maintain their confidentiality and are referred to a Mr, Mrs, Master or Miss followed by a single letter.
Introduction to the Chapter

This chapter presents academic work carried out over the three years of training on the Psych D in Psychotherapeutic and Counselling Psychology course. The first three essays were written following seminars which were concerned with the teaching of psychological theory linked to therapeutic practice. The chapter ends with two essays concerned with issues in the practice of counselling psychology which were written following presentations regarding the subject matter contained within them. All the essays presented here reveal topics which are of interest to the author. It is also hoped that they reflect the varied content of the course, its emphasis upon linking theory to practice and its concern with teaching a broad spectrum of therapeutic models in relation to diverse adult and child mental health problems.
<table>
<thead>
<tr>
<th>Chapter:</th>
<th>Academic Dossier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course:</td>
<td>Theoretical Models</td>
</tr>
<tr>
<td>Year:</td>
<td>1st</td>
</tr>
<tr>
<td>Title:</td>
<td>Describe the Major Themes of the Oral or Dependency Stage of the Infant's Development. How can the Therapist help Clients who have Difficulties Associated with this Stage.</td>
</tr>
</tbody>
</table>
The oral or dependency stage of an infant's life is one which has drawn the attention of many important theorists who have frequently viewed the first years of an individual's life as decisive in the formation of certain personality characteristics. In describing the major themes of this stage I shall mainly be referring to the theories of Freud, Klein and Winnicott, in the chronological order in which they presented their work on this subject. For the second part of this essay I will present relevant material derived from a case-study of one of my own clients with whom I have experienced 'dependency issues' in my work with her.

'Sexual life comprises the function of obtaining pleasure from zones of the body - a function which is subsequently brought into the service of that of reproduction' (Freud, 1940). According to Freud's theory of psychosexual development during the first year of life sexual pleasure is derived by the excitation of the oral cavity and lips (an erotogenic zone) mainly during feeding, this is called the 'oral phase'. From birth, the biological need for nourishment is controlled by a combination of id and ego forces, the latter of which controls the urge for self-preservation, which is reinforced by the id's desire for pleasure (libidinal impulses). Hunger induces a painful tension in the infant until satisfaction is gained through satiation. The satiation of hunger is the first experience of instinctual gratification in a child's life, therefore successful eating leads to a 'happy' infant (Anna Freud, 1946). Imposition of strict feeding regimes may lead to frustration due to postponement of wish-fulfilment and eating may become a forced labour, causing both mother and child distress and possibly future eating problems, which will later be discussed in further detail.

Within the oral stage two distinct sub-stages have been identified by Karl Abraham (1927) and others (referred to later) according to two different activities: sucking followed by biting. Sucking on objects in the infant's mouth produces oral erotic (sexual pleasure), whereas biting yields oral sadistic (aggressive) pleasure. The early (sucking) oral stage is 'preambivalent' in which no object is perceived to exist and only autoerotic gratification is sought. In contrast, the (biting) oral-sadistic stage (which occurs when teething begins) commences when the mother reacts to the pain
Academic Dossier

caued by the biting infant when s/he is unable to become satiated at the breast. This oral aggressive stage generally proceeds within an atmosphere of punishment as the mother may slap her child if s/he bites her nipple. The child’s ambivalence in this second sub-stage is manifested by the expression of libido and aggression directed towards the object (generally the mother’s breast).

If a child engages in successful feeding, s/he will ‘love’ the experience, this is what is known as primary narcissistic love. Later, when the infant is able to discern other qualities besides pleasure and pain (satiation and hunger) libido cathexis will develop, during which period the source of pleasure (the food and the breast) is identified. This libido attachment forms a transition stage between narcissism and object love. Eventually the infant will recognise his/her mother as the love object and the identity between food and the mother remain in the child’s unconscious even after weaning has taken place. During this first stage of an infant’s life the experiences of being fed provide a source of meanings through which the object relationship is expressed and organised (‘the love-relationship to the mother, for example, is marked by the meanings of eating and being eaten (Laplanche and Pontalis, 1973).

It is during the oral-sadistic stage that biting and devouring to ingest food become associated with the aim of incorporating the desired object, thus the excitation gained from satisfying an erotogenic zone is broadened to pleasure gained from having a ‘relationship’ with the libidinal object. This urge to become ‘united’ with an object is known as oral introjection and signifies the beginning of primary identification with the provider of the food and the unconscious belief that a person becomes like the object just eaten (Fenichel, 1946). As mentioned above there is also a fear of being eaten which accompanies the activity of eating. Such oral sadistic or cannibalistic fantasies are created by an underdeveloped ego to express ways in which oral frustration is perceived.

According to psychoanalytic theory infant sexuality is crucial to personality development: ‘the permanent character traits are either unchanging perpetuations of
the original impulse, sublimations of them or reaction-formations against them’ (Freud, 1908a). Examples of perpetuations of oral eroticism may be enjoyment of kissing, a delight in smoking or a love of food and wine. It seems that the extent to which eroticism of any one of the three stages is expressed or sublimated in an individual depends upon constitutional and environmental factors, i.e. how excitable the specific zone is and the duration and nature of the feeding and weaning process. An infant may become ‘fixated’ at a certain stage if excessive satisfaction is gained from it and naturally s/he is loathe to renounce the pleasure gained from it. Regression to such a pleasurable experience may therefore be used in the future as a defence against perceived threats and anxiety. Individuals who were overindulged, perhaps by demand-feeding or late weaning are likely to give rise to what is known as an ‘oral disposition’ or character.

Where cannibalistic fantasies exist which have not successfully been repressed by the action of defence mechanisms an individual may remain anxious and lack pleasure in eating, leading to neurotic self-starvation, thus turning their aggression away from objects and onto their own body. This type of fixation has been observed in sufferers of depression, addictions and orally fixated psychoses and thus may explain the ambivalence some anorexics and bulimics feel towards food and its providers (normally mothers).

On the basis of Freudian psychosexual theory several post-Freudians have set out to define the aetiology of the oral character, by attempting to impose scientific technique upon clinical observations. Kline and Storey (1977) constructed a factor analytic study, using well-known personality inventories and other measures of oral characteristics in order to demonstrate a constellation of personality traits under the oral character. It was found that there is evidence of two distinct syndromes formed of specific clusters of so-called oral personality traits: oral optimism and oral pessimism. The former includes the traits of optimism, dependency, fluency in words and ideas, giving, liking for the novel, sociability and relaxation whereas pessimistic traits include independence, verbal aggression, envy, coldness and hostility,
ambition, malice, reading and impatience. However, despite the apparent clarity of these clusters this does not necessarily link them to infantile orality. In subsequent research Kline and Storey (1980) attempted to demonstrate that oral optimist and pessimist characteristics correlate with suckling and weaning experiences in early life. Despite some interesting findings, such as oral optimists preferring creamy foods and oral pessimists preferring hot, spicy foods, results were unequivocal. Clearly research in this area is not easily carried out, mainly because of the difficulties in obtaining participants' recollections of their own feeding and weaning experiences and linking them to their personality traits as adults.

Since the establishment of Freud's psychosexual theory during the early part of this century post-Freudian psychoanalysts have continued to theorise on the major themes of the oral or dependency stage of an infant's development. Melanie Klein developed Freud's basic theory by placing more emphasis upon the early infantile determinants of behaviour and its instinctual basis. It is interesting to note that she agreed with her analyst, Karl Abraham that there are two distinct sub-stages associated with the oral stage. The child either gains sexual satisfaction from sucking the breast or aggressive pleasure by biting the breast.

Klein (unlike Freud) believed that the ego is sufficiently developed at birth in order to be able to project and introject, and that the super-ego begins its development in early infancy. Its presence creates the potential for anxiety to be experienced when the infant has the fantasy of biting the mother because of an innate aggression. This aggression (which is unacceptable to the developing super-ego and needs to be defended against) is projected onto the mother who is then seen as a violent hostile figure. By introjection these violent aggressions projected onto the mother are incorporated into the self, constituting the beginnings of the super-ego and guilt. The infant's ego is able to avoid the bad part of the object (metaphorically known as the bad breast) from contaminating the good part (the good breast) by this mechanism of splitting. Consequently, Klein described the first 3-4 months of life as the Paranoid-Schizoid Position because of the defences used by the infant to protect itself from its
own perceived badness. Later, as the infant is more capable of perceiving good and bad in the same object it experiences feelings of guilt and anxiety because of its fantasies to destroy the mother. This is known as the Depressive Position because the infant attempts to undo previous damage to the mother which it then internalises as part of its own inner world (Veasey, 1996).

Unlike Freud Klein saw these specific configurations of object relations, anxieties and defences as positions and not stages. She hypothesised that they remain a part of an individual’s personality throughout life, but excessive use of such defences leads to psychoses which distort perception of inner and outer reality, making communication impossible (Veasey, 1996). However, Klein radically believed that analysis with psychotic patients was possible because of the existence of a healthy and sane part of the personality which could make contact with the analyst (see her case study of a schizophrenic child, Dick; Segal, 1995, pp. 72-73). In therapy an adult may present with persecutory or depressive anxiety which Klein believed were useful indicators that a client is holding onto a secret and shameful problem. As clients recognise and accept these distasteful but true feelings anxiety and fear are alleviated which is accompanied by an increase in inner-strength (Segal, 1995).

The works of both Freud and Klein seem to have had a profound influence upon D.W. Winnicott despite the fact that his developmental theory has been noted to be ‘radically different’ from their’s, although he tried to preserve tradition ‘in a curious fashion, largely by distorting it’ (Greenberg and Mitchell, 1983, p. 189). Winnicott moved away from the strict tri-partite division of personality, the three psychosexual stages of development and even from Klein’s two positions, instead his theory centres upon dependence and independence. He (1965) wrote that ‘ego-psychology only makes sense if firmly based on the fact of dependence’ and explained that ‘there is no such thing as a baby - meaning that if you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship’ (Winnicott, 1964, Ch. 13). It appears that the word dependence
is the most important one that Winnicott used in his writings, he saw dependence in three stages: absolute dependence, relative dependence and towards independence.

During the first few months of life the infant has no means of knowing about maternal care and therefore is unaware of its complete dependence, Winnicott believed that the baby thinks it is creating what it desires. After weaning the infant begins to realise that someone else is involved and begins to gain knowledge of its dependence. When the mother is absent the child becomes anxious and learns about loss, it is during this stage that the infant also learns that it is a separate individual from its mother and the world, Winnicott referred to this as being able to say ‘I am’. The final stage called ‘towards independence’ is signified by the infants ability to develop means for doing without actual care. An infant accumulates memories of care, the projection of personal needs and the introjection of care details, with the development of confidence in the environment and the development of intellectual understanding (Davis and Wallbridge, 1981). This independence is never absolute because the healthy individual is environment-dependent, meaning that one necessarily relates to society and social life. Winnicott described this relationship graphically in the form of concentric circles which represent parents, family, school, local society, government etc.

Winnicott believed that there is a residual fear of dependence upon one’s mother that is not acknowledged because it is not consciously remembered. This fear may be dealt with by identification with her, however, this is clearly more difficult for men who may consequently develop a fear of woman or a specific woman. He hypothesised that the fear of domination of women has lead to very few societies encouraging women to rule or lead politically. Winnicott’s response to this unconscious fear of women was that ‘to ourselves we owe an intellectual recognition of the fact that at first we were absolutely dependent, and that absolutely means absolutely’ (Winnicott, 1987). This statement leads me to discuss the usefulness of therapeutic intervention in overcoming dependency problems in adult life, by
applying aspects of the above three theories to a specific case study of which I have personal experience.

The client, Mrs W, is a 26 year old woman who was referred by a consultant psychiatrist for the psychological treatment of an eating disorder. The symptoms of Mrs W's problem were that she controlled her (low) weight by restricting her food intake and obsessively weighing food and counting the calories of everything she ate. This behaviour began when she started a weight reduction diet one year before treatment began, but since reaching her target weight she was unable to relinquish the complete control she had developed over her eating. Mrs W would sometimes overeat to excess, but only when she had not prepared a meal herself and did not know the calorific value of the food. Following a binge she would feel extremely guilty and would promise to herself that she would diet strictly the following day. Mrs W had no history of eating problems or any other ill-health, however, it became apparent that there were several stressful aspects of her life. These included having had no contact with her father and sister for two months prior to the start of her treatment, commencing divorce proceedings following treatment when she will have been married for three years exactly, having to find a new home and live alone after she is divorced from her husband, re-applying for a position as an airline stewardess for which she failed to be accepted previously and a fear of fainting whilst travelling on the bus to work, following two fainting incidents in the year prior to her referral when she reached her target weight.

During our eight sessions together Mrs W always appeared very professional, I noticed that she always wore a business-like jacket and was anxious not to reveal her emotions, although she often appeared to be quite depressed. She was keen to discuss only her eating problem because it occupied her thoughts 'from the minute I wake up to the minute I go to sleep at night' and thus was described as the most important thing in her life at the time. Despite this, I hypothesised that her need to control her food intake stemmed from an need to prove to herself that she was neither dependent upon her husband nor her immediate family. Therefore she needed to show that she
could manage at least one area of her life independently and extremely successfully, for herself and those around her to see (a year prior to treatment she had weighed 13 stone, had since lost 4 stone and maintained that weight for more than 6 months). It seemed that the distance from her family, the imminent divorce from her husband and her future career were all areas of her life over which she felt she had no control and in which she was dependent upon other people's actions or decisions.

Although she was still seeing and speaking to her mother, she was unable to discuss her concerns regarding her marriage or her eating disorder about which her mother was extremely distressed to learn. She reported feeling very lonely and would have liked to have been able to depend on her mother who evidently rejected that aspect of her daughter which was not coping. Mrs W suggested that her mother was not very strong emotionally and was controlled by her father. It occurred to me that Mrs W may have identified with her mother as a weak woman, which according to Winnicott would have been an unconscious attempt to deal with her fear of dependence upon her. I was anxious that Mrs W may begin to feel dependent upon me, as her therapist because she had disclosed more to me than to anyone else. This hypothesis seemed to be confirmed when, following our fifth session together she said she would prefer to see me on a fortnightly basis in future, in order to give her more time to put into practice what we talked about during sessions. I was keen to look at what I believed to be a fear of dependency with her during the next session. It seemed that this fear was linked to the fact that she was let down by her mother upon whom she is no longer 'allowed' to be dependent. Unfortunately, it was not long after this that Mrs W came for her seventh session and announced that she felt she could cope alone and wanted to end our sessions together. This session followed a reunion with her family at the birth of her niece. It was apparent that this acceptance back into her own family was an important ‘turning point’ which I hypothesise enabled her to begin to take control of aspects of her life which she had ignored and feared previously. These included becoming financially independent by accepting a full-time job and acknowledging her role as the aunt of her sister’s new baby. As a consequence her
symptoms apparently dramatically diminished and she felt that she need not control her diet to such a great extent as she previously had done.

Having carried out a brief literature review of Freud, Klein and Winnicott I concluded that in order to be useful as a therapist I needed to provide a safe 'holding environment', to be trustworthy and reliable enough (Jacobs, 1986, p. 34) not to let my client 'drop' as her own mother had (metaphorically) done. Although I was disappointed not to have continued working for a longer period of time with this client it seemed that her fear of dependence was gradually being revealed and she was then able to continue to work alone to resolve her problems. I found that the theories of Freud and Klein enabled me to hypothesise about Mrs W's relationship with her mother and the significance of the fact that her symptoms were related to food, however these theories seemed to be more difficult to apply to practice than Winnicott's theory. I feel that his concept of 'towards independence' provided me with a useful insight into why Mrs W's isolation and 'aloneness' was an unhealthy environment for her to be in. Although I found it difficult to apply pure theory to my practical work with this client I believe that certain aspects of all three theories have provided me with material with which to make a formulation and tentative interpretations.
Academic Dossier

Bibliography


Chapter: Academic Dossier
Course: Advanced Theory and Therapy
Year: 2nd
Title: Discuss Psychoanalytic Contributions to an Understanding of Homosexuality
In an attempt to clarity and discuss how psychoanalytic theory has contributed to an understanding of homosexuality this essay will focus mainly on Freud’s original theories, referring to his most significant work concerned with sexuality, the *Three Essays in the Theory of Sexuality*. This will provide a base from which to comment upon how the psychoanalytic theory of homosexuality has developed since 1905 when the work was first published.

It has been said that of all Freud’s published work, the *Three Essays* was the most revolutionary and the most ‘important and original contribution to psychology after *The Interpretation of Dreams*’ (Richards, 1977). Subsequent psychoanalytic and non-psychoanalytic theorists have used this work as a basis from which to revise or condemn Freudian theory which has been criticised for being pansexual, i.e. equating all instinctual life with sexuality (Wollheim, 1991). It appears that there are at least two reasons for the revolutionary impact of this work, firstly that it suggested that human sexuality begins its development during infancy and secondly, that it suggests an extension of ‘the concept of sexuality, which stretches it beyond the sense in which it is ordinarily defined’ (Wollheim, 1991, pp. 108-109).

Freud’s discussion of his theory of homosexuality in the essay *The Sexual Aberrations* may have been one of the most controversial and shocking aspects of the work in light of the fact that homosexuality was, up until that time believed to be an indication of nervous degeneracy or disease. At the time that the *Three Essays* was published sexual instinct was believed to be absent in childhood and to develop during adolescence when one sex becomes attracted to the other. The sexual aim was believed to be nothing more (or less) than sexual intercourse. Freud challenged the theory that homosexuality could be due to nervous degeneracy or disease and pointed out that ‘many people are abnormal in their sexual life who in every other respect approximate to the average’ (Freud, 1905, p. 61) and also indicated that many homosexuals ‘distinguish themselves by especially high intellectual and cultural development’ (Socarides, 1978, p. 8).
In his deconstruction and analytic theorising of human sexuality Freud discussed the desired sexual object and the sexual aim of homosexuals separately. Thus, desire for a sexual object of one's own sex in Freudian terms constituted inversion: 'an inturning of libido on to an object like oneself' (Stafford-Clark, 1965, p. 118) and the pursuit of a sexual aim other than copulation was considered to be a perversion. He gave further examples of the desired sexual objects of inverts in addition to members of one's own sex, such as the sexually immature and animals. Perversions were considered by Freud to include the 'sexual use of the mucous membrane of the lips and mouth .... sexual use of the anal orifice .... fetishism .... sadism and masochism' (Freud, 1905, pp. 63-68).

Freud commenced his theorising about inverts by clearly stating that not all individuals considered to be homosexuals fall into a single category of absolute inverts. He suggested that there exist variations ranging from absolute inverts to amphigenic inverts who are 'psychosexual hermaphrodites (Freud, 1905, p. 47) and contingent inverts who 'are capable of taking as their sexual object someone of their own sex and of deriving satisfaction from sexual intercourse with him' (Freud, 1905, p. 47) under certain conditions, for example, when a member of the opposite sex is inaccessible. In more recent years, Freud's three categories of inverts have been extended to include two more categories by Kinsey et al. (1948) who conducted a survey of male and female sexual behaviour. Thus, it appears that there is a certain amount of agreement that absolute heterosexuality and absolute homosexuality may be represented at opposite ends of a single continuum. Kinsey et al's (1948) work has been criticised however, for its emphasis on behaviour rather than identity (Cass, 1990) and therefore may be misleading when studying the proportions of individuals assigned to each category according to their responses on the survey. For example, having experienced both heterosexual and homosexual relationships one individual may consider themselves to be bisexual, whereas another may now see themselves as homosexual having chosen to deviate from the 'norm' after a personal history of unsatisfying relationships with the opposite sex. Despite the fact that it is generally accepted that homosexuality and heterosexuality appear on a single scale there is a
belief that to be absolutely heterosexual is normal and to be bisexual or homosexual is to deviate from the norm.

Theorists have long questioned when and why individuals deviate from the norm. Freud suggested that 'the most extreme form of inversion will have been present from a very early age' (Freud, 1905, p. 48). He also discovered it to be the belief of absolute inverts that their sexual instinct has shown no sign of taking a course other than its present homosexual one and therefore they conclude themselves to be innately homosexual, which he suggests is in their interests and therefore an understandable conclusion to draw. Anthony Storr (1964) confirmed this view and added that if homosexuality is believed to be innate rather than the result of circumstances, the homosexual individuals themselves and their families are free of responsibility and criticism. In Freud's discussion of the possibility that homosexuality may be innate he concluded that it was a theory of no scientific value because of the very existence of the other two classes of inverts. In response to a general denial that absolute inverts have no memories of attraction to the opposite sex (including their mothers) Freud explained that such inverts lack any memory of any positive heterosexual feelings during infancy due to repression. He also believed he was capable of removing inversion by hypnotic suggestion, which he stated would not be possible if it were innate. Thus, he proposed that a tendency towards homosexuality or away from heterosexuality would necessarily have been caused by 'a sexual impression' very early in infancy or by an external influence 'of a favourable or an inhibiting character, which would have led sooner or later to a fixation of their inversion' (Freud, 1905, p. 50). He concluded, however, that not all individuals who experience such influences become inverted and that it is therefore not possible to choose one of these theories exclusively above the other.

Freud then moved on to consider the possibility 'that inversion should be regularly accompanied by the mental and somatic signs of hermaphroditism (Freud, 1905, p. 53) where 'traces are found of the apparatus of the opposite sex' (Freud, 1905, p. 52) and the original bisexual position has become modified into a unisexual one.
However, despite Havelock Ellis's (1897) statement that inverts present with a lowering of the sexual instinct accompanied by a slight anatomical atrophy of the organs, Freud concluded that the two conditions of hermaphroditism and inversion are generally independent of one another. Apparently a spokesman for male inverts suggested a theory of bisexuality which evidently interested Freud: 'a feminine brain in a masculine body' (Freud, 1905, p. 54). Freud dismissed this over-simplified understanding of male inversion, claiming that we do not know what characterises a feminine brain and reasoned that psychical hermaphroditism could only gain substance if the inversion of the sexual object were accompanied by parallel changes in the individual's mental qualities, instincts and character traits to those of the opposite sex, which it seems he had not observed in his clinical work. However, he did claim that psychical hermaphroditism regularly appears to be present in female inverts but failed to indicate any evidence upon which he could have justifiably based such a claim. Even Charles Socarides (1978) did not dispute such a seemingly unfounded claim in his chapter reviewing Freud's contributions to an understanding of homosexuality.

In his discussion of the Sexual Object of Inverts (Freud, 1905, p. 55) he went on to provide more evidence against the homosexual theory of hermaphroditism / bisexuality by pointing out that some male inverts present with a masculine mental quality and are attracted to those male prostitutes who purposefully dress and behaviour in a feminine manner. He suggested that such an unlikely attraction arises from a desire for a sexual object who 'combines the characters of both sexes; there is, as it were, a compromise between an impulse that seeks for a man and one that seeks for a woman, while it remains a paramount condition that the object’s body (i.e. genitals) shall be masculine' (Freud, 1905, p. 56). This is Freud's perception of the bisexual nature of male inverts, i.e. a reflection of their own bisexual nature in their choice of sexual object. Unsurprisingly (considering Freud's apparently limited view of lesbians) he stated that active female inverts exhibit masculine physical and mental characteristics and are attracted to femininity in their sexual objects and are therefore less ambiguous than their male counterparts. If this is the case in all
lesbians as Freud suggested then it would be assumed that female inverts are attracted to women, unlike themselves, who display very feminine physical and personality characteristics, and who are presumably not homosexual. Freud did not elaborate upon the above point and therefore leaves the reader with the question of how lesbians form relationships with same sex partners if their desired sexual objects are not lesbians. Interestingly, it is this section of the chapter entitled *The Sexual Aberrations* to which he made a large number of amendments in the form of footnotes in 1910, 1915 and 1920. It would seem that he too had difficulties in arriving at a theory of homosexuality which could explain all aspects of inversion which he presumably observed in his clinical work.

It is within Freud's footnotes that he appears to have tussled with a variety of hypotheses concerning homosexual object choice. In 1910 he stated that psychoanalysis could not comprehensively explain the origin of inversion, but had found the psychical mechanism which accounted for its development. This mechanism resulted in the male invert searching for a male partner who resembled himself and whom he could love as his mother had loved him. This was presumed to occur in response to a brief and intense fixation to the mother during infancy following which the male invert then identified himself with women and narcissistically took himself (or more accurately another male) as his sexual object. In contrast to this singling out of homosexuals due to a deviant psychosexual development, Freud's subsequent footnote of 1915 claimed that the differentiation of homosexuals from other human beings is inappropriate because all human beings have, in fact, made an unconscious homosexual object-choice and psychoanalysis views object choice as independent of gender. Therefore 'normal' and inverted types all stem from a common ground which is located in childhood, primitive states of society and early periods of history.

Freud indicated that 'a predominance of archaic constitutions and primitive psychical mechanisms is regularly to be found' (Freud, 1915, p. 57f) in inverts. However, the large variety of manifest sexual attitudes may result from a multiplicity of possible
determining factors or as a result of certain restrictions that cause individuals to develop in various different directions. Freud then discussed factors, (which may be interpreted to indicate the ‘restrictions’ mentioned above) which determine narcissistic object choice, some of which he suggested are constitutional in nature, others which he stated are accidental. Socarides (1978) elaborated upon by this point by indicating that a determining factor may be the absence of a father, or the presence of a weak father. Apparently being brought up in a female-orientated environment leads to feminine identification and homosexuality in males. However, he also added that the presence of an extremely cruel father may also lead to a disturbance in male identification. It is hypothesised that within such an environment, at an early age a boy will attach himself to his mother and then identify with her. As he grows up he represses his attachment to his mother and then spends his life fleeing all other women in order not to be unfaithful to his mother. Golombok and Fivush (1994) in their book on gender development, referred to the influence of parent-child relationships and discovered that a number of psychoanalytically orientated empirical studies on the development of homosexuality have produced inconclusive results with regard to such so-called determining factors.

Interestingly, Freud stated that object choice is not fully decided upon until puberty, presumably permitting the full effect of determining factors to play their part in the individual’s developing sexual preferences. However, Freud then said that the differences between absolute inverts and those individuals who have enjoyed both homosexual and heterosexual relationships is determined merely by quantitative differences in determining factors. It is not indicated what amount of determining factors is required in order to predict the development of homosexuality and it seems improbable that there would not be individual differences in reactions to the same amount of determining factors, thereby rendering a classification of predictive factors useless. Although he did not state it, this would appear to provide more evidence for a scale of sexuality or an ‘unbroken chain’ (Freud, 1915, p. 86) from absolute heterosexuality to absolute homosexuality which does not segregate homosexuality
from other sexual attitudes and therefore may render the pathologising of homosexual object choice less viable.

Freud's final footnote in this section of the chapter referred to Ferenczi's (1914) argument that a distinction should be made between 'subject homo-erotics' (individuals who feel and behave like members of the opposite sex) and object homo-erotics ('individuals who have merely made a same sex object-choice without taking on the characteristics of the opposite sex' and whom he perceived to be 'obsessional neurotics'). Apparently, Ferenczi (1914) believed such individuals to be disturbed by their propensity towards inversion and open to psychological influence. Freud added to this point that there are also people who may possess a combination of these two clearly differentiated types of homoeroticism or homosexuality. May (1995) pointed out that this last comment once again blurs the boundaries between different 'types' and indicated Freud's unwillingness to segregate individuals into categorical groupings. Although it may be easier to theorise upon distinct groups or 'types', it seems likely that Freud's clinical experience may have been responsible for his reticence in agreeing with such categorical differentiations. From this point, however, he turned to the unlikely subject of biological experimentation, as if seeking something concrete upon which he could draw a theoretical conclusion to this section of the chapter. He discussed organic determinants of homosexuality as explored by biologists as well as the possibility of 'curing' homosexuality. Although theorists such as Socarides appear not to have acknowledged Freud's hesitation in coming to a conclusive theory of homosexuality he ended the footnote by stating that the biological experiments did not provide 'a universal means of 'curing' homosexuality' (Freud, 1920, p. 59f). In addition, these studies neither validated nor invalidated his theory of the general bisexual disposition, and therefore he suggested that further research was necessitated in order for him to confirm his hypothesis.

It seems that in order to understand Freud's theory of the bisexual disposition it is necessary to look beyond constitutional factors such as genetic or anatomical make-up which were hypothesised merely to be responsible for the strength of the drive
(Rado, 1940) and to focus instead upon psychodynamic ones. Socarides (1978, p. 16) stated that 'ultimately, Freud felt that homosexuality represents an inhibition and dissociation of psychosexual development, one of the pathological outcomes of the Oedipal period'. Another description of the process is referred to as 'arrested development' (Socarides, 1978, p. 15) which particularly pathologises the development of homosexuality. According to May (1995) honouring the Oedipus complex and its model of cross-gender choice is typical of the ego psychologists of America and it therefore follows that in the United States homosexual individuals continue to be treated as if their sexual preference is indicative of a disease. Focusing upon the Oedipus complex as the source of the development of homosexual object choice renders it virtually impossible not to view it as pathological unless one refers to the work of Blos (1985) who discusses 'allogender' and 'isogender'. In Britain, however, emphasis on pre-Oedipal matters seems to have enabled homosexuality not to be viewed as pathological. In order for this approach to blossom it seems necessary to return to Freud's comment within his footnote of 1915 which states that 'from the point of view of psychoanalysis the exclusive interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature'. Thus, it is indicated that not only are we ignorant of what makes a man or woman develop a same-sex object choice, but nor do we know why people become heterosexual.

In concluding it needs to be noted that the style and vocabulary used by Freud may often be mis-interpreted and understood as if he stated that he had arrived at a conclusive theory of homosexuality. Friedman (1988) suggested that 'at times his literary genius appeared to dominate his scientific genius' which resulted in a blurring of distinctions between assertion, observation, inference and hypothesis. It is apparent that at the time of writing The Three Essays there were limitations of the gender psychology of the time which resulted in a confusion of terminology. For example, Freud referred to the concepts of 'masculine' and 'feminine' which at times meant the opposing states of activity and passivity and at others indicated masculine and feminine traits or even biological sex. May (1995) eloquently discussed how
such language and writing style has led to mistrust and suspicion of even the word ‘psychoanalytic’ within lesbian and gay groups, due to the belief that Freud was a homophobe and misogynist who thought homosexuality was an illness that could be cured. Far from arriving at such a conclusion, although he appeared to write as if he was making statements of fact rather than mere hypotheses, it is evident from the fact that he seemed to have such difficulty arriving at a final theory without the addition of several footnotes, that he acknowledged the failure of his many hypotheses to arrive at point where he was unable challenge a previous assertion that he himself had made.

It is evident that there has not been enough space within this essay to discuss how contemporary psychoanalysts have developed and moved on from the Freudian model of homosexuality. However, it seems that the nature of the psychoanalytic method is to repeatedly construct hypotheses and then dissolve them through frequent doubting and re-evaluation of existing theories. Therefore, it may be concluded that an important component of the psychoanalytic study of homosexuality is that it is constantly being researched and updated with the emergence of new knowledge as societal values shift and become, hopefully, more accepting that not being heterosexual is not a perversion but merely another version of sexuality.
Bibliography


Academic Dossier


Academic Dossier

Chapter: Academic Dossier
Course: Options
Year: 3rd
Title: The Effects of Maternal Mental Health Problems on Children
This essay will begin by presenting research findings which have demonstrated that up to two-thirds of children with a psychiatrically ill parent will develop some form of behavioural or emotional problem. The operative mechanisms behind the development of such childhood psychiatric problems will be reviewed and then the varying effects of different parental mental health problems upon children's psychological well-being discussed. These indicate that apart from a genetic predisposition to certain mental illnesses, hostile or neglectful parenting may have the greatest impact upon children's mental health. Of all the mental illnesses studied in this context maternal depression has consistently been shown to detract from the mother's ability to parent and form attachments with her child whilst an infant which may often result in the child suffering significant psychological damage. The extreme effects of parental mental illness are cause for great concern as there is evidence that child homicide occurs in a small proportion of cases. Consequently, the essay will conclude by identifying protective factors which exist to limit the development of child psychopathology and suggests how preventive interventions may be utilised with the children of psychiatric patients in order to minimise the onset of such problems in future.

It should be noted that in many cases research quoted refers only to maternal psychiatric illness or the effects on children of a mother suffering with mental health problems. The impact of this will be that although this essay is concerned with the effects of mental health problems of fathers and mothers, often it is only mothers who will be referred to. It seems that the impact of paternal mental health problems has been mainly neglected; unfortunately this essay is too short to explore reasons for this.

Numerous studies have demonstrated the substantially increased likelihood of a child of a parent with a diagnosed mental illness developing a psychiatric disorder compared with 'normal' populations. Rutter and Quinton (1984) suggested that this highlights a need for such children to be perceived as a psychiatrically 'at risk' group. In a four year follow-up study they identified a third of offspring of
psychiatrically ill parents as exhibiting psychiatric disorders which were not situation-specific, but were persistent over situations and time. Another third had purely transient psychiatric problems and the others, no emotional or behavioural disturbance at all. Interest in the study of the children of parents diagnosed with mental illnesses appears to have arisen from attempts to identify whether it is genetic or environmental factors which predispose individuals to psychopathology prior to the onset of illness and without the complicating effects of treatment (Garmezy, 1974). This research is focused most frequently upon the offspring of mothers diagnosed with schizophrenia, probably in the hope that the predisposition to schizophrenia may be elucidated (Rolf, 1972). It will be seen, however, that it is not necessarily parental schizophrenia which puts children at the most risk of developing psychological difficulties.

Although it is evident that for a significant proportion of children the presence of parental mental illness is an important indicator of psychiatric risk Rutter and Quinton (1984) found that it is not the presence of the illness per se that causes the risk. It is suggested that the associated psychosocial disturbance in the family may be a causal factor in childhood psychiatric problems (see also Billings and Moos, 1983). Thus there may be little or no connection between the presence of acute parental symptoms and the ebb and flow of the child’s disturbed behaviour and emotional life. It was found that ‘parental hostility, irritability, aggression and violence were more important than affective symptoms or psychotic manifestations’ (Rutter and Quinton, 1984, p. 876). Thus, it seems that consequences of parents’ mental health problems such as marital discord and disturbed intrafamilial relationships which result in children’s exposure to hostile behaviour account for much of the emotional and behavioural disturbance seen in this population.

Weissman and Paykel (1974) in a study of maternal depression found that children were more likely to be the recipients of mothers’ hostility and irritability to which they often responded with tyrannical behaviour. This finding is in keeping with the observation that most of the children in Rutter and Quinton’s (1984) study displayed
disturbances in their conduct. This is not peculiar to children with a mentally ill parent; similar effects have been observed for example, in divorcing couples where there is a high level of intrafamilial discord and hostility (Rutter, 1982). That is not to say, however, that merely the hostile relationships between family members are the only operative mechanism in families with a mentally ill parent. One of the reasons for believing this is that it was found that the presence of a parent with a personality disorder increased the psychiatric risk to the child even after taking hostile behaviour into account (Rutter and Quinton, 1984).

In an attempt to elucidate the varying effects of different parental psychiatric conditions upon offspring Grunebaum, Cohler, Kauffman and Gallant (1978) compared the children of well mothers and mothers diagnosed with schizophrenia, bipolar and unipolar affective disorder. It was found that the children of depressed mothers appeared to perform least well on tests of intellectual ability, attention and concentration. Depressed mothers also reported feeling that their children were doing significantly worse than the control or schizophrenic mothers. However, their children’s self-reports contrasted strikingly with their mothers’, which is probably indicative of their extremely pessimistic and unrealistic perceptions due to their depression. Both depressed and schizophrenic mothers performed worse than the controls on the attention and concentration tests, indicating that both illnesses have a cognitive component to them. The fact that depressive illnesses have both cognitive and affective components to them may be the reason that the children of the depressed mothers did least well on cognitive tasks and overall.

Social adjustment interviews revealed that children of schizophrenic mothers are more willing to acknowledge problems at home than children of depressed mothers. Possibly the ways in which the two different illnesses manifest themselves may partially account for this difference, i.e. children of depressed mothers may feel responsible for their parent’s low mood or irritability, whereas children of schizophrenics probably perceive that they are not responsible for ‘mad’ symptoms such as hallucinations, paranoia or delusional thinking.
Academic Dossier

The surprising evidence that the children of depressed mothers are at a higher risk of developing emotional or behavioural problems than the children of schizophrenic mothers may have more to do with the interaction between mother and child than the manifestation of the mother’s symptoms. However, it should always be borne in mind that depressed mothers are likely to perceive and report problems as worse than they actually may appear to others because of their negative thinking. In a study of depressed mothers and their infants Zajicek and De Salis (1979) mothers once again perceived that their children had more problems than other children, for example, eating problems, difficulties in attaining bladder control and fearfulness. From such reports it is possible to suggest that infants appear to mirror their mothers’ depression as their emotions and behavioural development seem blunted. Although it is probable that some mothers over-exaggerated the perceived problems due to their depressed states, there is evidence that such mothers find it harder coping with infants because they themselves are not well. In extreme cases this may result in neglect of everyday child care, in many instances the child will receive less attention and may be late in attaining developmental milestones, such as talking and potty training. Zajicek and De Salis (1979, p. 835) concluded that such situations may lead to ‘a distressing picture of mutual mother-child rejection’, sometimes resulting in child abuse.

According to Home Office statistics (1994) between 11 and 25 percent of all homicide victims are children and the majority of such deaths are perpetrated by psychiatrically ill parents, often as a result of fatal child abuse or neglect. Whereas children of schizophrenic parents seem to suffer most at adolescence (Mednick and Schulsinger, 1968), the children of depressed mothers suffer in early life possibly more than children of parents with other forms of mental health problems because they miss out on the closeness that is required in infancy especially with the main carer.

In order to comprehend how a mother’s depression impacts upon a child’s experience of their relationship with her it is helpful to look at Bowlby’s (1953) attachment theory. He believed that for a child to develop well it needs a warm, intimate and
continuous relationship with its mother. The quality of the mother-child relationship is clearly threatened by maternal depression because the mother’s responsiveness, sensitivity and physical and emotional availability to the baby are impaired leaving it prone to an insecure attachment (Ainsworth and Bell, 1970). Such children become anxious and over-dependent in the struggle to receive the care and attention they need, they are confused by mood changes and may become over-watchful or avoidant which may decrease further the likelihood of the mother feeling warm and loving towards her child.

One flaw with the above research studies which compare the effects of maternal depression and maternal schizophrenia is that they are concerned only with the parent-child relationship when the mother is the primary care-giver. Findings may be significantly different if researchers looked at the effects of paternal depression, schizophrenia and other mental health problems. If the aim of a study is to identify which are genetic and which are environmental antecedents to the development of child psychiatric problems, then it may be helpful to compare child effects with two sample groups: one of fathers with psychiatric problems and another with mothers.

It seems that some children are more vulnerable to environmental threats such as poor parenting than others. Rutter and Quinton (1984) found that when their participants initially attended hospital for treatment boys appeared more vulnerable to the effects of family discord due to a parent’s mental health problems. However, the longer the discord lasted the smaller the sex differences in vulnerability. Therefore it was tentatively concluded that girls were initially more resilient, but if adverse family conditions continued for long enough they too were likely to succumb to problems in psychological functioning. In a chapter by Werner and Smith (1982) concerned with the protective factors of offspring of parents with psychiatric problems it is shown that a significant proportion of children are somehow resilient in the face of poor parenting and a stressful family environment and consequently do not go on to develop psychological problems.
Academic Dossier

Offspring who go on to develop behavioural and emotional problems tend to be those whose mothers experienced perinatal and birth complications. It is reported that during the first two years of life the presence of pan-developmental retardation, including gross motor and visual motor development and cognitive development have later been related to psychiatric morbidity and perceptual problems at 10 years. Apparently such findings are reflected in ethnic populations and across all socio-economic groups, providing fairly reliable evidence that there are significant pre and post natal predictors of future vulnerability to psychiatric morbidity when one’s parent/s suffers significant mental health problems.

Indications of future psychiatric problems begin to present themselves at school age when both teachers’ and parents’ ratings of classroom behaviour and peer relationships discriminate significantly between high and low risk groups for mental health problems. High-risk children tend to become more upset in class, are disturbing to the class, have discipline problems and may be aggressive. Resilient children with psychotic mothers display fewer behavioural problems, are bullied less and concentrate better in the classroom. Thus it is concluded by Werner and Smith (1982, p. 118) that the resilient child will display ‘social responsiveness and an even temperament in infancy, independence and autonomy in toddlerhood, self-help and problem-solving skills .... in childhood, and a conviction of being in control of one’s life in late adolescence’. It seems that these qualities signifying resilience are formed on the basis of a mainly positive interaction with the primary caregiver in the first year of life (Anthony, 1974). The benefits of the formation of a good attachment with the mother from birth cannot be overemphasised. In this case it may be one of the earliest preventative interventions that could be offered to a child at high risk of developing psychiatric problems in a similar way to its parent/s.

Without a good attachment to the main care-giver children are likely to lack inner security in later life and experience disturbed relationships. Amongst the literature concerned with protective factors it seems that there is a notable lack of attention to potential mediating factors in an infant’s life. Little or no mention is made of the
child’s relationships with other care-givers, such as fathers, grand-parents or siblings, let alone child care workers, nannies, or teachers. Surely such figures are of vital importance in the life of a child whose mother suffers from psychiatric problems and is likely to be absent at some stages due to hospital admissions or respite care away from the family home. It seems that research focused upon finding what coping mechanisms well children of ill parents have used may be of benefit to those families who feel their children are vulnerable because of the difficulties encountered when a parent is suffering with mental health problems.

In a study by Shachnow (1987) it was concluded that a parent’s psychiatric admission is an opportunity to identify and assist children who are potentially at high risk of developing emotional and behavioural problems in response to difficulties at home. Interventions were provided in order to help families to recognise how children were affected when their parents became ill. It seemed that this succeeded when a good working alliance was built between families and helping professionals. Acknowledgement of the children’s experiences also improved the understanding of the staff involved in the care of the ill parent which in turn aided motivation and planning of aftercare.

It may be concluded that this is an important area of research that still has some way to go in identifying how children may be put at least risk to developing behavioural and emotional problems. However, the work that has been carried out which attempts to support families with a psychiatrically ill parent has so far proved promising. It seems that children of such parents are potentially ‘invisible’ until it may be too late and problems are manifesting themselves in the form of disruptive behaviour or problematic relationships. In order to avoid their neglect (by mental health care professionals) it may be necessary to implement preventive care plans which include attention to family functioning and support in parenting when a mother or father is ill. It has been shown by Rutter (1981) that if environmental circumstances improve sufficiently, i.e. a decrease in marital discord and intrafamilial hostility, children may
Academic Dossier

recover to function adaptively and decrease the risks of becoming psychiatrically ill themselves in later life.
Bibliography


Academic Dossier


<table>
<thead>
<tr>
<th>Chapter:</th>
<th>Academic Dossier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course:</td>
<td>Issues in Counselling Psychology</td>
</tr>
<tr>
<td>Year:</td>
<td>1st</td>
</tr>
<tr>
<td>Title:</td>
<td>A Discussion of the Appropriateness of Codes of Personal Conduct for Counselling Psychologists regarding Sexual Contact between Therapists and Clients</td>
</tr>
</tbody>
</table>
This essay addresses a specific issue concerned with sexual contact between therapists and clients, the discussion of which is relevant to the good practice of counselling psychology. The appropriateness of the guidelines for personal conduct laid down by the British Psychological Society will be discussed in the light of what is known about feelings of sexual attraction within the therapeutic relationship. The 1996 Code of Conduct published by the British Psychological Society dictates that practising and research psychologists shall specifically:

5.1 refrain from improper conduct in their work as psychologists that would be likely to be detrimental to the interests of recipients of their services or participants in their research.

5.3 not exploit any relationship of influence or trust which exists between colleagues, those under tuition, or those in receipt of their services to further the gratification of their personal desires.

Such a code implies that entering into a sexually intimate relationship with a current client is inappropriate for two reasons. Firstly, there is the strong possibility that such a relationship would not be in the interests of the client who may be psychologically harmed by a shift away from a purely therapeutic relationship with his or her psychologist. Secondly, it may be viewed that a psychologist who becomes sexually involved with a client is exploiting his or her position as a mental health care professional for his or her own personal gratification.

In recent years awareness of sexual harassment and exploitation (especially in the workplace) has increased dramatically. As psychologists, it is necessary to be aware of the dramatic effects that experiences such as child sexual abuse are likely to have on an individual's psychological development, and yet in recent years it has come to light that even professionals within the mental health care services are guilty of overstepping professional boundaries in order to engage in sexually inappropriate behaviour with clients (Russell, 1993).
Academic Dossier

One of the first studies to identify that a significant proportion of psychologists enter into sexual relations with clients was conducted by Holroyd and Brodsky (1977) in the U.S.A. on a nation-wide scale. For the first time the American Psychological Association specifically proscribed sexual contact between therapists and clients (APA, 1977). The American Psychiatric Association task force (1977) also reported that women considered erotic contact and sexual seduction by therapists to be a form of exploitation. At the same time, professional insurance carriers became unwilling to assume liability for suits stemming from sexual contact (Asher, 1976). It seems that during the mid to late 1970’s official bodies responsible for setting guidelines for the professional behaviour of psychologists and psychiatrists had begun to recognise that not only was nonerotic physical contact a part of the relationship between therapists and clients, but in some cases, therapists were exploiting their roles and the positions of power which they were able to command with clients.

Holroyd and Brodsky (1977) recognised the need for a survey which would indicate the frequency with which such unprofessional conduct occurred. An anonymous questionnaire was sent to 1000 PhD psychologists (equal numbers of males and females) who practised using a broad range of theoretical orientations. Following the return rate of 70% the authors suggested that the nonresponse bias for the 30% who did not return questionnaires seemed to point in the direction of lowering the estimate of erotic contact. Those practitioners who admitted having had sexual contact with clients (10.9% males and 1.9% females) had returned their questionnaires later than others, which suggested a reticence in submitting their responses. The significant differences in frequency of erotic contact reported by male and female respondents was in the anticipated direction and bore implications for female clients seeking therapy. This difference has been consistently found in similar and more recent studies (e.g. Pope and Bouhoutsos, 1986; Garrett and Davis, 1994).

Only 2.9% of respondents indicated that they believed erotic contact with clients might be beneficial, with the proviso that the therapist needs to remain objective, is not personally needy and is employing such contact primarily for the needs of the
Academic Dossier

client. Needless to say arguments against erotic contact were strongly disapproving, believing such conduct was ‘totally inappropriate, was exploitative or served the therapist’s needs rather than the patient’s, was unethical or unprofessional, could be antitherapeutic or end the therapy, and might result in legal and malpractice insurance problems’ (p. 848).

The attitude that sexual contact with clients is inappropriate has not always been an opinion shared by mental health care practitioners. According to Russell (1993) Ferenczi, Relch and Jung were not strangers to sexual encounters with current clients. It seems that the reasons for entering into such relationships varied from the belief that satisfactory sexual release was ‘a prime goal of therapy’ (Marmor, 1972, p. 3) to Ferenczi’s approach of ‘reciprocity’ (Stanton, 1990) which blurred boundaries between what is considered professional and personal behaviour. Sexual intimacy has even been viewed as a therapeutic tool by such theorists as Masters and Johnson (1970) and is possibly still advocated by sex therapists today, although legal, ethical and practical considerations make it difficult to practice without being considered exploitative.

Russell (1993) discusses how the task of mesmerism, an ancient form of talking therapy, brought into focus the consideration of sexual contact between therapists and clients because of the acknowledgement of possible erotic feelings within the therapeutic relationship. Chertok and de Saussure (1979, pp. 10-11) point to the fact that ‘the woman is always magnetised by the man .... whatever the nature of the illness, it does not divest us of our own sex, nor does it entirely remove us from the power of the other sex .... It is not surprising that the senses are inflamed’.

Although it might be disagreed that the relationship between a man and a woman or a male therapist and female client (or vice versa) always has the effect of inflaming the senses, it is important to recognise the erotic element of a therapeutic relationship, which one would imagine is possible with virtually any combination of genders of therapists and clients. It is a reality that much psychological theory is based upon
heterosexist assumptions and upon the belief that the therapist is generally male and the client female. However, it should be acknowledged that much theory was published earlier this century when such theorist/practitioners as Freud and Jung were most commonly treating ('hysterical') women.

Despite the heterosexist bias that is evident in Freud’s work (which it could be said was in accordance with the ethos of his time) it is important to acknowledge that he was responsible for enlightening future practitioners regarding the sexual dynamic present in many therapeutic relationships. It was his conceptualisation of the phenomenon of transference that enabled the power of the erotic component to be recognised: ‘.... the patient’s falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person’ (Freud, 1915/1963, p. 169). The possibility that erotic feelings experienced with a certain client are a subconscious response to the conditions of the therapeutic relationship and the client’s transference is of great value to the therapist’s understanding and therefore to the client’s psychological well-being.

Freud (1915/1963, p. 174) believed that this countertransference should never be acted out. ‘If her advances were returned, it would be a great triumph for the patient, but a complete overthrow for the cure .... The love-relationship actually destroys the influence of the analytic treatment on the patient, a combination of the two would be an inconceivable thing’. It is clear that the powerful erotic feelings aroused by the experience of countertransference, if not appropriately interpreted, may be cause for therapists to break the rules by which they are bound as professional practitioners. It seems obvious therefore, to include awareness and understanding of such feelings on any training course which sets out to provide individuals with the appropriate skills to become an ethical and valuable therapist. Despite the presence of a large body of literature asserting that countertransference, correctly managed, is a valuable therapeutic tool, there is also a view that it constitutes a weakness or error antithetical to the goals of therapy (Pope, Keith-Spiegel and Tabachnick, 1986). Baum (1969-1970, p. 635), for example, states that countertransference reactions are
‘undesirable and the analysis would be better off without them’. Langs (1982, p. 132) however, believes that such a view is dangerous and that virtually all mistakes committed by well-trained and experienced therapists are caused directly by countertransference: ‘unrecognised countertransference is the single most frequent basis for therapeutic failure. It is countertransference, rather than transference .... that is by far the hardest part of analysis - and therapy’. It is not clear how Langs makes this inference and it is doubtful that the ease with which he made such a statement may be said to apply to the researching of ‘the frequent basis for therapeutic failure’.

This concern leads to the question of the reliability and validity of research methods employed in studies designed to discover why therapy failed, or whether the motivation for an inappropriate sexual relationship was unrecognised countertransference and not genuine strong feelings of attraction to a client. Even less complex research studies such as that of Holroyd and Brodsky (1977) discussed earlier seem to have methodological flaws, for a number of reasons, not least of which is that it is unlikely that practitioners will be keen to admit that they have disobeyed the code of conduct by which they are bound. Clearly there are many questions regarding the issue of therapist-client sexual contact which are highly sensitive and difficult to research because of the subjective nature of erotic feelings which may or may not be aroused by the phenomenon of countertransference.

Putting so much emphasis on countertransference as a way of explaining erotic feelings may misguidedly lead one to assume that all mental health care practitioners are aware of this psychodynamic concept. Evidently this is not the case, however, it is appropriate to expect all counselling psychologists to be fully cognisant of it, to be able to recognise it and to be able to use it therapeutically to the benefit of the therapeutic relationship and, of course, to the client’s understanding of his or her problem. It is likely that many psychologists work within theoretical frameworks which do not include the possibility of transferential experiences. Therefore there may be a significant proportion of BPS members who deny the likelihood of feelings of attraction being merely due to specific sexual dynamics within the therapeutic
relationship and not due to the specific individuals involved. In such a case a therapist would be concerned about such feelings and may feel it is inappropriate to be attracted to a client. They may fear facing disciplinary action if they admit to the feelings publicly, or even within supervision (especially if the supervisor is unwilling to suggest the possibility of erotic countertransference).

It has been quite rightly suggested that there is currently a taboo surrounding the area of sexual misconduct which unfortunately restricts the amount of time and effort spent training psychologists on the specific subject of attraction to clients. It is naïve to believe that the establishment of professional codes of conduct will prevent the possibility of a large proportion of practising psychologists from experiencing such an issue at some time during their career. Psychologists are human and research evidence shows that, like the individuals they treat they are at their most vulnerable when they themselves are experiencing loneliness or relationship difficulties as well as other difficult life events. It is at these times that professional boundaries are most likely to become blurred and codes of conduct not adhered to. This is not always the case and it is important to acknowledge that attraction to a client is possible at any time and may be such a strong emotion that extreme resistance is experienced in attempting to deny the feelings towards the client or to take the problem to supervision. The complexity of the phenomenon of attraction seems to be equalled by the simplicity of the BPS code of conduct which does not provide guidelines for training, monitoring of professional conduct or supervision and therefore relies upon psychologists to employ professional judgement influenced by the ethos of the profession's society to influence behaviour.

This discussion is concluded by suggesting areas of research which might enable more explicit guidelines to be included in the BPS code of conduct, as well as more comprehensive curricula for the training (pre and post graduation) of psychologists and supervisors. Pope et al. (1986) suggested that the lack of systematic research in this area is due to the taboo surrounding sexual misconduct and yet the study of therapists' sexual feelings towards clients 'could form a crucial but long-neglected
part of our training as psychologists’ (p. 151). A qualitative study involving frank, open and honest interviews with participants (both therapists and clients) who had experienced therapist-client sexual intimacy would throw light upon some of the more subtle feelings of attraction within the therapeutic relationship, that so far seem to have been overlooked. It would also be useful to discover what encourages psychologists to betray their professional body, is it purely strength of attraction or is it because they can trust clients not to report inappropriate behaviour? Alternatively when therapists choose to remain within professional boundaries, is it the fear of expulsion from the society that influences such a decision or is it that they feel able to discuss it with supervisors?

Clearly, such research would be invaluable in helping to promote further training in this area. In future this may help to reduce the number of unfortunate incidents of inappropriate sexually intimate behaviour which may result in damage to clients and professional misconduct suits.
Academic Dossier

Bibliography


Academic Dossier


Chapter: Academic Dossier
Course: Issues in Counselling Psychology
Year: 3rd
Title: Individual Therapy for People diagnosed with Schizophrenia:
A Counselling Psychology Perspective
Introductory Note

The following written report focuses upon a discussion of an appropriate individual therapy for a specific client group with whom many counselling psychologists may currently or, in future will be working. Within the medical model these individuals are referred to as ‘schizophrenics’ and are identified by specific ‘symptoms’. However, it is understood that the philosophy of counselling psychology may find such labels are a hindrance to perceiving the client as an individual and whole person. Therefore less emphasis is placed upon diagnosis and the construction of a client’s current problems and personal history into one all-encompassing label, such as ‘schizophrenia’. Nevertheless, it is also observed that whilst working within a setting such as a National Health Service psychiatric hospital such terms are frequently used as a means of communicating a certain (vague) meaning between health service professionals and therefore it is likely that counselling psychologists may also be expected to use the labels as a ‘shorthand’. In the report below the term will be used, however, it is hoped that readers will understand that despite this blanket term such clients are perceived to be individuals who have been assigned a label which may be the only commonality between them. Such individuals will not be referred to as ‘schizophrenics’, but as people diagnosed with schizophrenia, thus intimating that agreement is not necessarily given to such a label.

Introduction and Reason for Interest in this Area

In a recent small-scale piece of research it was unanimously stated by parents of adult individuals who had been diagnosed with schizophrenia that they were dissatisfied with the National Health Service (NHS) treatment of their offsprings’ mental health problems (Willis, 1997, unpublished). This expression of dissatisfaction was explored and it was found that nearly all participants believed that insufficient treatment interventions were offered which enabled the client to speak regularly on a one-to-one basis with a qualified therapist; for example one mother said that:
'There should be counselling or psychotherapy and so on, to go with the medication so that the importance of maintaining medication is driven home.'

Another said: 'They need understanding, they need to have someone to tell how they feel, they need someone to talk to them about their feelings.'

It was suggested that the only opportunities to talk about medication or feelings occurred in group situations. However, most parents seemed to have concluded that although group interventions were commonly provided, these did not target the needs of clients which are identified above. Most reported that such groups activities were concerned with socialisation or art and craft activities which often seemed to make the assumption that the group members were unintelligent because of the low level at which they were pitched, which many apparently found condescending. Interestingly Schooler and Hogarty (1987) suggested that whilst schizophrenia is often managed in groups there is little evidence to support the differential therapeutic advantage of this approach over other interventions.

Implicit in the belief that individual talking therapies would be of benefit to clients diagnosed with schizophrenia was a suggestion that had this been provided there would have been less pressure upon the parents as primary care-givers. Many suggested that in an attempt to do the best for their children they frequently experienced feelings of divided loyalty between being a supportive parent and ensuring that they took their medication. The following quotation demonstrates one mother's anxiety:

'He's (her son) thought about stopping his injections which I'm very concerned about. I feel that I should tell the nurse that deals with him, but I don't want to feel disloyal to him by doing this sort of thing.'

Only one participant's child had received any form of individual therapy and this was arranged privately with a counselling psychologist who practised cognitive-
Academic Dossier

behaviourally. Interestingly, this was the only client in the study who maintained their medication during and after the therapy. It seems that by providing individual therapy much could be gained not only by the patient, but indirectly by family members or other caregivers too. Therefore it is important to question why individual therapy appears to be rarely prescribed by psychiatrists or other health professionals to individuals diagnosed with schizophrenia.

Why is Individual Therapy rarely suggested for this Client Group?

Reasons for the reported lack of individual therapy received may be due to the limitations of NHS financial resources or to a belief that pharmacotherapy and group activities alone are an appropriate treatment regimen for the mental health problems which are labelled ‘schizophrenia’.

In the US Wolff et al. (1989) found that there was a significant difference in treatment packages between private and state or county hospitals. This was namely that private hospitals offered more comprehensive care regimens which were generally inclusive of individual therapy. This type of finding may suggest that financial resources do play a significant part in the inclusion or exclusion of individual therapies in treatment programmes for such clients.

In Britain McIntyre et al. (1989) conducted a questionnaire study of patients’ own views of the psychiatric care they received and interestingly, the aspect of treatment which was rated most highly by participants was being able to confide in a professional caregiver. The authors suggest that this finding is ‘a reminder of the importance placed upon personal contact by psychiatric patients regardless of their diagnosis or chronicity.’ and quote the Royal College of Psychiatrists (1986): ‘The training of psychiatrists .... should emphasise the importance of acquiring psychotherapeutic skills’.
Although the McIntyre study suggests that patients perceive individual talking therapies to be extremely valuable, it seems that such treatment interventions are rarely offered. Perhaps this is because of a lack of empirical evidence to support an individual psychotherapy of schizophrenia that it is viewed as an inappropriate and possibly expensive treatment option.

What Evidence is there for the Efficacy of Individual Therapy?

In 1995 Hogarty et al. wrote that ‘research literature provides little or no support for an individual psychotherapeutic experience that is demonstrably effective for the schizophrenic patient.’ Possibly this is because most research papers concerned with psychotherapy evaluation point to methodological difficulties which may render any conclusion about its efficacy problematic.

The earliest studies of the treatment of schizophrenia utilised psychoanalytic approaches and for the most part failed to demonstrate any significant benefit (May and Tuma, 1964) and were often methodologically flawed (for a review see Mueser and Berenbaum, 1990). Since then the most comprehensive study of the psychological treatment of schizophrenia (Gunderson et al., 1984) called the Boston Psychotherapy Study attempted to compare exploratory insight-orientated psychotherapy (EIO) which consisted of three sessions per week with reality-adaptive supportive psychotherapy (RAS) which consisted of one or two sessions per week. Therapy lasted for two years and involved 164 hospitalised patients being treated by experienced and highly motivated therapists. Findings indicated that the RAS group spent significantly less time in hospital and had better occupational functioning than the EIO group. However, there were indications that the latter group showed a relationship between psychodynamic exploration and improvement in negative symptoms (poverty of speech, lack of affect etc.). Despite this finding the literature on the subject suggests a general consensus of opinion regarding appropriate psychotherapeutic approaches which is that insight-orientated psychotherapy is not appropriate for most people diagnosed with schizophrenia.
Academic Dossier

This opinion is supported by the results of a study of individual psychotherapy from the clients' perspective by Coursey et al. in the US (1995). Although it was found that 72% 'schizophrenia sufferers' themselves reported a positive change to their lives as a result of individual psychotherapy, 84% of respondents preferred brief, less frequent sessions of reality-orientated therapy over more frequent sessions of insight therapy. They rated human concerns as more important than illness-specific symptoms and reported that friendliness was the quality most desired in a therapist. Those respondents who felt empowered in therapy apparently spent less time in hospital, a shorter stay in therapy and knew more about their problems. The authors concluded that on the basis of these findings a client-responsive model of therapy would be most appropriate for individuals diagnosed with schizophrenia.

Other clinicians, such as Peter Slade (1990) in Liverpool suggest that symptom-specific behavioural and cognitive interventions are more appropriate in the treatment of schizophrenia. He distinguishes between positive symptoms such as hallucinations and delusions; and negative symptoms such as poverty or disorganisation of speech and affect. An example of how he might treat a client suffering with hallucinations would be to use systematic desensitisation. This would be carried out by reducing specific stresses which appear to be associated with the occurrence of hallucinations and possibly working to improve interpersonal and social skills. Other techniques for the treatment of positive symptoms include operant procedures, thought-stopping, distraction, self-monitoring, aversion and punishment techniques and ear-plug therapy. For the treatment of negative symptoms he suggests implementing token economies, social skills training, life skills training and self-instructional training. Although such interventions are reported by Slade to be frequently effective in reducing specific 'schizophrenic symptoms' this approach appears to ignore clients as a human beings who as Coursey et al. (1995) found often wish to explore issues of concern other than symptoms. As a counselling psychologist it is important to see the whole person and not just a cluster of symptoms to be dealt with. Such a symptom-orientated approaches seem to pathologise clients and may possibly be disempowering. This may encourage clients
to perceive themselves as patients and be anti-therapeutic leading to more frequent hospitalisations or increased dependence on carers.

The approach which may best suit clients diagnosed with schizophrenic and remain congruent with the philosophy of counselling psychology is a recently developed one called supportive psychotherapy which encompasses what appears to be of therapeutic value in cognitive-behavioural therapy, psychodynamic / insight-orientated psychotherapy and reality-orientated psychotherapy.

Supportive Psychotherapy

The basis of supportive psychotherapy is a collaborative nonauthoritarian therapeutic relationship which should be characterised by empathy, warmth and genuineness in order to establish a good therapeutic alliance. Frank and Gunderson (1990) have shown that although this is harder than usual to develop with this client group it is associated with improved outcome. In order to practice in this way it is necessary for the therapist to have a comprehensive understanding of the client including knowledge of intrapsychic conflicts, defences, coping skills as well as interpersonal, social, cultural and biological factors.

An important goal of this approach is relapse prevention and the therapist and client need to work together to monitor signs of impending illness. Once these have been recognised it is important to establish ways in which stress can be managed and coping strategies devised. It seems that a cognitive-behavioural approach can sometimes be helpful in providing the therapist with techniques to do this, however, it is important that this be accompanied by helping the client to develop a sense of competence and self-esteem as well as improvement of social and vocational functioning.

According to Katz and Gunderson (1990) the extent to which clients may benefit from insight into current life situations should be established individually and
interpretations should highlight connections between stressful life events and the development as opposed to the content of 'psychotic symptoms'.

Applications to the Profession of Counselling Psychology

It seems that the qualities and skills required by a therapist practising supportive psychotherapy are similar to those of counselling psychologists' because of the emphasis on the therapeutic relationship, an integration of therapeutic approaches and a flexible, holistic and client-centred approach to treatment. There may be a feeling that a counselling psychology approach is not appropriate for therapeutic work with individuals with severe mental health problems because it does not impose a diagnosis and is not symptom-led, unlike the medical model. However, the strengths of counselling psychology appear to match with research findings that indicate the importance to such clients of a good supportive therapeutic relationship. The integration of several therapeutic orientations is another feature of counselling psychology which provides further support for a good match with clients as the varying therapy requirements of an individual may be met by a single therapist at different stages in the treatment intervention, assuming the therapist is client-led.

In addition to the above point it seems that for a therapeutic relationship of this sort to be most beneficial to the client continuity of the intervention from in-patient to out-patient care (or vice versa) is essential. There is evidence that clients’ and therapists’ perceptions of therapeutic goals and processes are more phenomenologically congruent in long-term psychotherapy dyads than in the short-term equivalents (Horn-George and Anchor, 1982). This research suggests that if clients knew they could continue meeting with the same therapist regardless of whether they were in the community or in an inpatient setting then they may experience similar positive effects to the participants in long-term therapy. Continuity of care is apparently in place within some NHS trusts, however, this is not yet true for all trusts. It seems that this lack of continuity needs to be rectified in view
Academic Dossier

of the difficulty and importance of building-up a trusting therapeutic relationship over time and the positive effects of longer-term therapy.

Summary

In summary it may be argued that although individual therapy for people diagnosed with schizophrenia is rare, possibly due to lack of resources and empirical evidence of its efficacy, there is much support for it by both clients and their carers. If such an intervention were offered it is likely that carers would not feel so much pressure to act as therapists to their loved ones with whom they desire a loving relationship and not one in which they need to be a therapist or feel obligated to enforce the taking of medication. Research (if reliable) demonstrates that there is a preference for reality-orientated, brief psychotherapy and not exploratory insight-orientated therapy. Qualities which are valued are a good therapeutic relationship in which the client may confide in the therapist and feel empowered (which it has been shown may lead to a better outcome) such as client-centred approaches which do not focus solely upon symptom-reduction; goal-orientated relapse prevention strategies using a variety of therapeutic approaches and continuity of care.
Bibliography


Academic Dossier


Therapeutic Practice Dossier

Introduction to the Chapter

This chapter begins by describing the four different placement settings worked in during the three years of training on the Psych D in Psychotherapeutic and Counselling Psychology course. There is a discussion in the form of an overview of the experiences gained in those three years which demonstrates the integration of theory and practice. This overview attends specifically to the relevance of the placement setting, the client group, the theoretical orientation and the impact of the therapeutic frame upon the therapeutic carried out at each placement. Summaries of four client studies are presented which demonstrate the nature of the assessment, formulation and therapeutic work completed over the three years of the course. Finally, the chapter concludes with a discussion of process issues relating to three process reports produced out in the second and third years.
Chapter: Therapeutic Practice Dossier
Year: 1st
Type of Placement: Community Mental Health Team

NB: The placement and training agreement, supervisors reports and log book pertaining to this placement may be viewed in appendices H, K, L and R.
Duration of Placement: October 1995 - August 1996

Placement Setting: A newly formed Community Mental Health Team in one of the home counties.

Description of the Team: The Community Mental Health Team was multi-disciplinary in make-up and consisted of staff from a wide range of disciplines. There were namely, a psychiatrist, community psychiatric nurses, an occupational therapist, social workers, a clinical psychologist, two trainee counselling psychologists and administration/secretarial staff.

Placement Objectives: It was my the aim that during this placement I would develop practical and theoretical expertise in the practice of counselling psychology by working in a professional context, learning from other health care professionals. By working as a member of a multi-disciplinary team it was my objective that I would:

(i) Gain experience in the assessment, formulation and report writing of a broad range of client's presenting problems.

(ii) Form, maintain and end therapeutic working relationships with clients (individuals and couples) lasting from six weeks through to one of ten months.

(iii) Learn how to plan and provide appropriate therapeutic interventions with the help of supervision.

(iv) Aim to evaluate the effectiveness of these interventions using pre and post measures.

Client Population: Clients referred to me were a diverse mix of individuals of both genders, varying in age from 19 years to 56 years, who came
from a wide range of social backgrounds and presented with problems including anxiety, phobias, panic attacks, depression, drug addiction, relationship problems, lack of assertiveness, anorexia nervosa, bulimia nervosa and histories of child sexual abuse.

**Supervision:** I was supervised once weekly by a clinical psychologist whose primary therapeutic approach was cognitive-behavioural therapy. However, due to my lack of practice experience and the theoretical orientation which was being taught in the first year of the counselling psychology course the nature of my interventions were client-centred or Rogerian. As my confidence and therapeutic experience increased, I began to discuss in supervision how I could incorporate other theoretical orientations into my practice, such as monitoring negative automatic thoughts or considering transference relationships with the clients I saw over several months.
Chapter: Therapeutic Practice Dossier
Year: 2nd
Type of Placement: Child, Family and Adolescent Service

NB: The placement and training agreement, supervisors reports and log book pertaining to this placement may be viewed in appendices I, M, N and S.
Therapeutic Practice Dossier

Duration of Placement: September 1996 - August 1997


Description of the Team: The service was multi-disciplinary in make-up and consisted of staff from several disciplines, most of whom had specific training qualifying them to work with children or families. There were namely, child psychiatrists, community psychiatric nurses, family therapists, social workers, a child psychotherapist and a trainee child psychotherapist, clinical psychologists, one trainee counselling psychologist and administration/secretarial staff.

Placement Objectives: It was my the aim that during this placement I would develop practical and theoretical expertise in the practice of counselling psychology in the specialist field of child and family work by working in a professional context, learning from health care professionals. By working as a member of a multi-disciplinary team it was my objective that I would:

(i) Gain experience in the assessment, formulation and report writing of children’s, adolescents’ and families’ presenting problems.

(ii) Form, maintain and end therapeutic working relationships with clients (individuals, couples and families) lasting from six weeks through to several months.

(iii) Learn how to plan and provide appropriate therapeutic interventions from a psychodynamic or family systems theoretical orientation with the help of specialist supervision.

(iv) Evaluate the effectiveness of these interventions using pre and post measures.
Client Population: Clients referred to me were either individuals, mother and child couples or families. An even distribution of boys and girls varying in age from three to fourteen years from diverse social and ethnic backgrounds formed my caseload over the year. Presenting problems were complex and difficult to define but included separation anxiety, enuresis and encopresis, depression, relationship difficulties with parents and suspected child sexual abuse.

Supervision: I was supervised once weekly by a clinical psychologist who was in child psychotherapy training. Her primary therapeutic approach was psychodynamic in nature, but she also included aspects of cognitive-behavioural therapy in her interventions. There was much emphasis upon the influence of the therapeutic frame and transference and countertransference relationships with my clients. I often used my supervision to discuss ethical dilemmas which arose when there were difficulties over maintaining confidentiality with such young clients whose welfare and safety needed to be guarded, sometimes at the expense of confidentiality. As a member of the family therapy team I participated in peer supervision following family therapy sessions which were systemic in nature and permitted me to learn a different therapeutic approach. I also received psychodynamic group supervision in a psychotherapy peer supervision meeting once weekly. This enabled me to learn more about the practice of child psychotherapists.
Chapter: Therapeutic Practice Dossier
Year: 3rd (first semester)
Type of Placement: Community Mental Health Team

NB: The placement and training agreement, supervisors reports and log book pertaining to this placement may be viewed in appendices J, P, Q and T.
Duration of Placement: September 1997 - December 1999

Placement Setting: A well-established Community Mental Health Team in outer London.

Description of the Team: The Community Mental Health Team was multidisciplinary in make-up and consisted of staff from a wide range of disciplines. There were namely, a psychiatrist, community psychiatric nurses, an occupational therapist, social workers, a clinical psychologist, one trainee counselling psychologist and administration/secretarial staff.

Placement Objectives: It was my aim that during this placement I would further develop practical and theoretical expertise in the practice of counselling psychology by working as a specialist therapist for adult survivors of child sexual abuse and sufferers of eating disorders. By working as a member of a multidisciplinary team it was my objective that I would:

(i) Gain experience in the assessment, formulation and report writing of client’s presenting problems (mainly those referred for treatment of problems concerning child sexual abuse and eating disorders, but also a broad range of other presenting problems).

(ii) Form, maintain and end therapeutic working relationships with clients lasting from six to eleven weeks.

(iii) Learn how to plan and provide appropriate therapeutic interventions with the help of cognitive-behavioural supervision.

(iv) Aim to evaluate the effectiveness of these interventions using pre and post measures including psychometric testing.
Therapeutic Practice Dossier

Client Population: Clients referred to me were mainly female and aged between 17 and 43 years. Most came from poor, underprivileged backgrounds which were typical of general population residing in the geographic area in which the service was based. The presenting problems of clients included anxiety, panic attacks, obsessive compulsive disorder, depression, relationship problems, lack of assertiveness, anorexia nervosa, bulimia nervosa and histories of child and adult sexual abuse.

Supervision: I was supervised once weekly by a clinical psychologist whose primary therapeutic approach was cognitive-behavioural therapy. His approach to supervision was to teach specific interventions for various presenting problems, such as Jacobsen’s relaxation technique for anxiety problems. I was provided with specialist supervision for my eating disorders clients by another clinical psychologist within the trust. This enabled me to discuss assessment procedures and treatment interventions with a psychologist who had developed expertise specifically in the area of eating disorders.
Chapter: Therapeutic Practice Dossier
Year: 3rd (second semester)
Type of Placement: In-Patient Therapy Team on Two Acute Psychiatric Wards

NB: The placement and training agreement, supervisors reports and log book pertaining to this placement may be viewed in appendices J, P, Q and T.
Therapeutic Practice Dossier


Placement Setting: Two acute psychiatric wards in a large psychiatric hospital in one of the home counties.

Description of the Team: The in-patient therapy team was established in January 1998 by my supervisor in order to provide a psychology service for individuals and groups admitted to the acute wards. The aim of the service was to try to prevent the frequent re-admittance of this client group by addressing underlying psychological difficulties which previously had rarely been attended to. The team was made-up of a consultant clinical psychologist, three trainee counselling psychologists, a staff nurse, a nursing assistant, an occupational therapist and an art therapist (both of whom worked half-time).

Placement Objectives: It was my the aim that during this placement I would further develop practical and theoretical expertise in the practice of counselling psychology by working with clients with severe mental health problems as a member of an in-patient therapy team. By working as a member of a multi-disciplinary team alongside a psychiatric team which was based on the wards it was my objective that I would:

(i) Gain experience in secondary care in the assessment, formulation and report writing of a broad range of client’s presenting problems.

(ii) Form, maintain and end therapeutic working relationships with individual clients and groups from the time of referral until their discharge.

(iii) Learn how to plan and provide appropriate therapeutic interventions with the help of ego psychopathology and cognitive-behavioural supervision.
Therapeutic Practice Dossier

(iv) Aim to evaluate the effectiveness of these interventions using pre and post measures including psychometric testing.

**Client Population:** Clients referred to me were male and female ranging in age from 20 to 64 years from diverse social and geographic backgrounds. The presenting problems of clients included depression, bi-polar affective disorder, borderline personality disorder, schizophrenia, alcohol addiction, parasuicide (self-harming), relationship problems, and histories of child sexual and physical abuse.

**Supervision:** I was supervised once weekly by the same supervisor as in the previous placement, a clinical psychologist whose primary therapeutic approach was cognitive-behavioural therapy. Whilst working with in-patients, however, he broadened his teaching to include learning how to use the ego psychopathology interview with clients who had been diagnosed with schizophrenia. This approach enabled the therapist to build rapport during a first meeting with such clients and permitted assessment of the type of difficulties they were experiencing with regard to their self-experience. Supervision was also concerned with the planning of groups such as a pre-discharge group and the discussion of appropriate treatment evaluation procedures using specific measures, such as the Hospital Anxiety and Depression Scale (HADS).
Chapter: Therapeutic Practice Dossier
Years: 1st, 2nd and 3rd
Title: An Overview of Three Years Placement Experience, with Particular Reference to Theory-Practice Links
Year One

Placement Setting

The setting for my first year placement was a newly formed Community Mental Health Team in one of the home counties in a fairly affluent area. Fortunately, this meant that there was no existent waiting list for clients and so there was little pressure on me to see more clients than I could manage. This was obviously a benefit to me as an inexperienced trainee because I was then able to receive enough supervision to enable me to discuss each client thoroughly. This supervision was supplemented by informal case discussion with other members of the multi-disciplinary team, some of whom were professionally involved with the clients I was seeing.

Client Group

Once again, due to my inexperience and lack of confidence I was able to discuss with my supervisor the type of clients I should offer appointments to. It was agreed that I would work in primary care, only seeing those clients who had little or no psychiatric history and who would benefit from client-centred Rogerian Counselling. During the year that I was at this placement I saw both men and women of a wide variety of ages and social backgrounds. The type of difficulties for which they had been referred included depression, anxiety, eating disorders and relationship difficulties.

Theoretical Orientation

As a novice at the start of the first year I practised basic counselling skills such as active listening, reflecting and summarising. As the year progressed I began to incorporate other techniques, for example, with one client who presented with low self-esteem and depression I employed the cognitive-behavioural technique of monitoring negative automatic thoughts so that we could analyse the client's
dysfunctional assumptions about herself which led her to feeling ineffective and disappointed in herself. Also, I found myself and my work greatly influenced by the workshops and seminars I was attending at the university, because many of these were focusing upon psychodynamic theory in preparation for the following year's placement I attempted to incorporate some of these ideas into my more long-term therapeutic work. One client, whom I saw for the entire year seemed to have developed a very good therapeutic relationship with me and so I felt secure enough, despite my lack of expertise to make tentative interpretations of a psychodynamic nature during some of our later sessions together. Although this sometimes seemed helpful I felt restricted in how I was able to discuss this type of approach with my supervisor who was cognitive-behavioural in orientation and showed little understanding of the importance of the client-therapist relationship or transference relationships.

**Therapeutic Frame**

Due to the lack of pressure on me to see a specific number of clients I was fairly free in my first year to offer therapy contracts of varying lengths. It was agreed that I would meet all my clients on a weekly basis, often initially for six sessions, but this was extendible following negotiation with my supervisor and clients. The range of sessions varied from less than six to approximately thirty sessions with one client.

**Year Two**

**Placement Setting**

The setting for my second year placement was a specialised one which I had particularly requested, due to an interest in the area. I was lucky enough to work in a Child, Family and Adolescent Service which was well-established and respected and comprised of an experienced multi-disciplinary team of experts in their field. Unlike the previous placement setting there was a long waiting list of clients of individuals
Therapeutic Practice Dossier

and families, many of whom already had entrenched and serious mental health problems. The pressure on the team to see as many clients as possible was tangible and I felt that this led to a fairly stressful environment. Fortunately, as a trainee there was no pressure placed upon me to see more clients than I could manage and so I built up my caseload to approximately seven clients per week. However, due to the pressure of work upon the team there were often difficulties in booking rooms in which to see clients as there were a lot fewer consultation rooms than there were staff members and so this caused frequent anxiety, but had the positive effect of staff making a conscious effort to begin and end sessions at the pre-arranged times.

Client Group

As in my first year I was able to discuss the appropriateness of referrals with my supervisor prior to agreeing to offer them appointments. An attempt was made to see individuals of a variety of ages and of both genders, this included seeing mothers whose children were being seen by another professional in the team. Due to the theoretical orientation of the placement it was suggested that I see at least one child from each of the developmental stages, i.e. infants up to the age of four years, latency stage up to puberty and adolescents up to the age of 16 years. In one case I saw both a three year boy and his mother together, in many cases I saw the child client whilst my supervisor saw his or her mother. Another aspect of this placement was that it permitted me to gain experience of family therapy whilst working in a close-knit family therapy team. The benefit of this was that it enabled me to learn more about systems theory and whilst observing behind the one-way mirror to make suggestions for interventions or formulations. I particularly enjoyed the level of peer support that this approach offered as well as appreciating the efficacy that a family intervention can sometimes have in families experiencing significant difficulties.
Theoretical Orientation

The theoretical orientation of this year's placement was psychodynamic, but as indicated previously there was also the opportunity to learn about systems theories and to participate in its practice with families. The majority of my work with individuals and mother-child couples was psychodynamic, however, and drew upon the theories of Winnicott, Bowlby, Klein, Anna Freud and to a certain extent, Sigmund Freud. My supervisor was a very experienced clinical psychologist and was also nearing the end of her training as a child psychotherapist and so I felt had much experience and knowledge to share. Unfortunately, I think I was somewhat in awe of her expertise and felt very de-skilled by this and possibly did not make the most of my supervisory relationship with her. This led to a decrease in my feelings of confidence developed in the first year and I think I was very much aware of my position as an inexperienced trainee amongst a team of what I perceived to be extremely busy experts. I think that part of my anxiety about requesting time with her was caused by my observation that she was always very busy with her large caseload and psychotherapy training and all that accompanies such training. With hindsight, I can see that I felt far more at ease practising family therapy than psychodynamic individual work and I think that this may be due to me perceiving that I needed to be more knowledgeable and more of an expert than I was in order to practise psychodynamically.

Therapeutic Frame

During my second year I was far more aware of the impact of the therapeutic frame upon the therapy than I had been in my first year. I succeeded in maintaining better time boundaries than previously and thought a lot more about the meaning of broken boundaries, such as missed sessions. One frame issue which I believe was badly managed by myself and my supervisor to the detriment of the clients occurred whenever I saw a child client and she saw their mother. The maintenance of the promised client confidentiality was clearly an issue when we met to discuss clients.
Therapeutic Practice Dossier

in supervision. In practice I was often told things about my client by my supervisor which she had learnt from their mother which then influenced my perceptions of my client. Eventually, when I felt one of my clients was not sharing things with me because she suspected this lapse in confidentiality I requested my supervisor not to share such information with me because I felt I had been unable to be honest and genuine with my client.

Year Three

Placement Setting

The first third of this placement was spent once again in a Community Mental Health Team where I was specifically employed as the only female psychologist in two localities to work with women, especially those presenting with histories of abuse and eating disorders. This suited me well considering one of my research interests is in the area of eating disorders. However, before the end of 1997 my supervisor was informed that he would be moving to a large psychiatric hospital to form an in-patient therapy team in order to attempt to minimise the regular re-admittances of past in-patients. Consequently, in January of 1998 I moved from the out-patient setting to an in-patient one, working specifically on two acute wards.

Client Groups

As mentioned above the client group seen during the initial part of this placement consisted mainly of adult women, many of whom had suffered some form of abuse and/or who had an eating disorder. Amongst these clients were some who had already received psychiatric in-patient care in the past, but most were primary care clients who had received little or no previous treatment for their difficulties. Unlike my initial experience as a trainee in this type of setting I felt very much more confident in my work and was perceived as someone with a certain level of experience and expertise in the area of eating disorders. I think that being perceived
in this way helped me to feel more confident and work more effectively and has certainly prepared me for work as a qualified psychologist in the future.

Now in the second part of this placement I am working with individuals who have been diagnosed with severe mental health problems. Despite previous experience as a nursing assistant with this client group in Paris it has been a worthwhile experience learning how to develop rapport in order to develop a good working alliance with such clients. In order to do this I have benefited from learning a specific phenomenological approach with my supervisor which I believe I would not have achieved had I only worked in primary care settings.

Theoretical Orientation

In my work in both settings this year I have worked using cognitive-behavioural techniques in conjunction with phenomenological and interpersonal approaches. I feel that these have very much been couched in a way of being with the client that I have developed over the past two and a half years which involves developing a good therapeutic relationship and borrowing therapeutic interventions from a variety of orientations, such as interpretations from psychodynamic approaches.

Therapeutic Frame

During my time at the Community Mental Health Team which lasted only three and a half months I arranged to see some clients for brief therapy (six sessions) which seemed sufficient. However, there were other clients whom I saw for longer and whom I referred on to other agencies, such as a day hospital eating disorders group when I left at the end of the year. Despite receiving cognitive-behavioural supervision I have continued to maintain clear boundaries around the therapy as I did in my second year and have tried to question what it means when such boundaries are broken and discuss these issues with clients.
Unlike out-patient services where it is the client's responsibility to attend sessions, clients on the acute wards are frequently unable to miss their sessions unless out on leave. However, it is possible to interpret a client lying on their bed in their bedclothes as possible resistance to attending a session and to bring this up with them to explore their feelings about attending therapy. Most clients at the hospital seem fairly pleased to be referred to the in-patient therapy team for either individual or group sessions, possibly because it breaks up the day which can apparently be very dull due to the lack of ward activities available. On the downside I have found it frustrating that it is often impossible to agree to see a client for a certain number of sessions without them being absent on leave or discharged due to pressure upon psychiatrists to make beds available for more urgent cases. For similar reasons it has not been possible to run any closed groups and so I have been involved in a pre-discharge group once a week which is concerned with psychoeducation and social skills development.

Conclusions

I feel that I have benefited from the variety of placement settings I have worked in over the past two and a half years, partly because of the variety of experiences but also because it has helped me to think about the kind of environment and client group I would like to work with in future. Writing an overview such as this has also enabled me to contemplate my professional development and increasing (and sometimes decreasing) levels of confidence in what I am doing.
Chapter: Therapeutic Practice Dossier
Placement: Humanistic Placement in a Community Mental Health Team
Year: 1st
Title: Client Study (Summary) I: Mr L

NB: To view this client study in full, please refer to Appendix A
Client and Presenting Problem

Mr L was a 42 year old unemployed man who was referred for psychological therapy by his psychiatrist. The referral described him as having experienced 'low-lying depression' since leaving school. The client stated he had not been compliant with prescribed anti-depressant medication because he believed "it never changes anything". He described himself as "an emotional person" who had difficulties forming relationships with women and consequently felt his life was "unfulfilled". In the two months prior to the referral he reported being more depressed than usual which he suggested manifested itself in a disturbed sleeping pattern, leading to difficulties motivating himself and getting out of bed before lunch-time.

Background to the Client's Difficulties

Prior to his referral for psychological therapy Mr L had attended a day centre where he had participated in self-awareness and craft courses. He did not complete these because he said he could "not relate to other people" there. His apparent lack of motivation to attend the day centre may have been linked to an incident to which he attributed the increase in his depressive symptoms two months prior to the start of his psychological therapy. The incident he described involved an unexpected sighting of a former female friend with whom he had wished to share a more intimate relationship than she had wanted with him.

Relevant Personal History

Mr L was the second of four born into a middle class family. He recalled receiving regular beatings from his father whom he described as extremely strict and of whom he "lived in fear". He perceived his mother as "cold", un-loving and compliant with her husband’s strict rules which included not being allowed to play with other children once home from school.
As a child and a young man he reported that he was often bullied at school and at work which he attributed partly to his small stature, but mainly to being socially inexperienced and fearful of male teachers. Mr L had one sexual relationship when he was 23 years old which lasted for four years. Since that time he was apparently unsuccessful in forming intimate relationships and regrets that a woman he knew from a café he frequented was not interested in becoming his girlfriend and never acknowledged his “feelings for her”. She left the area following an incident where he lost his temper and punched her.

Although Mr L was a member of a local badminton and tennis club he reported having no social relationships, but enjoyed metal-detecting alone. He felt he was “the odd one out” in his family because his siblings have partners and children. He was still living with his mother who was widowed ten years previously which he believed was preferable to living alone despite an unsatisfactory relationship with her.

Formulation

It seemed that Mr L’s depression and lack of confidence in social and intimate relationships were linked to un-loving relationships with his parents which left him feeling inadequate and insecure. His particular fear of men was probably attributable to his father’s aggressive treatment of him as a child which led to an unsuccessful academic and working life, thus reinforcing his low self-esteem as an adult. His strong feelings regarding his unrequited attraction to a female friend which ended dramatically may have accounted for the increase in his depressive symptoms when he saw her again prior to the start of therapy.
Therapeutic Relationship, Dilemmas, Interventions and the Outcome of the Therapy

The therapeutic relationship was signified by Mr L's difficulties in relating to me without concerns that I perceived him to be attracted to me. During our final session he requested a 'date' with me and became very angry and upset when this was refused. It seemed that he had misinterpreted the unconditional positive regard bestowed upon him as possible friendship. It was reflected that through the transference he had probably perceived me as the former female friend with whom he had wanted a more intimate relationship. As a last attempt to maintain contact with me he subsequently requested that we extend our therapy contract. This was refused because of a lack of confidence that we would be able to re-establish a more appropriate working alliance upon which to continue therapy.
Chapter: Therapeutic Practice Dossier
Placement: Specialist Placement in a Child, Family and Adolescent Service
Year: 2nd
Title: Client Study (Summary) II: Miss S

NB: To view this client study in full, please refer to Appendix B
Client and Presenting Problem

Miss S was a six year old girl of mixed race who presented with encopresis and enuresis which had endured for two years. Her mother had received complaints from her primary school reporting that she was soiling herself at least once a day and wetting daily a number of times. She was referred to the service by her paediatrician who had found no physical reason for her lack of bladder and bowel control.

Background to the Client's Difficulties

Miss S lived with her mother and 11 year old sister near her maternal grandparents who frequently cared for her whilst her mother was at work as a secretary. She had difficulties at school with reading and had been assigned to a level two special needs tutor who reported that she had difficulties concentrating and became very upset when she couldn't do her work satisfactorily.

Relevant Personal History

Miss S was born to a white middle class mother and a black Afro-Caribbean father who left the relationship when Miss S was three years old. Since her parents' divorce her mother remained single whilst her father set-up home with another woman. He continued to see his two daughters but was reported to be very unreliable. His relationship with his younger daughter was characterised by him spoiling her and treating her like a baby, giving her bottles of warm milk at night. Her mother suffered with depression for which she received regular counselling and time off work.

Miss S reached all the appropriate developmental milestones and was toilet-trained at 18 months. At four years she developed a kidney infection for which she received many intrusive examinations and treatment in the form of antibiotics and an operation. The result of this was that she was left with only 40% functionality in her right kidney and was prone to further infections. She was reported to be very
ashamed of the 'mess' she made when soiling and frequently hid or tried clearing-up her 'mess'. Miss S was reprimanded for her soiling by her maternal grandfather who told her that she was unclean. He also expressed disappointment that his daughter had married cross-culturally and blamed Miss S's problems on being half black.

Miss S's 11 year old sister was very confident and successful at school and in extra-curricula activities. Unlike Miss S whose appearance indicated she was of mixed race, her sister looked black and seemed to have less identity confusion than her sibling. There were indications that Miss S felt she was a failure compared to her sister and lacked confidence in most areas of her life.

**Formulation**

Miss S's psychosomatic symptoms and anxieties regarding her abilities at school developed at the same time as she underwent intrusive examinations and an operation on one of her kidneys. Her treatment was probably very distressing to her and the strange surroundings of the hospital may have led her to regress to an earlier life stage so that she would be cared for like a baby. It was evident from how her father treated her that she enjoyed the role of being the baby of the family and not having to be responsible and successful as her sister was. Her lack of confidence and self-doubt were probably linked to her identity confusion which had been fuelled by her grandfather's implication that it was the black part of her that was responsible for when she did 'bad things' like soiling.

**Therapeutic Relationship, Dilemmas, Interventions and the Outcome of the Therapy**

Miss S developed a very trusting relationship with me which enabled us to confront 'the sneaky poo' by making her more aware of when it might escape into her pants and get her into trouble. The frequency of her soiling and wetting decreased and I then began to interpret her confusion over her racial identity when she began drawing
hearts which were coloured differently on each side. The therapy concluded at the end of the summer term after 17 sessions and much preparation for our separation which she managed to accept was not because she was bad or naughty.
Chapter: Therapeutic Practice Dossier
Placement: Specialist Placement in a Child, Family and Adolescent Service
Year: 2nd
Title: Client Study (Summary) III: Master A

NB: To view this client study in full, please refer to Appendix C
Clients and Presenting Problem

Master A was four years old when he was referred by his GP for treatment of disruptive and aggressive behaviour. He was accompanied to sessions by his 21 year old mother (Miss T) who described him as disobedient and said that he often lay on the floor kicking and screaming in her company. She was also concerned that her son cried a lot, continued to need to wear nappies at night and frequently required a bottle to comfort him.

Background to the Problem

Master A was an only child who no longer had any contact with his father, but had been relating his mother's boyfriend as a father, calling him 'Dad'. Prior to the start of therapy her boyfriend moved back to his parents' home because he wanted a less intense relationship with her. Master A was often cared for by his great grandmother whilst his mother was working in the evenings. There was concern that he rarely spoke but following a speech therapy assessment it was confirmed that there was no physical reason for this. He attended playgroup three mornings a week where he had few friends but was apparently well-behaved and affectionate with other children.

Relevant Personal History

Master A's mother was being treated for depression and found it very hard looking after her son. She herself had a difficult childhood which was characterised by a turbulent relationship with her own mother, no contact with her biological father, relationships with more than one father figure and a close relationship with her maternal grandmother. She became pregnant at 17 years after leaving home and for six months after his birth Master A and his mother lived with his grandmother with whom he developed a close mother-son type relationship. Miss T, her boyfriend and their son then moved into a council flat together. During this time Miss T was treated violently by her partner which Master A witnessed and eventually the relationship
ended, although he continued to harass her after he had left. Miss T then formed a relationship with another man who was not violent whom Master A liked and with whom he was well-behaved.

**Formulation**

Master A’s behavioural problems seemed to be attributable to the significant similarities in his and his mother’s personal histories regarding confusing, insecure and ambivalent attachments to both father figures and their mothers. Although it seemed that he benefited from the temporary security of his relationship with his grandmother during his first six months of life he must have been confused when this changed and he went to live with both his parents elsewhere. His sense of personal security seemed to be undermined when he was witness to his mother’s inability to protect herself and her son from his aggressive father. It was probable that Miss T perceived herself not to be a ‘good enough’ mother which was picked up by her son who constantly needed to test her ability to survive and protect him by being difficult and aggressive himself. Due to her own depressive state it may be that Master A had to act in a more and more attention-grabbing way in order that she respond to him appropriately. Presumably this increased her sense of inefficacy and low mood which in turn encouraged her son to become more demanding.

**Therapeutic Relationships, Dilemmas, Interventions and the Outcome of the Therapy**

During the six sessions we spent together it was difficult forming any kind of attachment to Master A especially considering his reticence in talking. His play and facial expressions were interpreted and we talked about how he gets worried when people leave him as his mother’s boyfriend did because he is scared she cannot look after him alone. There was no noticeable difference reported in his disruptive behaviour which was understandable considering the complexity of his difficulties. However, his mother seemed to benefit from sharing her concerns without feeling
judged or criticised and so before I left the placement I referred the couple on to another child psychologist for continued psychotherapy.
Therapeutic Practice Dossier

Chapter: Therapeutic Practice Dossier
Placement: Specialist Placement in two Acute Psychiatric Wards
Year: 3rd
Title: Client Study (Summary) IV: Mr C

NB: To view this client study in full, please refer to Appendix D
Client and Presenting Problem

Mr C was a 21 year old man who was referred for individual and group therapy in order to help him come to terms with his recent diagnosis of schizophrenia (negative symptoms). He was admitted to the ward following a suicide attempt having shown signs of depressive illness for at least the two months prior to this. His symptoms were characterised by social withdrawal, increased appetite and sleep, negative affect and suicidal ideation.

Background to the Problem

Mr C first became ill two years prior to this admission when he was at university studying for a degree in computer science. He was socially withdrawn and became paranoid that he was being looked at in his room. He was able to return to his course following treatment for the negative symptoms of schizophrenia. However, he became ill once again whilst on an industrial placement in Germany and presented with suicidal ideation, delusions that his computer was communicating with him, inappropriate laughter and aggressive behaviour. Following this he was hospitalised in England. His last episode occurred nine months prior to his suicide attempt when he ran away from home to Paris and was eventually found barefoot by relatives looking dejected and disorganised having been missing for a week. Subsequently Mr C gave up his university course and found temporary employment in casual jobs.

Relevant Personal History

Mr C had an older sister who was diagnosed with chronic schizophrenia. She was also receiving treatment on another ward at the time of her brother’s admission; however, unlike her brother she had little insight into her difficulties. They seemed very close and Mr C acted as if he was responsible for her. His mother had also suffered with schizophrenia for many years but was able to care for her mother who also suffered some form of mental health problem. Mr C did not speak much about
Therapeutic Practice Dossier

his up-bringing but remembered his father finding it hard to understand his wife when she was delusional or hallucinating. Although his parents divorced and found new partners they kept in contact with each other and Mr C who was living with his father prior to admission.

Formulation

Although Mr C did not report any significant life events which may have preceded the onset of his difficulties it is likely that his mother's ill-health and his parents' divorce may have decreased his feelings of security and confidence. However, in the absence of any evidence of a particularly distressing childhood it was likely that Mr C may have had a genetic vulnerability to the development of a mental health problem. The age at which he first became unwell is fairly typical for schizophrenia and so it seemed that he resigned himself to the same diagnosis of schizophrenia as his mother and sister had. However, due to the lack of florid symptoms and his high level of insight into his problems it was possible that Mr C may have fallen into the category of individuals who only ever experience one schizophrenic episode and who are able to control negative symptoms with medication.

Therapeutic Relationship, Dilemmas, Interventions and the Outcome of the Therapy

The ego psychopathology interview was used at the outset of therapy in order to establish rapport and to explore whether Mr C had ever experienced any disorders of self-experience. His delusion involving his computer was believed to represent an ego demarcation problem which was discussed and found to no longer be a concern to him. We worked together to challenge his identity as 'a schizophrenic' on the basis that he had only ever experienced a single schizophrenic episode and was not necessarily going to develop chronic schizophrenia. This helped to lift his mood so that he was no longer suicidal and improved his unrealistic self-perception that he has become someone who is mentally ill. Finally, prior to his discharge we discussed how he could maintain his mental health by monitoring his thoughts, moods and
behaviour in case he re-experiences a schizophrenic episode in future.
<table>
<thead>
<tr>
<th>Chapter:</th>
<th>Therapeutic Practice Dossier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years:</td>
<td>1st, 2nd and 3rd</td>
</tr>
<tr>
<td>Title:</td>
<td>A Discussion of Process Issues derived from Process Reports written during Years Two and Three</td>
</tr>
</tbody>
</table>

NB: To view the process reports referred to in this essay please refer to Appendices E for Miss J, F for Master D and F for Mrs B.
This essay will address process issues pertaining to the therapeutic frame in relation to two different placement settings. The first setting was a child family and adolescent service where the theoretical orientation of the therapy was psychodynamic and the second was a community mental health team (CMHT) where the dominant orientation of therapy was cognitive-behavioural (CBT). In addition, the nature and impact of the therapeutic relationship upon individual sessions and overall therapeutic outcome will be discussed using examples from previous process reports.

It is understood by practitioners that each individual therapy session needs to be contained in order to establish boundaries around it which keep the world outside separate and permit the therapist to focus upon what is inside the frame (Gray, 1994). Psychodynamic approaches may use this special ‘space’ to enable clients to explore their internal worlds and relive past experiences through transference relationships with the therapist (Casement, 1990). Clients’ perceptions of these transference relationships will be clearer and less distorted when a protective frame is in place. From the point of view of the practitioner it is easier to observe the client’s behaviour in relation to the therapy and the therapist when there is a well-defined therapeutic frame and both parties are cognisant of the accepted boundaries.

Necessarily the setting in which therapy is taking place impacts upon the therapeutic conditions to be agreed by therapist and client (Clarkson, 1994). For example, in my child and adolescent placement I was able to see some clients for long-term work of up to ten months duration, whereas in the CMHT I was limited to therapy contracts of not more than ten weeks. With the benefit of hindsight and nearly three year’s placement experience I am now able to see how time constraints upon therapy contracts limit how much a therapist is able to interpret clients’ behaviour in relation to the clearly defined boundaries of the therapeutic frame.

During my second year placement in a psychodynamic setting working with children and adolescents the therapeutic frame was frequently ‘violated’ and this provided
valuable material about clients which aided understanding and (sometimes) discussion of their difficulties. In a therapeutic encounter with one 13 year old girl (Miss J) which lasted for ten months the pattern of her attendance to our sessions provided useful information about her feelings regarding our relationship as well as other close relationships through the transference. Such material was relevant to her presenting problem which concerned her relationship with her mother which I formulated was very enmeshed, but ambivalent, reflecting her anxieties about separation and individuation. She initially arrived late for our sessions and then gradually attended earlier and earlier.

The session presented in the process report was our twelfth session and followed the client's first missed session which occurred after the Christmas break (the first imposed break in therapy since its start). Due to the three week break between the eleventh and twelfth sessions I felt it was important to try to re-establish a working alliance and to explore how the client felt about the long break:

Therapist: So .... It seems like a long time since I've seen you then?

Client: Ummmm (affirmation).

Miss J was particularly quiet at the beginning of the session which left me hypothesising about the meaning of the break to her. I reflected the potential difficulty of returning to the intimacy of a therapeutic relationship after an absence of several weeks:

Therapist: I wonder if it feels quite difficult to start up again?

Client: Yeah.

It seemed that Miss J had become increasingly more attached to me prior to the imposed break because she had been arriving for our sessions earlier and earlier.
However, following the break it appeared that her trust in me had decreased. Although I did not voice this interpretation to her I hypothesised that she felt that I had let her down and was cross with me, as she frequently is with her mother when she shows her less attention than Miss J would like. I considered it possible that she was cross with me because she showed this by missing our first session back after the break which could have been a ‘punishment’ for me not seeing her over the Christmas holidays.

With the benefit of hindsight it may have been useful to have shared my interpretation of Miss J’s breaking of the therapeutic frame with her. However, I think that because of my lack of confidence and experience I withheld the interpretation of her absence following the break from her. As our therapy sessions progressed I became less inhibited with regard to making interpretations, especially concerning the meaning of imposed breaks to her feelings of security in her relationship with myself.

During the same placement I also saw a 13 year old boy (Master D) with whom I had fortnightly sessions. It was he who suggested the frequency of meetings and I felt that because there were understandable reasons for less intensive psychotherapy it was appropriate to agree to this in our therapy contract. However, in practice if he missed one session it resulted in a four week long break between sessions. This made it extremely difficult to engage with him or to gain a sense of continuity from one session to the next. I often had the sense that he chose not to share difficult thoughts or feelings with me because there was often so much time in between sessions when I was not available to him as a therapist. I believe this is demonstrated in the passage below:

The eighth session with Master D followed a four week gap in therapy during which I had been worried about him because he had appeared very depressed during our seventh session. During that session he had suggested that something was troubling him, but he had said that he did not wish to talk about it with me. Due to my concern
that the matter may be contributing to his particularly low mood I raised the matter again when I next saw him:

Therapist: Last time you were here it seemed that something very difficult had happened which was hard for you to talk about. I am wondering how things are for you now?

Client: Okay. They just took time to get over. When I thought about them I understood more and then began to think about them less and less.

Master D then suggested that he did not wish to talk about what had worried him and said:

Client: I spoke to one of my close friends about it, but it was personal.

This statement came across as a clear message that he did not feel secure enough in our relationship to share his concerns with me, which I felt sorry and concerned about because I felt that I was not being a good enough therapist. However, with hindsight, I felt I was right not to push him or to make interpretations about his withholding of personal information because of the infrequent nature of our sessions. The infrequency of our meetings was probably not sufficiently containing for Master D to risk sharing such thoughts or feelings. This experience taught me that it is important to arrange therapy sessions of a psychodynamic nature on a weekly basis (if not, more frequently) in order to permit the formation of a containing frame at least at the beginning of a therapeutic encounter.

In this, my final year I have returned to work in adult mental health firstly within an outpatient setting and then as a member of an acute services in-patient therapy team. The contrast in the two settings has raised issues of how the therapeutic frame and relationship is influenced not only by the client group, but by the therapeutic environment. In relation to an eating disordered client (Mrs B) at a community
mental health team it was a relatively straightforward task establishing a well-defined therapeutic frame with regular sessions and time boundaries etc. It is possible that this was made simpler by the fact that the frame was untainted by the client having contact with any other health care professionals (such as the adolescents did during my previous placement). Her attendance was so regular that I was concerned about her dependence upon the sessions and felt almost 'abusive' when I had to move to another service and refer her to an eating disorders group because there was no other therapist who could see her individually.

Our sessions were typified by me trying to shift her cognitive dysfunctions concerning her attitudes to weight or her role in relationships. In my process report of our fifth session I noted that she focused almost solely upon her father for the entire session. I tried to use her material to show her how her own beliefs about herself, such as she is 'fat and stupid', have arisen from not challenging her father's descriptions of her. However, I felt that I was not succeeding and became quite frustrated that Mrs B just seemed to accept that he could dominate and scare her even though she is in her fifties and no longer lives with him. When I indicated the end of the session she commented:

Client: We've talked about my father all the time.

Mrs B seemed surprised by this which made me wonder whether I should have tried harder to implement a CBT intervention which brought the focus back onto her earlier in the session. I was glad not to have done when she later said:

Client: Get him out of my system .... I'm going to have to say though he can't come this weekend .... I'm going to have to pluck up the courage for that.

It seemed that she had actually heard what I had been indicating throughout the session about challenging him by being assertive and stating her own needs, but as
she said, she needed an opportunity to tell someone about him in order to ‘get him out of her system’. Although I had wondered whether I should have stuck more rigidly to the therapeutic orientation of CBT, it seemed that it had been beneficial to Mrs B to have an almost ‘cathartic’ session where she didn’t allow the mode of therapy to dominate her as her father does, by complying with it when she obviously wanted the opportunity just to tell someone at length about her experiences of her relationship with him.

She broke the time boundary at the end of the session after I had told her it was time to finish by talking about how she would tell him he could not come and stay with her that weekend:

Client: I'll just say there isn't any room for him to sleep.

The value of the therapeutic relationship was evident when she concluded:

Client: I'll have to tell you all about what happens (next week).

Although I did not realise it at the time of writing the process report, it seemed that for Mrs B, having the regularity of weekly sessions gave her some sort of support as well as the opportunity to share her obvious anxiety about having to confront her father at last. Without the security of the therapeutic frame I sensed that she may not have felt so free to move forward in this way and so we both seemed to value its containing qualities, even within this brief focused therapeutic work.

It has been a useful exercise reflecting upon my therapeutic practice over the past two and a half years. It has helped me to consider the impact not only of different theoretical orientations, but also of therapeutic settings and therapist experience. The one outstanding aspect of this reflecting seems to be that in all cases a meta-perspective upon what was happening in the therapeutic relationship would have helped me to have gained greater understanding of my clients' difficulties and would
have been a useful tool to work with those issues in the here-and-now. The benefits of hindsight cannot be underestimated and it is certainly easier to see what was going on between myself and my clients and any significant others (such as parents, supervisors or other health care professionals) when there is temporal distance from the therapy. Despite this, the experiences mentioned above have all added to my increasing confidence and awareness of what is important in therapy with clients whatever the setting or theoretical orientation.
Bibliography


Introduction to the Chapter

This chapter contains three research projects completed over the three years of the Psych D in Psychotherapeutic and Counselling Psychology course. The first piece of work is a literature review concerned with family systems and psychodynamic theories of cross-generational coalitions. It was undertaken because of the author's interest in working with families. After completion of this project the opportunity arose during the second year placement to work with families applying the psychodynamic and family systems therapeutic approaches discussed within the research.

The second year piece of research which was concerned with qualitatively analysing the accounts of parents' experiences with regard to their children's severe mental health problems (mainly diagnoses of schizophrenia). This too reflected a special interest of the author in working with individuals who present with severe mental health problems. Fortunately the opportunity to work with this client group was fulfilled during the second semester of the third year whilst working as a member of an in-patient therapy team on two acute psychiatric wards. Having done this research it was felt that familiarity with some of the literature on the subject of severe mental health problems was useful in informing therapeutic practice.

During the third year the subject of the research was concerned with participants' accounts of their experiences as sufferers of eating disorders. Of particular interest to the researcher were individuals' understanding of their difficulties and in what ways their treatment had influenced their opinions. One of the primary aims was to explore ways in which participants had made links between their feelings and their disordered eating behaviour (gaining interoceptive awareness). This was thought to be particularly relevant to the planning and implementation of eating disorders interventions. Recommendations were made with regard to treatment in which the author hopes to continue to be involved as a practising therapist.
<table>
<thead>
<tr>
<th>Chapter:</th>
<th>Research Dossier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year:</td>
<td>1st</td>
</tr>
<tr>
<td>Title:</td>
<td>Cross-Generational Coalitions: Theoretical Explanations and Therapeutic Implications</td>
</tr>
</tbody>
</table>
Research Dossier

Abstract

The dysfunctionality of certain triadic intra-familial relationships is symptomatic of marital discord and the break-down of intergenerational boundaries. This phenomenon is known within family systems literature as a cross-generational coalition. Theoretical literature concerned with their formation and maintenance is discussed in an attempt to establish why certain individuals are more vulnerable than others to becoming elements within such dysfunctional patterns of family interaction. Psychodynamic theory provides some possible explanations of the intra-psychic dynamics and experiences which might indicate vulnerability factors within the family and the individual. Finally, the apparent deficiencies and positive attributes of both theoretical approaches are discussed and ideas concerned with identifying appropriate therapeutic interventions are presented.
Introduction

The 1960s heralded the naissance of family therapy and since that time it has been widely accepted as one of the most valuable treatment approaches to take when a child or adolescent is the identified patient (Mann, Borduin, Henggeler & Blaske, 1990). General systems theory provides family therapy’s most prominent conceptual basis and signifies a departure from traditional individual therapy by focusing upon interpersonal interaction patterns as opposed to individual cognitive, emotional and physiological states (Searight & Merkel, 1991). However, it has been noted that some of the fundamental theoretical assumptions of this approach have rarely been evaluated and questions concerning its efficacy have still to be answered, due to a paucity of outcome research in the area (Hazelrigg, Cooper & Borduin, 1987). In spite of such a discrepancy the practice of family therapy is now a well-established therapeutic intervention which has often been demonstrated to be effective in treating child and adolescent behaviour problems and psycho-social problems (Henggeler, Borduin & Mann, 1993).

Those in support of a family systems approach view the de-pathologising of the ‘identified patient’ as one of its major achievements (Wachtel, 1994). Although it is not easy for anyone brought up in a Western culture to look beyond the individual (Minuchin & Fishman, 1981) it is by taking the novel stance of treating the whole family as a dysfunctional system that this ‘de-pathologising’ of the individual has been achieved. Interest in relationships with other individuals, one’s environment and their effects upon an identified patient significantly increased in the 1950s when there was a “progression from descriptions of individuals to descriptions of dyads (such as mother and child) to triadic descriptions (such as parents and disturbed child) .... the triangle appears to be a “natural unit” (Haley, 1967, p. 16). Since that time it has been confirmed that it is generally more appropriate to view any form of family conflict, whether it be marital distress, parent-child interaction or sibling relationships in triadic terms, the triad being seen as the basic unit of interaction (Minuchin, 1985).
A major premise of systems theory, is that the mother-father coalition or parental subsystem, is vital in sustaining a healthy balance of affective relationships and a hierarchy to maintain order within the family (Bowlby, 1951). When a parental subsystem deteriorates however, children are frequently observed to exhibit symptoms associated with affective and control problems. Family therapy literature explains that such symptomatology develops because the desirable alliances between mothers and fathers are supplanted by cross-generational coalitions between children and their parents (Vuchinich & Angelelli, 1995). Thus it is assumed by professionals who work within a systemic framework that cross-generational coalitions are dysfunctional and if maintained over a significant time period are the primary cause of the development of children's symptoms.

The way in which children or others are triangulated in dyadic disputes not only influences the pattern and outcome of the conflict itself, but it may also have long-term implications for the individual adjustment of those involved (Minuchin, 1974). The tenet that cross-generational coalitions play an important role in the etiology and maintenance of child symptomatology (Minuchin, 1974; Haley, 1976, 1977) seems to represent one of the original and most important concepts of family therapy.

The Contribution of Family Systems Theory to an Understanding of Cross-Generational Coalitions

Systemic treatment of a child apparently involved in a cross-generational coalition (as indicated above) necessitates addressing at least three individuals who form not a dyadic, but a triadic relationship, or triangle. Such triadic pathological systems have been appropriately referred to as 'perverse triangles' (Haley, 1967) and 'rigid triangles' (Minuchin, 1974) and are characterised by inappropriate behaviour between the different elements involved, resulting in continual conflict and/or symptomatic distress. Haley's (1967) description of 'perverse triangles' specified that firstly, one individual in the triangle is of a different generation or hierarchical level from the other two; secondly, that one person forms a coalition against his/her peer
Research Dossier

which is different from an alliance (which is signified by two people joining together for a common interest independent of a third person) and lastly, that the coalition is covert and denied by the colluding dyad. It is necessary for this pattern of interpersonal relationships which breaches the inter-generational boundaries (which are the rules which dictate who participates and how; Minuchin, 1974), to occur repetitively in order for the system to be recognised as pathological (Haley, 1967). It seems that the importance of parents being united and supportive of each other over fundamental issues cannot be emphasised enough by family therapists, mainly because the spouse and parental subsystems provide models for children’s moral, emotional and intellectual growth (Minuchin & Fishman, 1981).

When such a subsystem is divided in its opinion or in its actions it is understandable that it loses authority and control, making it difficult to discipline and guide a child or adolescent. Where elements of a parental subsystem are not allied it is implied that there is greater opportunity for inappropriate coalitions to form which breach inter-generational boundaries (Haley, 1967) and jeopardise the authority not only of the ostracised parent but also of the parent who has over-stepped the border which once gave him / her a higher position in the family hierarchy (Mann et al., 1990). An example of how such a situation arises is that a mother may for some reason form a peer like relationship with a son or daughter. By condoning such a relationship intergenerational boundaries are breached and parents are no longer perceived to be in a higher hierarchical position. This ‘dysfunctional’ relationship negates the authority of both parents because they are no longer in an appropriate position to be able to effectively discipline their child. Subsequently the child may then develop problems as diverse as delinquency, anorexia, educational difficulties, conduct disorder, etc. (Searight & Merkel, 1991).

Family therapists seem to be in agreement that long-term, problematic cross-generational coalitions are established in reaction to some kind of discord or stress between the members of one generation or hierarchy with a member of another generation (Johnson, 1993; Mann et al., 1990). Most often a child is perceived as
being drawn into his / her parents’ relationship difficulties and is then used in spouse conflicts in one of several ways (Minuchin, 1974). These are identified as detouring (when the elements of the parental subsystem apparently unite by scapegoating a child, labelling him / her as ‘bad’ (detouring-attacking) or ‘sick’ (detouring-supportive) in order to deny conflict in their marriage and maintain the illusion that their's is still an harmonious relationship); triangulation (when the child is constantly perceived to be siding with one parent and automatically attacking the other) and lastly, forming a stable coalition with one parent against the other, thus providing a substitute gratification for the 'lost' partner whilst simultaneously having to make a loyalty-laden decision.

In each of these of triads it is evident that the child is overinvolved with the parental subsystem to his or her own detriment, but for the overall good of the family by ‘absorbing’ any problems between the parents and therefore frequently succeeding in keeping the system together. In some instances the child is seen as being naively ‘sucked’ into a triangulated role; in others the child is perceived to be self-sacrificing by actively taking on the bad or sick role in order to save the marriage or family unit (Haley, 1967). The motivation for self-sacrificing in order to save the parents' marriage is postulated to be feelings of attachment as well as guilt (Skynner, 1981). However, the problem that the child ‘creates’ may turn out to be worse than the one he / she is trying to solve (Madanes, 1991). Consequently it is no surprise that many parents turn their attentions to alleviating their child's problem before their marital situation is resolved, which presumably reinforces the child's attempts to intervene and try to save it.

Research has shown that children of divorced parents report feeling caught between their parents in terms of either emotional or practical issues (Gano-Phillips & Fincham, 1995). Pressure may covertly or even overtly be applied to children to decide with which parent they are going to side, which may cause the child concern about the impact that confirming an alliance with one parent will have upon the child’s relationship with the other parent. If this pressure is introduced a significant
amount of time prior to actual separation (which is quite feasible) it is understandable that cross-generational coalitions will develop whilst the family is still intact. When a child is required to choose between parents he/she is necessarily drawn into the parental conflict and possibly into conflict with siblings too.

Dysfunctional triadic relationships provide the epistemological basis of family systems theory and account for the development of behavioural problems and affective disorders observed in children whose parents are dis-united. However, it is only by carrying out empirical studies that such theoretical assumptions can possibly be validated. Vuchinich, Emery & Cassidy (1988) carried out a study concerned with the strategies, alliances and outcomes of those family members who intervene in dyadic disputes. Using a diverse sample of 52 families (none of which was involved in psychotherapy) confirmation was found for systems theory’s concern with triads: the involvement of a third person was seen in one in three dyadic disputes. As one would anticipate, in ‘healthy’ families parents rarely sided against each other, whereas children did not discriminate between the generations with which they allied themselves. This would seem to indicate that as a parent it is more important to maintain one’s role in the family hierarchy than it is for a child, who is presumably at the base of the hierarchy and cannot be any lower than he/she already is. A coalition with a parent may be perceived to be climbing the hierarchy and therefore be experienced as a way of increasing a child’s autonomy or power within the family system. Female members of the families intervened more frequently than males which may be because they associated their role as a female within the family with ‘peacekeeping’ duties (Vuchinich et al., 1988). If this sex difference is significant then one would expect to find more girls than boys presenting with control or affective disorders. This, however, does not seem to be the case. Conversely, it has been found (Emery, 1982) that there are similar proportions of girls and boys presenting with affective or behavioural problems. However, how and how much children react to problems within the family differs according to gender. The authors conclude from their study that effective therapeutic interventions may be approaches
which clarify and redefine family rules and roles which presumably consolidate the parental subsystem's position above that of the children's.

Successful family therapy appears to result in the establishment of inter-generational boundaries which leads to an appropriate hierarchical system and subsystem-appropriate roles. Although there seems to be little doubt on the part of family systems and ecological theorists that the quality of the marital relationship and that of the parent-child relationship are interdependent (Easterbrooks & Emde, 1988) this therapeutic approach to the resolution of cross-generational coalitions assumes, however, that marital discord came first and was the cause of the child's problems. Consequently, it appears that the focus of much family therapy is on the spouse subsystem and not on the child presenting with behavioral problems. Indeed, Johnson's (1993) model for the 'detriangulation' and conflict management of parent-adolescent relationships assumes that an underlying parental split is the cause of poor parent-child relations and goes so far as to recommend it as an "invariant prescription" for all families with adolescent children. The danger of such an approach must surely be that the marital problems experienced by the spouse subsystem could have arisen from stressful events associated with trying to care for a difficult child and not always the other way around. It is possible that a child may realise that whilst he / she is acting up the overt parental conflict diminishes, consequently reinforcing his / her undesirable behaviour and providing the motivation to continue fulfilling the bad or sick role.

A study concerned with the differences in strengths of alliance in distressed and nondistressed families (Gilbert, Christensen & Margolin, 1984) found that weak alliances were typical of distressed families, as anticipated, but were not localised in any particular subsystems. Curiously, excessive tension was found in the mother-target child dyad which contradicts family systems theory which states that such a dyad would be mutually supportive when there are marital difficulties. The authors conclude that the data suggest displaced maternal tension, however, the tense relationship between mother and target child could possibly result from the fact that
Research Dossier

it is less easy or pleasurable forming an alliance with the target child because of his / her behavioural problems, which may not be a product of the weak marital alliance.

The question of why one child and not another (if there are other siblings) is drawn into or chooses to become overinvolved in a relationship with one of his / her parents is one which has not been frequently addressed by systemic theorists. The above study confirmed that siblings in distressed families thought their parents treated them less similarly than their counterparts from non-distressed families. They also perceived significantly greater maternal negative behaviour than children in nondistressed families (Gilbert et al., 1984). Evidently the strain of poor marital relations in the distressed families accounts for a decrease in consistent parenting behaviour (Gano-Phillips & Fincham, 1995), and naturally, some children who think that they have been treated less well than their siblings may start acting out.

One would imagine that pressure to express allegiances would be uniformly distributed amongst siblings equally, assuming that this is true for most families why do some children inappropriately form coalitions with parents and others not? Obviously, as a child gets older the possibility that he / she will be required to choose between separating or conflicting parents increases. However, there is no evidence to show that it is always the older child who is drawn into coalitions. It has not been possible to show sibling differences in reaction to marital conflict in intact families due to difficulties in satisfying the need for statistical independence (Gano-Phillips & Fincham, 1995). Therefore it is difficult to know what protective factors might be present in those children who manage not to become involved in inappropriate relations with one parent against the other. According to Greenspun (1994) the triangulated child “was probably identified at an early age as being quite mature and capable” and is therefore better able than less mature siblings to “meet the adult’s dependency needs. Children who take care of their parents are clearly more vulnerable to inappropriate involvement in the marital system”. There is an indication that due to the nature of the traditional female role within the family it is frequently daughters who are triangulated (Vuchinich et al., 1988) by being placed in
the wife’s role and taking part in the ‘caregiving’ whilst parents are in conflict. As noted above (Emery, 1982), gender accounts for some of the differences in the amount and type of symptomology observed in boys’ and girls’ reactions to family stress. An indication of how these gender differences present themselves is that there appears to be a considerable body of research concerned with the scapegoating of boys who present with anti-social behaviour or who have been labelled delinquent (Mann et al., 1990; Vuchinich & Angelelli, 1995), whereas examples of scapegoated girls tend to be diagnosed with anorexia (Minuchin, 1974; Minuchin & Fishman, 1981). Overall a pattern emerges that portrays boys as reacting to marital conflict with problems of undercontrol or externalising problems and girls with undercontrolling behaviour or internalising problems, such as depression or anxiety.

Clearly, it is not an easy task to find a theoretical explanation of what traits or situations need to be present for a child to be vulnerable to becoming involved in a cross-generational coalition. It is known that only children show more externalising problems than those children with siblings, which indicates that the presence of siblings may be providing a buffering effect against overinvolvement in the marital subsystem (Kempton, Armistead, Wierson & Forehand, 1991). It could be inferred from such a fact that the sibling / child subsystem is weakest when there is only one child in the family system and an intra-generational alliance or coalition with a sibling is not possible. Interestingly, there has been little written about the possibility of more than one child being the identified patient in any one family. Assuming that marital conflict is generally the cause of cross-generational coalitions (as indicated by systems theorists), it would be expected that both parents would be keen to enlist the support of a third person against their spouse. The focus upon one cross-generational coalition at any one time is explained by the aspect of systems theory that states that only one element of a system is required to be the identified patient in order to maintain the homeostasis of the system, which would explain why parents rarely complain of more than one child being a problem. Despite knowing this information about only children’s increased vulnerability, and the fact that marital conflict and children’s affective and behavioural problems seem to co-exist (it is not
always clear which came first) it seems that family systems theory does not provide a theoretical understanding of what kind of precipitating factors might exist to render a child responsible for maintaining the equilibrium of a dysfunctional family system.

The Contribution of Psychodynamic Theory to an Understanding of Cross-Generational Coalitions

In an attempt to gain an understanding of family and individual factors precipitating cross-generational coalitions focus will now turn to the psychodynamic theory from which family systems theory was spawned. Understandably family systems theory developed because psychotherapists realised that the young clients with whom they were working were not able to sustain the positive changes achieved in personal therapy when they returned home, to the family environment (Jones, 1993). As a consequence it was agreed that the relevant system of individual family members involved with the identified patient should be treated as a whole in order to achieve sustainable change. Thus contemporary systems family therapy is based upon the marriage of psychodynamic and Batesonian (systems) theories. However, it has been criticised for evolving without adequately acknowledging the contribution of psychoanalysis, sometimes even disparaging its influence. This apparent negligence has meant it has had a great impact as a revolutionary new approach, but has also reduced the role of experience to one of insignificance (Kraemer, 1994). It seems that with the shift in focus away from intrapsychic phenomena attention has been diverted exclusively to interpersonal interaction patterns. Commitment to the de-pathologising of the identified patient seems to have accounted for this significant move away from viewing elements within the family system as individuals who carry with them their own past history and unique intrapsychic systems. However, if the answer to the question of what makes a child susceptible to becoming involved in a cross-generational coalition is to be found, it appears necessary to look at internal systems and the individual’s past experiences in addition to the functioning of the family system at large.
Research Dossier

Just as ‘perverse triangles’ are perceived by family therapists to represent pathological systems so too are they believed to be the central thesis of psychodynamic theory (Haley, 1967). The specific pathological triadic relationship of which much psychological distress is thought to be the product is the Oedipal or Electral conflict. The distress viewed by Freud in his first patients was thought to be a result of being secretly sexually assaulted by an older relative, thus a covert breaching of inter-generational boundaries. Upon his realisation that such an incident could not have actually occurred in all the cases with which he worked, he concluded that, in fact, the cause of the associated neurosis was not an incestuous family, but a fantasised wish to have sexual relations with one's parent of the opposite sex, and therefore was merely the result of an intrapsychic phenomenon (Haley, 1967). With the help of defence mechanisms the wish to develop sexual relations with one's own opposite-sex parent is rendered unconscious at an early age. However, the forming of a covert cross-generational coalition with an opposite-sex parent may be driven by the need to satisfy unresolved Oedipal or Electral conflicts. Such a theory might explain some opposite-sex / cross-generational coalitions from the point of view of how the child's needs may be satisfied by such an overinvolved relationship. However, it does not explain what wishes or needs are being fulfilled for the parent.

One of the clearest explanations of how a parent might be satisfying an unconscious wish by entering into a covert cross-generational coalition with a child is described by Greenspun (1994). The high incidence of intergenerational patterns of all types of abuse led her to investigate the dynamic underlying such an effective transmission process. It is best explained by the concept of projective identification (Klein, 1946) as “a mental mechanism used to transfer an intolerable part or parts of the self into an object” (Greenspun, 1994, p 4). In the case of incest a parent who was abused themselves (as a child) will project that specific aspect of themselves into an individual with whom they have a close relationship (frequently a child). Thus his / her relationship with the intolerable part of him / herself changes from being an intrapersonal one to an interpersonal one with the child who has introjected the split-off aspect of the parent. The unwanted part of the projector can then be observed,
interacted with and reacted to in the adult’s relationship with the child who begins to act in ways consistent with the projection (Greenspun, 1994). The parent is able to reinforce his / her defences against whatever split-off aspect the child has introjected by expressing disapproval when those aspects are acted out. Equally, an adult can identify with certain aspects of the child’s behaviour and simultaneously be vicariously gratifying a forbidden wish (for example throwing a tantrum) without feeling guilty that they are the individual perceived to be misbehaving. In cases of cross-generational coalition where the triangulated child is induced to be dependent, tyrannical or angry the parent has projected unmet needs to show such feelings into the child. Although it may appear that the child is extremely dependent upon the parent the truth may, in fact, be the other way around and when the child finds it hard to leave the family home it is because the parent still has dependency needs, such children may be referred to as the ‘parentified child’ (Burkett, 1991). This also occurs if a child is drawn into his / her parents’ relationship difficulties and overtly serves as an emotional caregiver to them as well as taking on certain adult roles and responsibilities (Greenspun, 1994). The complexity of the mechanism of projective identification may be realised when it is considered that the external reality in the family parallels the child’s Oedipal or Blectral fantasy to enter into sexual relations with the opposite-sex parent.

Thus an explanation of what might render a child vulnerable to a parent’s wish to form a cross-generational coalition is available: “if a child is developmentally delayed or fixated at the Oedipal or Blectral stage of psychosexual development he / she is more vulnerable than usual to receiving projections due to poor ego boundaries” (Greenspun, 1994). After the effect of the parent’s projections have shaped the child’s behaviour for a significant amount of time they become internalised and the same mental mechanism may be utilised in the next generation when the child wants to shape other close relatives to match with his / her internal world.
During the initial stages of therapy the focus upon only one identified patient within a pathological family is explained psychodynamically by the theory that siblings may unconsciously be colluding with the scapegoating or sacrificing of one of their siblings in order to prevent themselves from being the object of a parent’s projections or to maintain the parents’ apparent satisfaction with the family. It is possible that more than one child can be the target of abuse within a family, but it is apparently common for siblings to be unaware that they are not alone in their predicament (Greenspun, 1994). Clearly the interpersonal boundaries within such families are diffuse. This permits the formation of inappropriate cross-generational coalitions (including abuse) to occur. However, it appears that role confusion and some inappropriate distancing for example, from siblings, means that acceptable alliances are sadly diminished.

A Discussion of Possible Therapeutic Interventions based upon Family Systems and Psychodynamic Theory

Family systems therapy and psychodynamic child therapy share certain similarities. Both approaches are rarely studied in experimental outcome research, despite their apparent popularity (Kazdin, 1986). In comparative studies both forms of therapy have been found to reduce behavioural and emotional problems when the child is the identified patient, as well as reducing psychodynamic ratings of child functioning. It has been found however, that one significant and important difference between the two approaches exists: family therapy improves family functioning whilst psychodynamic child therapy brings about a deterioration in family functioning (Szapocznik, Rio, Murray, Cohen, Scopetta, Rivas-Vasquez, Hervis, Posada & Kurtines, 1989). Such a finding indicates that it is necessary to involve the whole family unit in at least some family therapy sessions in order to improve family functioning. This should render positive changes in the identified patient sustainable in the family environment. Clearly a form of intervention that involves the family in its entirety has specific benefits which are not present in an individual approach. These include the de-pathologising of the identified patient, realisation that causality
is circular and not linear, for example, marital conflict being deflected or expressed through a child who is being sacrificed in order to maintain the family homeostasis and relationship problems, which are in fact, a symptom of the family’s dysfunction. Focusing upon ‘here-and-now’ interpersonal communication and interaction patterns (Laird, 1995) with all elements of the dysfunctional system should enable the identified patient to break free from his / her role as scapegoat and re-establish the family hierarchy and inter-generational boundaries.

Despite the positive attributes of this relatively new therapeutic approach it should be recognised that family therapy is not a ‘cure all’. As early as 1966, Nathan Ackerman listed a number of situations in which family therapy is contraindicated. Unlike individual psychotherapy, for which there are treatments of choice depending upon the type of disorder, for example, behavioural therapy for the treatment of phobias; family therapy training programs still adhere to the “uniformity myth” which states that family interventions are appropriate for all forms of family dysfunction (Searight & Merkel, 1991).

An important tenet of the family systems approach is that a child’s symptoms will be alleviated once he / she has been relieved of the role of symptom bearer. This assumes that marital conflict preceded the onset of the child’s problems and that symptoms derive from inappropriate or dysfunctional family interaction patterns. The assumption that marital difficulties are the cause of subsequent family dysfunction means that children are sometimes excluded from family therapy (Wachtel, 1994).

This type of practice seems to contradict the central concept of causality being circular and not linear. It may be explained by the possibility that some family therapists are not appropriately trained to work with children and would rather work solely with conflicting parents, assuming that the positive effects of therapy will trickle down to relieve the child of his / her role as the third person in their dyadic dispute. There is of course evidence that such problems co-exist, but it may be negligent to assume that relieving the child of the role of mediator or scapegoat will
necessarily lead to a symptom-free and well-adjusted development (Papp, 1983). Although a family intervention attempts to rescue the child from his / her triangulated position, such an approach may in fact be neglecting the child by not acknowledging neurological, genetic, biological or intrapsychic reasons for the development of a child’s behavioural or emotional disorder (Wachtel, 1994). In addition to these oversights it is possible that a separate system with which the child interacts, e.g. peers, school, hobbies etc. may have contributed to the problem, but has not been acknowledged because it is not perceived to be central to family life.

Evidently, the therapeutic methods promoted by family systems theorists and psychodynamic theorists differ substantially. The most outstanding difference would appear to be conjoint family therapy as opposed to a traditional individual approach. Although neither approach supports the pathologising of the identified patient, family systems therapy seems to positively suggest the normalising of the child and the pathologising of the family system in its entirety. Despite such a criticism however, the value of de-pathologising a child should be recognised as a positive attribute of family therapy that may help to alleviate a triangulated child of his / her conviction that every family problem is his / her fault. Nevertheless, a balance is required which acknowledges not only the effect of the family system upon the child but also the influence of the child upon the system. This influence will not be know about unless the family therapist becomes aware of the child’s contribution to the family, not only in terms of his / her role as mother’s ally, parentified child etc. but as an individual in the system (Wachtel, 1994). It is acknowledged that children are generally harder to get to know than adults because their communication and socialisation skills are less developed. However, children are reported to be eager to please and improve family interactions, this enthusiasm and energy should therefore be taken advantage of and used therapeutically. It is important therefore for family therapists to be better trained in order to be able to inform themselves about the child’s style of communication, details of their problem behaviours and personal history (which may provide information relevant to current problems). The teaching of age-appropriate skills such as play therapy would need to become part of the training of family therapists in
order to elicit such information successfully. Wachtel (1994) suggests that not enough attention is paid to long-established therapeutic models which may be useful in family therapy work, for example, the work of Winnicott.

It may be concluded that there are positive and negative attributes of both family and individual approaches and that neither technique is better than the other. Several theoretical assumptions and therapeutic claims of both approaches have yet to be researched and qualified before direct comparisons concerning efficacy can be made. However, no two families or individuals are alike and so it would be counter-productive to consistently prescribe one type of approach for the treatment of a specific problem such as cross-generational coalitions. For example: in some cases the involvement of the entire family may not be justified if only three members are involved in a cross-generational coalition which only marginally affects other family elements. The fact that there is likely to be a combination of problems or factors responsible for the onset of family discord provides support for approaches which integrate the two therapies, enabling families to address problems both of interpersonal interaction in addition to individual concerns (Wynne, 1965). The fact that individual and system or family concerns are equally valid, but are distinct and separate also supports complementary therapies, which would possibly influence each other in a positive manner. Certain issues need to be worked through with the identified patient independently, such as the experiences which led to the individuals' current vulnerability in the current family situation (Wachtel, 1994). Individual psychotherapy enables the client to work through past unresolved issues by looking at internal dynamics. Working in a two-person relationship individually with a therapist enables the reliving past child-parent relations and the possibility of removing destructive elements within such relationships (Ackerman, 1958). It is important for abused and abusing parents to have the opportunity to work individually to reintegrate the split-off aspects of themselves, just as it is vital that the child abuse victim works through trauma and internalised family relationships (Greenspun, 1994).
Research Dossier

There is little available literature concerned with the either the integration of a family systems approach with an individual child psychotherapy intervention, or with the two approaches being used complementarily. This is possibly because as a relatively new approach family therapy was initially concerned with its own distinctiveness and emphasised the importance of the attendance of the whole system to therapy sessions. As long ago as 1978, Bowen suggested the integration of family concepts with psychoanalytic theory, but acknowledged that little had been achieved at that time. In recent years however, the possibility of individual systemic therapy has been discussed and researched and even been found to be more successful than conjoint family therapy (Szapocznik et al., 1983; Jones, 1993). Most of this work assumes the client is adult and generally living away from his / her family of origin, however, it may be a useful approach to use with the adult survivors of child abuse or with people with HIV/AIDS who do not wish to inform their family of origin of their seropositivity but would like to work through certain family issues (Walker, 1995). The benefit of one-person family therapy would presumably be that without the presence of other family members issues not relevant to a conjoint family therapy session could be explored with the same therapist who is helping the individual to deal with dysfunctional interpersonal interactions in the family. Evidently this assumes that the therapist is trained as some sort of individual therapist as well as systemically. If this were possible it would have the benefit of providing an integrated approach without the problem of having to be cautious not to breach client confidentiality in the presence of other family members.

Conclusion

It seems that despite the apparent success of the family systems approach to family dysfunction there are certain domains (such as developmental problems) or skills (such as play therapy) for which family therapists alone are generally not qualified. By the same token, individual therapies (not including one-person family therapy) do not address family interaction issues such as triangulation and are frequently observed not to provide sustainable change. The various limitations of these two
Research Dossier

approaches support arguments for the integration of family systems and individual approaches or for the complementary use of the therapies. The integration of the two therapies may be achieved by treating the identified patient in one-person family systems therapy which theoretically, has the benefits of both a systems approach and individual approach. However, unless the therapist is specifically trained in both techniques and it is appropriate that other members of the family are not seen (if the client is an adult and has already left the family home), this approach may not be as comprehensive as a complementary treatment program. Efforts have already been made to design integrated family systems and individual approaches (Wachtel & Wachtel, 1986; Sugarman, 1986; Duncan & Parks, 1988; Wachtel, 1994). Although these new approaches sound promising outcome research concerned with their success appears to be sparse and it may be some time before practitioners are familiar with such methods.

If a child is the identified patient it is frequently necessary to involve the whole family system in treatment, in order to avoid continued scapegoating or pathologising by working through dysfunctional interaction patterns. In addition to systemic treatment an appropriate form of individual (child) therapy may be appropriate, to enable the identified patient to work with another practitioner to deal with issues not adequately addressed in the presence of other family members, and which need to be worked through using an approach other than systems. The benefit of involving two therapists in the treatment of a family with an identified (child) patient is that there would be distinct boundaries between the two forms of therapy, which would ensure not only confidentiality, but a comprehensive treatment program which does not underestimate either the power of family relationships and nor the importance of the child’s intrapsychic life and extra-familial relationships.
Research Dossier

Bibliography


Research Dossier


Research Dossier


Chapter: Research Dossier
Year: 2nd
Title: A Qualitative Analysis of The Experiences of Parents of Children with a Mental Illness with Reference to Theories of Social Representation and Identity
Research Dossier

Abstract

A semi-structured interview schedule was devised in order to elicit experiential data from ten parents of adult children with serious mental health problems. Due to the potentially sensitive and emotive nature of the material the research counselling interview approach (Coyle & Wright, 1996) was used. Participants were accessed through contact with carers’ support groups and had lived with their child’s mental illness for between one and 24 years. The aim of the research was to question how social representations (Moscovici, 1983) of people with mental illnesses may have affected participants’ ability to cope with their child’s illness both practically and emotionally. Hypotheses regarding potential threats to the identities (Breakwell, 1986) of respondents were made due to the perceived difficulties of being the parents and main carers of individuals with a stigmatised illness (in most cases, schizophrenia). It was found that nearly all participants had experienced significant difficulties in gaining the information and support they believed they required from health and social services and this may have had a negative effect upon self-esteem and self-image. Parents believed that when they eventually found support at carers’ meetings their anxiety was alleviated. Group membership also seemed to aid acceptance of the illness which many felt was the key to coping with their children’s problems.
Introduction

Social representations of the mentally ill in Europe and the U.S. have often been the subject of social science research (Belleli, 1987; Farina & Fisher, 1982; Jodelet, 1991). Moscovici (1983) believed that social representations are necessary in providing not only order and meaning to individuals’ beliefs, but also in directing their actual behaviour, so that they conform with the social group to which they belong. Since the development of ‘care in the community’ programmes in this country there has necessarily been a significant decrease in the numbers of psychiatrically ill people who are ‘out of sight and out of mind’ locked away in institutions (Miles, 1981). For the purposes of this small scale, in-depth study these carers are the parents of people with a serious mental health problem, as diagnosed by a psychiatrist prior to, or, during admittance to an in-patient psychiatric unit.

A substantial body of research has focused on the impact of de-institutionalisation upon the (ex-) psychiatric patient (Laws & Dear, 1988) and the effect of the family upon that patient (Leff, 1985; Vaughn & Leff, 1976; Vaughn, Snyder, Jones, Freeman & Falloon, 1984). However, rather less attention is directed at the potential three-way, non-linear interaction of social representations, reforms in the psychiatric treatment of the mentally ill, and the impact upon the patient’s family. This study will attempt to elicit how a group of parents themselves have managed the care of their child in relation to the provision of treatment by psychiatric services and how social representations and stigma have played a part in their ability to cope both practically and emotionally.

Miles (1981, p. 115) describes the family as “a meaningful social entity .... in which mental disturbance affects its social position, life-style, internal relationships and links with the outside world”. Assuming this to be the case, it is likely that at least
during the initial stages of the mental illness the identities not only of the patient, but also of close family members will be potentially threatened. Breakwell's (1986, 1992) model of identity suggests that in order to cope with such threats to the individual's identity there is a continued need for continuity, self-esteem, self-efficacy and distinctiveness. Although her model places emphasis upon the continually changing nature of the identity in the context of the social environment, it is threatened when the processes of change to identity (assimilation accommodation and evaluation) are prevented from obeying the above principles (as is hypothesised to occur when a parent learns that their child is mentally ill). It is hoped that this exploratory study will succeed in identifying how the presence of mental illness in the family may threaten parental identity and will elicit how this threat is managed, including the role played by psychological services.
Method

Parents of individuals diagnosed with a serious mental health problem were accessed through the National Schizophrenia Fellowship (NSF) which runs monthly support groups for the carers of people with schizophrenia and, in some cases, other mental health problems. The researcher attended these meetings in order to present the research proposal and ten members from three different groups volunteered to be interviewed about their experiences as a parent and carer of someone with a serious mental illness. There was no attempt to match the number of male and female participants. The Manic Depression Fellowship (MDF) also assisted the study by advertising for participants in their newsletter, but no members volunteered to take part.

The counselling research interview devised by Coyle & Wright (1996) was the approach used for data collection. Due to the potentially sensitive nature of the material it was believed that using counselling attributes such as unconditional positive regard and empathy may enable participants to access and describe in detail emotive (and other) experiences. It was hoped that using such skills as summarising and reflecting would also provoke exploration of material in order to elicit rich and varied personal accounts and opinions.

Data were collected using a semi-structured interview schedule (see Appendix C). The first two sections were designed to elicit information concerning the onset of their child’s mental illness, including the parents’ reactions to diagnosis and treatment, as well their feelings about changes in their child’s behaviour and in their relationship with them etc. The third and fourth sections of the interview addressed the participants’ thoughts regarding how other people perceive mental illness and how these opinions may affect them and their families personally. Finally,
participants were asked if they had ever spoken to anyone before about the issues discussed in the interview, and, if so, how they had found the experience(s).

Prior to the start of the interview participants were requested to read a one page explanation of how the researcher intends to maintain participant confidentiality and anonymity in the way in which the research material (audiotape recordings, transcriptions etc.) is treated (see Appendix A). Having understood and agreed to this participants were then asked to sign two consent forms to confirm their informed consent to the research procedures. The researcher also signed both copies of the agreement in order to confirm that the research material would be treated as defined in the research consent form. One copy was kept by the participant and the other by the researcher.

At the start of the interview participants were also requested to complete a brief demographic questionnaire (see Appendix B). This also contained questions about family structure and the care of the person with the mental illness, which it was thought may provide useful background information to aid understanding of the interview data.

Upon completion of the interview participants were offered follow-up counselling sessions in the event that they had found the experience of the interview upsetting and would benefit from talking further about the material outside the context of a research interview. No participants reported any negative feelings at the conclusion of the interview and all declined the offer of a follow-up session.

Data were transcribed (see Appendix U) and subjected to thematic content analysis (Krueger, 1994). In order that reliability of the identified main themes could be checked a 'non-researcher' was requested to act as moderator. This person was
Research Dossier

provided with written quotations extracted from the data by the researcher and asked to place these quotations into envelopes labelled with the names of the researcher's main themes. Where there was inconsistency in the placing of the quotations in the main theme envelopes the researcher and moderator either omitted these quotations or negotiated where they should be placed until an agreement could be reached. The exact titles of these were then negotiated until an agreement could be reached on the names of the main themes. The subthemes, links between themes and interpretations of the data were not submitted to the moderator as it was concluded by the researcher that in view of the subjective nature of such analysis such an exercise would probably be futile.

Neither the subthemes nor the researcher's interpretation of links between themes were submitted to the moderator as it was concluded by the researcher that at the micro-level this type of analysis becomes very subjective and it is inevitable that high agreement could rarely be achieved. It appears that the nature of this type of qualitative analysis is such that different individuals studying the data set would probably interpret it in many different ways. Consequently, it seems important to include in the results section a sufficient number of quotations for readers to have the opportunity to consider and possibly criticise the way in which material has been analysed and meaning interpreted from it.

The frequency with which major themes appeared in participants' responses to the interview questions has been indicated in most cases. However, the use of adjectival quantitative phrases as suggested by Krueger (1994) has been adopted instead of quantitative indices in the reporting of main themes arising from the interview data which follow. Due to there being no pre-defined criteria for the frequency with which main themes must recur in respondents' responses it is neither possible nor
Research Dossier

appropriate in a qualitative study to use such quantification methods as percentages, which may play down the significance of themes which are identified.
Results

Demographic information

Of the ten parents interviewed for this study, six were mothers and four were fathers of individuals diagnosed with a serious mental illness (Asperger’s syndrome, paranoid and catatonic schizophrenia and schizo-affective disorder). The mean length of time since diagnosis of the illness at the time of the interview was 12.8 years (range 1-24; SD = 7.0). The mean age of the participants’ children at diagnosis was 21.2 years (range 6-32; SD = 6.9). Participants’ mean age was 64.1 years (range 55-76; SD = 6.2). Every parent interviewed was married and living with the other parent of their ill son or daughter. Two married couples participated in the study, thus four participants spoke about only two individuals with mental health problems. Eight participants were retired and two still working. No participants had relatives other than younger offspring living in the family home and only one participant said that other relatives (other children) sometimes helped to care for their ill child. Only one parent in the study had a daughter with a mental illness, the remaining nine were parents of a son with a mental illness. Two children of participants were one of two children, five were one of three children and one was one of four children. Four of participants’ offspring were living away from home in their own accommodation and four were at home with their parents.

In the quotations that follow the omission of material is indicated by ellipsis points .... and clarificatory material is placed in [squared brackets]. Participants’ anonymity is guarded by replacing their names with a single letter.
Delay in the Provision of a clear Diagnosis

Much of the interview data collected was concerned with parents’ experiences of their son or daughter’s psychiatric diagnosis and treatment. In the chronological order in which treatment occurred the first theme to emerge was parents’ criticisms of the length of time it took for their child to be given a clear diagnosis.

Participant E (pE) said: "In the very early stages, we didn't know exactly what was wrong with him, we didn't know the diagnosis. The communication from the hospital authorities wasn't very clear."

A few parents went on to explore why this might have been so:

"He [psychiatrist] didn't really give us a proper diagnosis. I just don't know the reason, perhaps they don't think you're ready for the shock. With hindsight I would sooner have been told." (PF).

It seemed in a minority of cases that if there was reticence in psychiatrists giving a clear diagnosis it may have been because of the reactions of parents to the news. (As pB remembered) "[I was] totally shocked .... and devastated. I don't think you can accept it at first."

However, it seemed that all parents were keen to end the anxiety brought about by uncertainty over the diagnosis; as pC said "the combination of not knowing that he [our son] was very ill and not knowing what the illness was and what to do was very traumatic for us". This anxiety was reported to be increased further by the reluctance of some psychiatrists to provide a diagnosis and in some cases "that [the diagnosis] only came after a lot of pressure" (pI).
In summary, the effect of not being given a clear and early diagnosis was that parents found it more stressful than knowing that their child’s unusual behaviour was due to a specific illness which could then possibly be managed.

**Discrepancy between (the level of) Help Provided and that Required by Parents**

Even when parents were told what the diagnosis was, the trauma of the situation was not alleviated owing to a lack of follow-up guidance. As pH said:

“It was a real punch in the stomach sort of thing and we were desperate to get help, any help and we didn’t know where to turn.”

In the absence of psychiatric help nearly all parents discovered that it was (as PI described it) “a suck it and see exercise”. Most participants reported an absence of practical advice from the psychiatric team as illustrated:

“They [the psychiatric team] gave us no indication of what the procedure was, no indication of what happens, no indication of how we should .... conduct ourselves, whether it would be good for us to come and visit him [our son in the psychiatric unit].” (PC).

Many parents seemed to think that the reason for the psychiatrists’ lack of information-giving and contact with parents was because “the attitude is that they [psychiatrists] don’t want parents involved. I think that parents need more explaining to them. I think that would help a great deal” (pB).

This interpretation of psychiatrists apparent lack of contact with parents was not unique and other participants could not understand why psychiatrists had not wanted
more communication with them, because they could only perceive that such contact would have helped their children in the long run.

Once again it may be that psychiatrists avoid such contact with parents as they do not wish to burden them with the shock of the realities of the illness. PI said that “nobody told us what we were in for” and this may suggest that psychiatrists feel it is better for parents to know nothing or to develop their own understanding through experience rather than be told about the possible distressing ways in which the illness may develop.

In response to the reported lack of information provided to parents, respondents acquired their knowledge of their child’s illness “mostly because we read books” (pA).

In all cases the acquisition of such knowledge was reported to have been essential. PD wondered if the information had not been given to her by her son’s psychiatrist because “maybe nobody could help me, maybe I had to find my own way with him [my son]. The only thing is that you feel very lonely.”

An example of why parents probably found the acquisition of such knowledge about the illness so important was that as pE stated “they [patients] look like zombies and it really upsets you to see them like that”. Without a comprehensive explanation of the medication “one didn’t realise fully that it was a side effect .... the stooping and the shuffling and the dribbling from the mouth .... One associated it with the illness and that was fairly distressing. If the doctors had told us clearly enough that this was the sort of reaction you should expect .... it wouldn’t have felt quite so bad.” PF reported that the psychiatrist had not told her that the medication “takes ten days to build up and ten days to wear off” and as a consequence of this alleged lack of information
was shocked to find her child’s symptoms returning nearly two weeks since stopping
the medication, when she had thought that the illness must have abated. PG, a parent
whose son was diagnosed within the last year suggested that the prescribing of
medication is done by “trial and error”.

All participants felt that learning about the illness and medications themselves was
necessary not only for practical reasons (to help them to know ‘what to do’ with their
ill son or daughter) but also for their own psychological well-being. It was evident
that insufficient information may have caused more anxiety that parents perceived
was avoidable in the presence of a thorough knowledge of what to expect from the
illness and from the effects of medication.

In addition to dissatisfaction with psychiatric treatment, when parents approached
their GPs for extra help and support at the outset of the illness, they were often
discontented with the treatment they received:

“Our own GP was not trained in any psychiatry .... he was one of the old school who
didn’t deal with it and we didn’t get a lot of support .... On one occasion we called
him out in some distress and he told us that there’s nothing wrong, just a family
dispute.” (PE).

This perceived inadequacy in GPs’ training is reflected in another respondent’s
expectation that the patient would comply with standard procedure appeared to
hinder the provision of support: “It depends on the GP .... She [my GP] didn’t seem
to see that you couldn’t get him [my son] to put his name on her list .... She said until
then I can’t do anything to help you ....” (PH). Notwithstanding this experience, the
respondent also reported that “things may be better now .... even ten years on ....”
However, she was unable to provide an example to demonstrate this improvement.
Research Dossier

Although it seemed that in the absence of guidance from the psychiatric teams treating participants' children, respondents sought help from GPs (whom they perceived to be more approachable) most parents reported, as pF did, that "it would have been a tremendous help to have had time alone with the psychiatrist .... in order to speak to him about certain aspects of the illness". PI perceived psychiatrists' and GPs' lack of motivation to communicate with families to be a response to the unrewarded extra effort it requires: "I got the impression that doctors know about schizophrenia, but don't like it very much: it involves them in massive hassle. They're not paid extra money for hassle".

In summary, all participants (except for one whose child was diagnosed only one year ago) reported a reticence by psychiatrists to share knowledge that parents believed they must have regarding their child's mental health. It is not clear whether this assumption is correct, but it is evident that this group of parents were not satisfied with the amount and quality of communication they received from psychiatrists and, in some cases, GPs treating their children.

Allocation of Blame on Carers

In addition to respondents feeling that a lack of communication had had a negative effect upon their psychological well-being it was also indicated by a few of the female participants that in the absence of an alternative explanation of the cause of the illness, they felt that blame for their child's mental health problem had been placed upon them.

PC explained that "I found it all very frightening and very worrying .... because a lot of people seemed to think that there must be something in terms of the relationship I had with him [my son] that was causing him to behave in this way."
The attribution of such blame seemed to be perceived as coming not only from participants’ friends or family, but also from healthcare and social services professionals. PD remembered her son’s psychiatrist telling her “maybe it was my fault, maybe I was taking too much care of him [my son] so I sent him to boarding school .... it was a bad experience.” It is understandable that the attribution of blame is likely to make one doubt one’s ability to be a good enough carer and result in the individual feeling powerless in particularly demanding and stressful circumstances, as pD possibly did.

Another mother (pF) whose child was diagnosed in the 1970s said that “every social worker who had anything to do with mental illness had a cryptic knowledge of Laing’s theories and it was all the mother’s fault”. It seemed that such theories were abundant at that time and even the general population seemed to know about them, as another parent’s (pC) comment illustrates:

“I mean Laing thinks that it’s all the mother’s fault .... It was always presumed it must be the mother’s fault. The father played the passive role; so I am quite angry that .... people attributed it to being my fault .... One even sensed it in one’s friends.”

All the mothers who had had this experience no longer seemed to possess feelings of guilt, some even felt angry that such a belief could have pervaded the psychiatric profession, social services and wider society several years ago. It was implied that when such feelings were present they may have had a damaging effect upon respondents’ self-esteem and possibly upon their efficacy as the main carers of individuals suffering from serious mental health problems. One mother (pF) felt that “the stigma [of schizophrenia] had rubbed off on me too. I felt humiliated several times: I was seen as the mother of a schizophrenic child”. Such feelings, which may include feeling powerless to change other people’s perceptions, may have decreased
Research Dossier

participants' confidence, thus rendering it difficult to approach healthcare and social services professionals in order to request help and information which were apparently lacking (as indicated in the first two themes).

What did and would have Helped Parents

All parents interviewed commented that it would have been helpful early on in their child's psychiatric history to have spoken to someone who had experience or knew about their child's mental illness who could have told them "how to deal with them [children with mental health problems], how to approach them, how to talk to them .... because you're frightened you're going to say the wrong thing to them .... you've got no inkling how it affects them or how it affects families". (PB).

It has already been indicated why participants felt that help and information were vital, especially at the onset of the illness. It has also been suggested that services involved in the care of people with a mental illness have been perceived to be inadequate with regard to such provision. In the light of such a discrepancy between what was provided and what was required all participants were in agreement that:

"I would have liked to have [spoken about the illness] but there was no one really I could talk to .... It is the exchange of information I am after". (PI).

It seemed that an answer to parents' unrequited need for information was involvement in a carers' group. As PB indicated "had I known about it [the NSF] from the beginning, it would have helped me a lot, because at least I'd have known what to expect and things like that."
A few respondents believed that it would be easy for health or social services to inform parents of the NSF if the attitude to mental illness was similar to that towards physical illness. One parent (pH) gave the example: “my husband had a heart attack and he had a leaflet telling him how to cope, you have somebody with mental illness and you get nothing, all you want is a leaflet saying you can go to the NSF and they will do the rest.”

Optimistically there was evidence (from just one participant) that in recent years parents’ suggestions and possibly the expansion of the NSF have ensured that psychiatric treatment services have acted on the advice that parents are informed of the NSF at an early stage in the illness. One parent (pG) whose child was recently diagnosed said that “it [the NSF] was actually suggested by the consultant at the hospital and I think it helps”.

As well as receiving information from such a carers’ group one parent suggested that “they [the psychiatric team] should have told me about organisations like the NSF that would give me some kind of support .... I wouldn’t have felt so left out on a limb, I would have known better how to help him [my son] in the sense of responding in a more positive way .... by the time I found out about the NSF I was pretty much in control.” (pC). It seemed that one of the benefits of such meetings is that experienced members can help newer members as one parent (pE) said “we are so to speak veterans; we tend to help the newer sufferers rather than getting assistance ourselves. The essential thing is that my wife and I are able to talk to each other.” Although pE explained that he and his wife no longer benefit from an exchange of information it seems important to him that they maintain contact with the group of parents of schizophrenia sufferers. Maybe it is important for parents to feel that they are not the only ones with the burden of caring for a child with a mental illness. Belonging to a group may have enabled them not only to share experiences, but also
to identify with other parents in a similar position to their own. Further, the negative self-image, which it was implied by some participants developed as a result of feeling blamed and guilty, may be altered by receiving genuine support from other parents with similar experiences.

Possibly as a result of not being supported by the NSF or other individuals or organisations, a small minority of parents were helped either by seeing a psychotherapist or a psychologist during the time of the onset of their child’s illness:

“She [a clinical and counselling psychologist] was very helpful to us and this was what we needed: information, help and support; and she was most helpful.” (PH).

In contrast to most participants’ desire for support and the chance to talk about their feelings one respondent (pD) reported that “I was completely inside the problems and there was no time to think about how I was feeling”. It is understandable that coping with a child with a mental illness could fully consume one’s time, however, the participant acknowledged that it would have benefited her to have had some time to herself, which may also have helped her to cope in her role as primary carer.

What Parents felt they needed to Discuss

All parents were certain that it would have, or, actually did help, to be able to talk to either other members of carers’ groups, or a psychotherapist or psychologist to gain information and support. The importance of these opportunities is indicated by the strength of feelings experienced by parents, especially at the start of the illness when “it was the end of the world really. I don’t know that one can accept it from the beginning” (pH). The necessity of being given support and skills to help parents accept and manage the illness may have helped the same respondent who also said
that “it [the illness] becomes a major part of your life and you feel as if you are living on a time bomb, because you don’t know what’s going to happen next.”

One of the issues which seems to concern most parents is the dilemma of what to do when their son or daughter stops taking their medication, as pB explained:

“He’s [her son] thought about stopping his injections .... which I’m very concerned about .... I feel that I should tell the nurse .... that deals with him .... but I don’t want to feel disloyal to him .... by doing this sort of thing.”

Participants expressed feelings of divided loyalty between doing what is best for their ill child’s health (contacting psychiatric services) and respecting their child’s wishes (to stop taking medication). Parents seemed trapped because they seemed to understand how difficult it must be for their children to maintain their medication, but also felt that in the absence of professional help, they themselves should persuade their children to take their medication. PC explained that “they don’t like taking the medication, you can’t blame them for that .... you can see the person going downhill and there is nothing you can do .... I would just like to know there was someone I could contact before it gets out of control.” It seems that what is meant by ‘there is nothing you can do’ was explained by pE who said that “even when they [psychiatric services] acknowledge he’s [my son] on a downward slope there’s not much they can do .... they can’t do anything until he gets so bad they can do a Section III of the act.” Once again the emotional impact of such a dilemma became clear when one parent whose son is currently refusing his medication said:

“You cannot describe how I feel, my world is coming down again .... nobody will take this pain away .... Now I feel at the moment I have a knot in my heart.” (PA).
A further issue which a few parents had previously spoken about and felt doing so had helped them was "finding there was a genetic component to it .... It was a relief" (pF). This seemed to have taken the burden of guilt off the mother who expressed such relief.

Another parent (pH) who had seen a psychologist said that speaking to her "did help us and through that we helped him in a way, because calming us down must have helped him in the end". The benefits of talking were reiterated by pB who said "it helps you to release your feelings, you know your frustrations". It is implicit in such comments that coping with an illness such as schizophrenia can be frustrating and stressful and the benefits of releasing emotional tensions evident. However, only one member of the group of ten participants was guided by his son's psychiatrist towards any form of emotional support (the NSF). It may be that many parents share the view of pG who said that "whilst the emotional things are there, it's best to rise above it .... my approach is to be pragmatic and keep emotions out of it, because they only weaken you .... However, I'm sure talking to someone can help you to take the steam out". Another parent (pA) also felt that talking was ineffectual and said that "the only thing that will make me happy is to see my son happy".

One parent did seem to speak for several others when she said that "I would have liked to have talked and to have learned how to treat her" (pF).

Finally, it seemed that all participants were in agreement that "you have to accept that it is not going to get any better [,]. There is no cure and all that can happen is that you accept it" (pH). "It's a lifelong illness [and] it's got to be managed like you manage diabetes" (pC). It seemed that once participants had accepted that their child's mental health problem was an enduring and treatable illness they re-gained a sense of control over their lives and seemed not to possess the strong feelings of
powerlessness, which were suggested in the earlier themes. Having found ways to manage the illness one participant (pF) stated "it's important to have a life of your own", to avoid being identified solely as the mother of someone with a mental illness.

Parents' Beliefs about what would Help their Children

Participants seemed to be drawing attention to the powerlessness experienced by both carers and health service professionals in ensuring that patients maintain their medication. In response to such difficulties parents believed that services could be improved to take some responsibility off them, for example:

“There should be counselling or psychotherapy and so on to go with it [medication], so that the importance of maintaining the medication is driven home .... We’ve had a number of psychiatrists who have dealt with him [our son] and two or three of them should be drummed out of the profession. I don’t think they had any sympathy or empathy with the patient and have pretty fixed ideas that if you pump in enough drugs that'll do the trick.” (PE).

Evidence that such an idea may help patients to continue to take their medication came from pF who reported that her daughter “had psychotherapy which was very very helpful, cognitive-behavioural, I think it was” and had never stopped taking her medication.

A few other parents suggested that a psychological intervention may help for a different reason, this being that “they need understanding .... They need to have someone to tell how they feel .... They need someone to talk to them about their feelings” (pA). It was implied by many participants that it is sometimes inappropriate
for children to talk to their parents about how they feel. Perhaps this is because as the main carers parents are unable to be unbiased listeners because of their personal involvement and feelings for their children.

Despite believing that the involvement of another type of mental healthcare professional such as a counsellor or psychologist would possibly benefit the patient, parents gave the impression that their children did not receive help other than in the form of medication. PC suggested that “there should be some kind of opportunity for them to actually feel they are doing something worthwhile,” and pA said more specifically “they .... need some activities, some consolation, [they need a] therapist or the gym”. Where other people were in contact with their children parents were appreciative, for example pD said that “being with normal people [at college] has helped him [my son] a lot” and that “they [people with mental illnesses] must be very lonely” people because the “illness itself makes him [her son] isolated .... he could do with some help getting into a social group” (pC).

In conclusion, the last two themes have shown how parents perceive health and, possibly social services could be improved to help their children and themselves, as carers. It seems firstly, that dissatisfaction arises from parents feeling it is not enough to only provide treatment in the form of medication. Secondly, because practices (such as psychological interventions) which may ensure that prescribed medication is taken regularly are not in place an added burden seems to be placed upon parents. And lastly, parents suggested that until the patient’s mental health has sufficiently deteriorated, and Section III of the Mental Health Act is imposed, further treatment cannot be provided. PH suggested that “once they’ve been sectioned and they’re discharged .... they should have the follow-up and I don’t think they all get it”. Perhaps she is suggesting that ‘follow-ups’ would help to maintain contact between
patients and psychiatric services which would take pressure off parents which it has been seen leads to feelings of divided loyalty, in their positions as ‘go-betweens’.

Perception’s of Society’s View of Mental Illness

Some of the difficulties that participants encountered regarding the treatment of their children by health and social services may have been hard to cope with because of the stigma that is attached to such illnesses as schizophrenia. All parents at one time or another chose not to tell other friends or relatives about their child’s mental illness, because as pF said “most people think it’s a Jekyll and Hyde situation, you hide it under the euphemism nervous breakdown; people are afraid of schizophrenia”. Virtually all respondents felt that “people withdraw from people where they’re afraid of these sort of archetypal displays of mental illness like Jack Nicholson in ‘The Shining’”. Thus, not being able to talk openly seems to have left parents isolated (until they joined carers’ groups) and unable to get emotional support from friends and relatives because of the perceived fear that other people have about mental illness.

Respondents were fairly clear about what other people’s preconceptions were about mental illness, possibly because prior to their own child’s mental health problems they held similar beliefs. Nearly all participants felt that other people “think they (people with a mental illness) are violent people” (pA) and “are frightened of it really .... because you read in the papers of the horrific incidents” (pH) and that it’s ‘the fear of the unknown more than anything else’ (pC). Interestingly, ‘the fear of the unknown’ reflects participants’ fears that they reported earlier in the interview, during the initial stages of their own children’s mental health problems. As pC explained “it’s very frightening for you as a parent, it must be very frightening for them as a patient also, but I think this is an illness where everybody suffers”. It
seemed that after receiving the information they so longed for parents' fears were somewhat alleviated. Possibly as a result of this learning experience parents were keen that other people should know some of the things that they now know in order to detach stigma from mental illness.

The effect of informing others may be perceived to be that people would be less avoidant, more understanding and friendly towards people with mental health problems. Prior to being informed one parent (pH) said "you don't know what people are going to do and you can be worried", however she added "it's very sad for sufferers because most of them just aren't violent at all and the only people they would inflict any injury on is themselves".

In addition to wanting people to know that their children are unlikely to inflict harm on others, parents were to keen to say that their children are intelligent. However, several parents suggested that "I think they [other people] think they're [people with mental health problems] simple, like when they see the Mongol people" (pJ) and "they don't know how to react, or people will think he [her son] is completely stupid" (pD). Most parents believed that all these reactions are present because "people aren't able to deal with it [mental illness] .... I think it's just basic unawareness" (pC) and because "on the whole people don't really want to know" (pB). This ignorance and desire not to know about mental illness may explain the participants' lack of knowledge and fear prior to their own information-gathering when their child became ill. Consequently, their experience has differentiated them from the general population as pF said "it's an illness with so much stigma attached to it that you don't want to broadcast it to people if you can help it."
Parents' Perceptions of Efforts to De-Stigmatise Mental Illness

Despite about half the participants feeling that they didn't want to tell friends and relatives about their child's illness, all wanted the general population to become more aware and educated about mental illness. Most parents agreed with pE's statement that "I would like to see it brought much more into schools in discussions of illnesses of different types". It seemed that since learning about a specific mental illness through personal experience a few participants agreed that "my knowledge of the illness has been improving and maybe now it is like I am teaching the others .... so I will try to inform people when I can" (pD).

Most participants could already perceive an improvement in people's knowledge about mental illness compared to that of their parents' era, for example pH said that "in that era it [mental illness] wasn't spoken about at all, it was taboo really and I don't think it is taboo any more .... However, I don't think it gets the attention that AIDS or cancer get and yet I think it's probably just as bad". PF felt that "the older generation just wouldn't understand at all. They think of people being shut away in mental homes. I think the younger generation are much better informed".

There was a feeling that participants would like people to be better informed and are irritated that other illnesses such as AIDS and cancer receive more public attention than mental illness and specifically schizophrenia. PF said that "it's [media attention] mainly about manic depression. I think because it's [schizophrenia] the illness that's got the most stigma".

It was implied that added media coverage would make people more understanding, which may make it an easier subject for parents to talk about with friends and relatives. However, in most cases members of the immediate family seemed to
provide each other with a special kind of support that people outside may not have been able to give, as pG said “we discuss matters between ourselves .... from a social standpoint, outside the family nobody would understand.” In addition to a lack of understanding, participants kept discussion within the family because “people don’t like to discuss these kind of things, you know when they have got something in the family .... it used to be a terrible shame at one time” (pB). Even within families it seemed that there were often difficulties in accepting the illness, as one participant said “my husband wouldn’t accept it [schizophrenia] for many years, you couldn’t mention the word schizophrenia” (pF). However most felt “it’s terribly important not to be ashamed about it”, probably because being ashamed may hinder people from trying to understand the illness.

Implicit in the wish that other people become better informed was the message that they would like such individuals to see people with a mental illness as being afflicted with an illness and not merely as violent and stupid people. PA said she would like people to know that their children “are not all mad people, they are sick people,” and pE stipulated that “mental illness is an illness and is a physical illness as well, the difference is it’s not visible”. Ideally it seemed that all participants wanted people “to know that it’s an illness that requires treatment and caring”. Possibly parents would like to be able to talk about their child’s ill-health as if it were a physical illness, in which case none of the stigma and beliefs such as it being the mother’s fault would prevent them from being able to speak openly about it.

Difficulties, such as stigma seemed to have made participants aware of any media presentations concerned with mental illness, which they felt contributed greatly to people’s perceptions of people with mental health problems. For the most part parents felt that people had adopted negative opinions of people with mental health problems because “the media do seize upon isolated incidents so they [other people]
think .... all of them [people with mental illnesses] are running round with weapons to duff up anybody in sight” (pE). In contrast to this however, there was a belief that “there have been some quite good programmes on the television .... and in the commentary side [of newspapers] .... some articles .... have been fairly constructive and helpful” (pE).

Another subtheme was that half the respondents praised the way in which a televised soap opera had featured a young man suffering from schizophrenia and had sought advice in preparing the script for the character. PF commented “I think it was so important that 'EastEnders' approached the NSF to ask if they could help”, because there seemed to be a feeling that ‘an educational process’ via the media would help to raise awareness and understanding.

The Emotional Impact of Mental Illness

It seemed that participants’ enthusiasm for education about mental illness through the mass media, schools and personal contact may have been fuelled by the emotional impact of being the parent and one of the main carers of an individual suffering from a stigmatised illness. In many cases it seemed that “it’s very frightening for you as a parent, it must be very frightening for them as a patient also, but I think that this is an illness where everybody suffers” (pC). Throughout each of the interviews the emotional impact of the mental illness on the sufferer’s family was evident. Some families had had to adapt in order to avoid upsetting their ill son or daughter, for example pF said that “my husband and I have not dared to have an argument in the last 23 years .... she [our daughter] very often misjudges atmospheres .... so that’s been a terrible strain on the whole family”. PH said “we [she and her husband] feel we've given up a bit of privacy in our retirement and we've given up holidays".
Despite the adaptations that participants reported having made to their lives, none seemed resentful, but appeared glad to have found ways to cope with the illness.

Another effect of the illness is that the amount of attention required by the ill child often seemed to lead mothers to believing they had neglected their other children. One mother's (pD) (well) son told her "when things went wrong you were not there". Another (pF) said "I think with hindsight it all had a terrible effect on my youngest daughter". Understandably these feelings were only expressed by a minority of mothers whose children had become ill during childhood or adolescence. However, the effect of being unable to give each of their children the same amount of care and attention seemed to have left these mothers with guilt feelings, despite circumstances making it unavoidable that their ill child should rob siblings of equal amounts of parental attention. Such parents expressed the opinion that if they had had the chance to talk about these concerns their anxieties may have been less intense. Another mother whose son has left home and whose children are all adults still expressed the feeling that her ill son occupied most of her time and energies by stating profoundly "all my life is my son" (pA). However, despite her current willingness to ensure she cares for him, she expressed concern about the future in the statement: "I may be here now but I may not be tomorrow". This was not an uncommon concern as another participant (pH) said "you know it's a bit like a life sentence" and "I am actually much more concerned that he should actually get to be in control of himself, I'm not going to live forever" (pC). It is possible that these parents would not express such concerns if their children were diagnosed with physical illnesses. Having recognised the stigma which is attached to mental illness it could be hypothesised that their worries are a response to beliefs that other people would not want anything to do with their children, let alone care for them as they have.
In summary, many varied practical and emotional pressures were reported by all parents involved in caring for a child with a mental illness. However, they seemed to have accepted that such a situation was permanent and consequently had made the appropriate life-style and attitudinal changes in order to be able to cope with it as best they could.
Discussion

The scale and nature of this study render it inappropriate to draw conclusions from the data which may be applied to groups of individuals other than those who participated in the study. There were methodological problems in the way in which the sample was recruited which mean that it was a self-selecting group of individuals who had sought support from a charitable agency running carers' support groups. Unfortunately due to the sensitive nature of the subject it was not possible to contact parents who had not become members of organisations such as the NSF. Interestingly, no members of the MDF volunteered for the study, but this was probably because the method of recruitment was an advertisement in the MDF newsletter (a less direct approach than was the case with the NSF, who met face to face with the researcher at carers' meetings). However, there is the possibility that parents of schizophrenics volunteered because they were very keen to express their opinions. The nature of the illness is such that participants felt it to be more stigmatised and less well-understood than depression or other mental illnesses.

Another interesting characteristic of the sample was the ratio of men to women. Although four men participated, only one was not volunteered by his wife and saw himself as the primary carer. This situation seemed to reflect the fact that responsibility for care of the patient lay primarily with the mother in all but one of the ten families encountered. Unusually all participants were still married to the other parent of their ill child. In contrast to many previous studies (Brown, 1966) which indicate that mental illness places strain on marriages which frequently end in divorce, all participants had succeeded in maintaining mutually supportive relationships with their partners.
It is possible that as members of established and well-respected support groups the participants who volunteered were unrepresentative because unlike other parents who are possibly alone with their mentally ill children, these individuals may be coping well because of the support they receive. Also being in supportive marital relationships may have helped all ten participants to cope better than single parents.

It may be concluded from the interview material acquired that contact with such groups may have provided the chance for parents not only to gain important information about the illness, but also a chance to identify with other parents in a social group in which they felt they belonged. All parents interviewed remembered how joining the group (whether at an early or late stage in their child’s illness) provided them with information and support that had not previously been offered by social or mental health care services.

Prior to joining the group, many parents reported feelings of confusion, devastation, trauma or felt that they were to blame for the development of their child’s mental illness (especially mothers). In many cases these feelings seemed to threaten the identities of some parents who were often only helped to re-establish a positive self-image once they had ‘accepted’ it was an illness with a ‘physical’ or ‘genetic component’, thus relieving them of the burden of responsibility for its onset. Often it seemed that the psychiatric services encountered did not help to dispel myths that mothers’ relationships with their children could be wholly responsible for their offspring’s breakdowns. Fortunately, however, it seems that those mothers who expressed such feelings were reflecting upon experiences of between 15 and 24 years previously, suggesting that current practice is not to place blame upon mothers.

Despite there being only a small minority of participants who themselves had received professional help in the form of psychological or psychotherapeutic interventions, nearly all parents said they would have liked to have had the chance to
talk about their feelings, when coming to terms with the illness was most painful. It seemed that discovering the NSF provided most participants with a lot of the knowledge and support that they required. However, in many cases it seems that a more personalised one to one relationship with someone outside the family would also have helped the transition from the shock of learning about the illness to accepting it, as well as enabling parents to talk about anxieties such as feelings that they were neglecting their other children. Possibly because much attention was directed at the person with the mental illness at the time of most stress, most parents in this study tended to neglect their own needs and probably did most of their reparative work at a later stage after they had accepted the illness.

It seemed that participants felt that the key to coping emotionally and practically with their children’s mental health problems was acceptance. This seemed to coincide with parents learning how to manage the problems by making the appropriate changes to their life-styles and ensuring that their emotional needs were met, both of which appeared to be satisfied by joining the NSF carers’ groups. It is possible that prior to discovering a group of other parents in a similar position to their own, participants felt that they could not conform with the social groups in which they found themselves because others could not identify with the role of a carer of someone with a mental illness. Having the chance to speak without fear of stigmatisation may have alleviated participants’ poor self-image and feelings of isolation.

Asking parents how they thought other people perceive people with mental illnesses seemed to provide an indication of current and past social representations of the mentally ill and specifically schizophrenics. It was not clear, however, what the impact of increased care in the community may have had upon perceived social representations. A discussion of how people are informed about mental illness and
Research Dossier

how views can be changed demonstrated how the participants themselves had altered their own perceptions through self-education and meeting with other parents in order to avoid a threat to their own identities.

Some respondents had avoided telling others about the illness in order to avoid potentially difficult future relations with those people whom they felt would not be as understanding as they themselves had become. In contrast others had educated those close to them, which may have benefited their cause by correcting any misconceptions about the nature or causes of the mental illness. A positive reflection on this discussion was that parents felt that mental illness is no longer the taboo subject it once was and in certain media contexts a more favourable and educative picture is being presented, resulting in the younger generation being better informed and accepting than their older counterparts. Due to participants’ own improved knowledge, personal interest in this area and contact with other sympathetic and informed individuals it is possible that such an impression of current trends was overly optimistic. Nevertheless, it seems that the views of participants does reflect some degree of increased media interest in mental illness, possibly because increased care in the community has heightened curiosity about the subject.

The heterogeneity of the sample meant that it is possible to tentatively make comparisons between the experiences of those parents whose children first became ill approximately two decades ago and those who have such experiences dated within the last ten years. Although the number of hospital admittances appears to be dictated more by the nature and severity of the illness as well as many other variables, it seems that parents have noted a slight positive change in the quality of services provided as opposed to a mere decrease in in-patient admissions. Included in these improvements were the informing of one parent of the NSF meetings by a treating psychiatrist. However participants presented many more suggestions for improving
health and social services provisions, including psychological interventions, better out-patient supervision and opportunities for some ‘worthwhile’ patient activities.

Conclusions

Implicit in all the interview material collected in this study was a dissatisfaction with the way in which parents have been treated by the psychiatric team or GP involved in their child’s diagnosis and treatment. Recommendations for how improvements could be made varied from very simple suggestions such as all carers of people with mental illness being provided with a leaflet informing them of the NSF, to ones where a solution is less easily devised, for example the issue of what a parent should do when they know their child has stopped taking their medication and their mental health is deteriorating. The intensity of emotion expressed during interviews suggested that most parents had not had the chance to convey their dissatisfaction with the treatment services before this study; they were keen to know whether their views might eventually be heard by those in the profession who might actually attend to their grievances and suggestions.

Finally, it seems important to conclude by suggesting that in light of the increased moves to maintain psychiatric care in the community, more attention should be paid to the individuals who spend the most time and energy caring for people with mental illness. According to participants in this study this should take the form of adequate provision of information about the illness and its treatment, immediate provision of information regarding support groups and the opportunity for a one to one psychoeducation or therapeutic intervention.
Bibliography


Research Dossier


The aim of this research is to investigate the experiences of parents of people who suffer from a severe mental health problem and to look at how they cope with their experience.

You will be asked to take part in an informal interview about your experiences of this subject. The interview will be recorded on audiotape so that, in writing up the research people's experiences can be cited accurately. Naturally, to protect confidentiality the researcher will not quote any identifying information such as names and locations. In making transcriptions, therefore, your name will be replaced by a letter and the names of other people or places that may arise during the course of the interview will not be recorded. Once transcribed the audio-tape will be destroyed.

If you have any questions or feel you would like further information about this research please ask the researcher before reading on.

Please read the following paragraph and if you are in agreement, sign where indicated.
I agree that the purposes of this research and what my participation in it may entail have been clearly explained to me in a manner that I understand. I consent to be interviewed about my experiences of being the parent of a person who suffers from a severe mental health problem. I also consent to an audio-tape being made of this discussion and to all parts of this recording being transcribed for the purposes of research.

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

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

Signed ................................................ Date ....................................
Demographic Information Questionnaire

Please tick the appropriate response or write in the spaces provided.

1. Please indicate your gender:
   Male .....  Female 

2. How old are you? ..... Years

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

4. What is your occupation? ........................................

5. Family make-up:
Research Dossier

(a) What is your marital status?

Single ......
Living with partner ......
Married ......
Separated ......
Divorced ......
Widowed ......
Other (please specify:........................................)

(b) If living with a partner, is this person the parent of your son/daughter who suffers from mental health problems?

Yes ...... No ......

(c) Do you have any daughters?

Yes ...... No ......
If yes, how old is she/are they? ...... Years old

(d) Do you have any sons?

Yes ...... No ......
If yes, how old is he/are they? ...... Years old

(e) Do they all live at home?

Yes ...... No ......
Research Dossier

If not, where do they live?

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

(f) Do any other relatives live in your family home?

Yes ..... No ..... 

If so, who are they?

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

(g) Are there any other relatives who frequently visit your home or take care of your child/ren, such as grandparents, aunts, uncles etc.?

Yes ..... No ..... 

If so, who?

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

Thank-you for completing this questionnaire, please let the researcher know that you have finished and are now ready to begin the interview.
Appendix C

Interview Schedule

Introduce research and explain about tape recorder, gain consent and signature on consent form.

Ask if there are any questions participant would like to ask prior to the interview. Explain that there are some questions which it might be difficult to respond to and tell participant that they can tell me to go on to the next one if this is the case or indeed if they want to terminate the interview at any time.

Section I: The Psychiatric Patient

For NSF/MDF only:

1. Which member of your family suffers from schizophrenia/depression/other mental illness?

For unspecified carers only:

2. What is your ill child diagnosed with?

3. Do you remember how old your son/daughter was when you first knew that they had a mental illness?

Prompt: How did you feel when you first learned about this?

4. Do they receive any type of help for their illness?
Prompt: Do they take any medication or see someone to talk about their problem?

5. Have they ever been admitted to hospital, how long for? and when?

If the response is no, go to question 8 immediately.

6. How did you feel when they were admitted to hospital?

Prompt: Why do you think you felt like that?

If a positive response go straight to question 8.

7. Can you think of anything that would have helped you to feel better about them going into hospital?

Prompt: How would that have helped you?

8. Would you find it useful if someone was able to tell you more about your son’s/daughter’s illness?

Prompt: Can you tell me what it would be useful to know more about?

What difference do you think that might make?
Section II: Information gathering about participant's understanding of their child's illness.

1. You said that your son/daughter has depression/schizophrenia/other. Can you tell when he/she is not well because of their illness?

If an example is also given go straight to question 3.

2. Does he/she act in unusual ways that are different from normal?

Prompt: Can you give me some examples?

3. How does it make you feel when he/she does that/is like that?

Prompt: Do you feel like that just when your son/daughter does that or all the time when they are ill?

When someone is ill it often affects relationships with their family and friends.

5. Can you think of any ways in which your relationship with your son/daughter changes when he/she is ill?

Prompt: Can you give an example of that?

In what way does he/she act differently with you?

In what ways do you act differently with them?

Question 6 is optional for use when the respondent has given very brief answers to the above questions.

6. How does it make you feel when things are different between you and your son/daughter because of their symptoms?
Prompt: What makes you say that?

7. Do you ever worry that you could be saying or doing something to upset your son/daughter when she/he is ill?

Prompt: If respondent gives an example of a time when they thought they had said something to upset their child ask:
How did you feel when you felt you had upset your son/daughter?

Quite often people feel that there was something they could have done to prevent someone from getting ill again, or think that they must have done something to make that person act differently.

8. Do you ever think these things?

Prompt: If yes:
Can you give an example of that?
What do you think you do/could have done to make your son/daughter act differently?

If more appropriate place this question at the end of this section

9. How does it feel to be thinking and talking about these things with me?

Sometimes it helps people who are worried about their ill son/daughter to share their feelings with other people.

10. Can you think of a time when you have ever talked about your feelings with anyone else?
If no, go straight to question 14.
Research Dossier

Prompt: If yes:
Who was that person?
Why did you choose to speak to that person about your feelings?
What were you feeling when you decided to tell that person?
If participant spoke to everyone:
Who was particularly useful to speak to?
Was there anyone who did not respond how you had hoped they would?
Why, what did they say?

11. Can you remember if it helped to have someone to talk to about your worries?

If no, go straight to question 14.
If yes:

12. What did that person say or do that helped you?

Prompt: How did that help? Anything else?

13. Was there ever a time when you chose not to talk to someone about your worries (about your son/daughter’s illness)?

Prompt: What made you decide not to discuss these worries?

Go straight to question 15

If no:

14. How do you feel about not being able to talk about your feelings about your son/daughter?
Prompt: How do you feel about that?
15. Can you identify what it is about your feelings about your son’s/daughter’s illness that is difficult to share with (some) other people?

Prompt: (For those that could talk about their feelings to others) How do you feel when you are unable to talk about these feelings?

16. How do you think it would help if you felt able to talk about these things with other people?

17. Do you think it would be helpful to talk to people who know about schizophrenia/depression/other?

Prompt: Why do you think this is/isn’t important?

18. What helps you now to feel and manage better when your son/daughter is ill?

Prompt: How does/would that help?

19. Is there anything else that might help you feel and manage better when your son/daughter is ill?

Prompt: How would that help?
Can you give an example of what you mean?
Section III: Other people's understanding of mental illness (Social Representations)

I would now like to go on to look at other people's perception and understanding of mental illness.

1. You said earlier that you can/cannot talk with friends/relatives about your son's/daughter's illness. What is it about him/her/them that allows you to/stops you from talking to him/her/them?

   If they can talk to others:
   Prompt: How does he/she/they show this?
   What do they say or do to make it possible to talk to them?

   If they cannot talk to others:
   Prompt: What do they say or do that makes you feel unable to talk to them?

   Lots of people don't know anyone who suffers from a mental illness and have a limited understanding of what it is like to live with someone who is mentally ill.

2. What do you think other people think about people with a mental illnesses?

   Prompt: What makes you say that?
   Do they see it the same way as a physical illness?
   What makes you say that?

3. What, if any, undesirable traits or behaviours do people associate with people who have a mental illness?

   Prompt: Is there an element of truth in any of these beliefs?
   What makes you say that?
Research Dossier

How do you feel about these beliefs?

4. What do you think are the sources of these beliefs?

Prompt: What do you think people learn from that?
What makes you say that?

5. You have told me how you think other people view people with mental illnesses. How do you feel about how mentally ill people are represented in our society?

Prompt: What makes you say that?

6. What, if anything, do you think could be done to help people to be more understanding and sympathetic towards people with a mental illness?

Prompt: What makes you say that?

7. What, if anything, would you like people to know about mental illness from your own experiences?

Prompt: If people knew that, what difference do you think that it would make?

Section IV: Participant's identity in relation to those social representations of the mentally ill outlined above.

We have discussed your own experiences and other people's views of mental illness. I would now like us to look at your feelings regarding those views.

1. Have you ever felt that you might be treated differently because your son/daughter is depressed/schizophrenic/other?
Research Dossier

If yes:
Prompt: What was your experience of this?
How do you feel about this?

If no:
Prompt: Is this because not many people know that your son/daughter is ill?
Do you think there are any reasons for this?
Go straight to question 4.

If yes:
2. Why do you think that people might act in this way?

Prompt: What makes you say that?

3. How do you deal with this treatment of you?

4. Do you ever worry that you (or any of your other children) might get ill like your son/daughter one day?

Prompt: What makes you say that?

5. How does it make you feel thinking about this?

6. When you think like this do you wish there was someone independent with whom you could talk?

7. Have you ever spoken to such an individual?
If yes:
Prompt: Who was that person?
How was that helpful?
8. Have you ever spoken to a health care professional, such as a psychologist or counsellor about the issues discussed during this interview?

If yes: How did you feel about seeing that person?
If no: What would you feel about speaking to such a person?

9. What, if anything, do you think would be/was helpful about speaking to a psychologist or counsellor?

Prompt: What makes you say that?

10. What would you want such a person to provide if you were to see them (again)?

Prompt: How do you think that might do that?
How do you think that might be helpful?

Section V: Closure of the interview

1. Is there anything that you would like to tell me about your experiences which I have not asked you about during the interview?

2. Finally, may I ask you how it felt taking part in this interview?

Prompt: Was there anything which was helpful or unhelpful about the questions I asked?
In what way was that helpful/unhelpful?

3. How do you feel now?
Research Dossier

If negative, prompt for feelings and check out with them where they can find support etc.

If you have found our discussion today helpful I would be pleased to offer you a follow-up session. Also, if you are feeling distressed as a result of this interview or if you feel that it would help you to get some support regarding what we have spoken about today I would be pleased to help you.

I would now like to end the interview by thanking you for your help in participating and by reminding you that all that you have said today will remain anonymous and confidential.
Chapter: Research Dossier
Year: 3rd
Title: A Qualitative Analysis of Clients' Accounts of their Eating Disorders: If and How Treatment Experiences Provide an Insight into and Aid Recovery from Eating Disorders
Abstract

Due to the notoriously high failure rate of eating disorder treatments, and the ever-increasing size of this clinical population it seems salient and necessary to attempt to discover which aspects of psychological interventions clients have found useful in helping them to overcome their eating problems. A counselling interview approach with a semi-structured interview schedule was used to elicit the personal accounts of ten female participants who had been diagnosed with an eating disorder and who had received some form of psychological intervention. The research aim was to explore firstly, if and how they had developed an insight into the link between their feelings and their disordered eating during or following treatment and secondly, if and how this had helped them to recover. Data were subjected to interpretative phenomenological analysis (Smith et al., 1997) which generated several common themes. These indicated that participants perceived there to have been precipitating events prior to the onset of their eating disorders which had caused them to seek a form of control in response to feelings such as a sense of inadequacy, ineffectiveness and low self-esteem. Their accounts described how they believed that therapy had helped them especially in developing a more positive sense of self through exploration of dysfunctional cognitions and developing interoceptive awareness through self-monitoring of eating disordered behaviour and feelings, and through positive identification with other eating disordered individuals in group situations, such as Overeaters Anonymous.
Introduction

Great interest in the research and documentation of eating disorders has been stimulated over the past thirty years by a marked increase in the recorded incidence of such problems (Bruch, 1978; Darby et al., 1983; Reeves & Johnson, 1992; Szmukler et al., 1995). For practitioners in the field, research findings are vital in gaining an improved understanding of how best to diagnose and treat this ever-increasing clinical population. However, follow-up studies, such as those summarised by Garfinkel & Gamer (1982) indicate that at least 30% of patients with anorexia nervosa were either dead as a consequence of their illness or still chronically afflicted at the time of follow-up. Only 17-40% of participants were symptom-free, whilst others continued to present with obsessive, compulsive or depressive symptomatology. Equivalent findings for individuals diagnosed and treated for bulimia nervosa indicate that at least one in four cases at follow-up is perceived as a treatment failure (Mitchell et al., 1989) with enduring symptoms not only concerning eating behaviour, but concomitant dysfunctioning in interpersonal relationships, anxiety problems and depression (Zerbe, 1993).

The Etiology of Eating Disorders

The findings that eating disorders are notoriously difficult to treat successfully may be due to their complexity. Although it is not difficult to distinguish the clinical features of an eating disorder from other mental health problems, there appears to be no single pathogenesis. It has been suggested (Garfinkel & Garner, 1983; Garner, 1991) that there are a number of predisposing factors common to most eating disorders, but dependent upon the timing and interaction of them an individual may or may not develop such a problem.

Predisposing factors include those which relate to the individual’s difficulties in autonomous functioning, sense of personal identity and sense of mastery over their own body. In 1973, Hilde Bruch attributed these to fundamental ego deficits, and
although some psychologists may not describe them as such (depending upon their theoretical orientation) they are factors which are generally agreed to form the basis of all eating disorders etiology (Szmukler et al., 1995). Bruch (1973) indicated that these deficits are responsible for the later development of body image and interoceptive disturbances in restrictive and purging anorexics. Disturbances of interoception are described as the inability of individuals to label or describe the emotional arousal they experience (Bruch, 1985). Interceptive disturbances are often associated with alexithymia (Lesser, 1985), which is a disruption of both affective and cognitive processes which leaves individuals experiencing relatively undifferentiated emotions and thinking, so that they tend to dwell excessively on the mundane (Reber, 1985). Body image distortions, on the other hand, are attributable to perceptual disturbances which are responsible for incorrect self-perceptions of body size and internal visceral states, associated with a fear of a loss of control which have been identified in all types of eating disordered individuals (Bruch, 1973, 1978, 1985; Garfinkel & Garner, 1983).

Those personality and behavioural vulnerabilities which are most strongly associated with risk status for eating disorders have been found to be not only a lack of interoceptive awareness and body image dissatisfaction, but also negative emotionality (high stress reactivity and generalised negative arousal) (Leon et al., 1993). Recent research by Taylor et al. (1996) has found that there are also significant links between alexithymia and other psychological and cognitive characteristics associated with eating disordered individuals. One of these was previously identified by Selvini-Palazzoli’s (1970) and Strober’s (1991) work which highlights the sense of personal ‘ineffectiveness’ common to individuals diagnosed with anorexia and bulimia. This has been perceived as symptomatic of the anorexic’s unpreparedness for maturity and increased responsibilities during adolescence (Crisp, 1978; Rodin et al., 1990) which was confirmed by Taylor et al.’s (1996) study which revealed participants’ fears about maturing.
Another potential predisposing factor is concerned with personality structure. There have been disputes within the field challenging the opinion that obsessional or hysterical traits typically form part of the picture of eating disordered clients (Morgan & Russell, 1975; Slade, 1982; Levy & Adams, 1998). More commonly, compliance, perfectionism and dependency have been believed to be characteristic of this clinical population (specifically, clients diagnosed with anorexia or bulimia) (Bruch, 1973; Guidano, 1987). These traits manifest themselves in the setting of high personal standards, conscientiousness and conformity. Johnson & Connors (1987) have suggested that reliance on external rather than internal cues in the need for approval from others is a response to the combined sense of personal ineffectiveness and lack of interoceptive awareness that was indicated earlier. It is perhaps this dependence upon others that leads researchers to propose that anorexia nervosa and bulimia nervosa are linked to difficulties in separating and individuating from parents (Bruch, 1978). Evidence concerning this factor is mixed (Lyon et al., 1997) but it is generally accepted that such individuals have low independence within the family (Williams et al., 1990) as a result of their sense of inadequacy and low self-esteem.

The timing of the onset of an eating disorder in the presence of a number of the above predisposing factors is dependent upon events which affect an individual’s personal or emotional life. In some cases the onset does not coincide with any external event, but requires the individual to change their personal and social behaviour in response to biological maturation, for example (Garfinkel & Garner, 1983). No matter what the particular precipitating event is, the response is fairly predictable: the individual will experience a threat of loss of control, and/or a threat to, or, a perceived loss of self-worth. It is therefore theorised that in order to minimise this, the individual seeks a sense of control through strict control of their diet and weight in order to re-gain a stronger sense of self (Duker & Slade, 1988).

It should be noted that where the terms anorexia and bulimia have been used above in relation to theory or research findings this has been effected because the general term eating disorders includes binge eating disorder (within the eating disorder not
otherwise specified category (EDNOS) in DSM IV, APA, 1994). Research evidence concerning its etiology is sparse, probably because it was identified within DSM IV (APA, 1994) only four years ago. According to Fairburn et al. (1992) it is probably more common than anorexia or bulimia with onset occurring later in life than that of the other two eating disorders discussed above. This indicates a slightly different etiology although similarities in clinical features have been found with regard to perceptions of loss of control over eating, perfectionism, standards for dieting, fear of weight gain, weight preoccupation, eating attitudes and depressive symptoms.

From the point of view of the mental health practitioner treatment may only succeed in the long term if attempts are made to alleviate 'symptoms' (starvation, bingeing and purging) through helping the client to recognise and respond to emotional and internal visceral states. This is done by addressing body image distortions, maturity fears, reliance upon external rather than internal cues and depressive thought patterns in order to develop a more secure sense of self. Cognitive behavioural approaches which involve monitoring behaviours such as eating, exercising, laxative abuse and vomiting may help the client to link stressful events and consequent negative feelings to their dysfunctional behaviour (Fairburn, 1983; Fairburn et al., 1993). This approach endeavours to encourage the client to identify and express feelings that would normally be buried, unacknowledged in their behaviour regarding food. Eventually it is observed that the dysfunctional behaviour is superfluous as the individual becomes more 'emotionally literate' and aware of their own needs, desires and personal identity.
Research Dossier

Research Aims

The acquisition of insight and interoceptive awareness in the eating disordered client is reported to develop during therapy at different rates (Duker & Slade, 1988). It is necessary, however, that it occurs in order that a stronger sense of self be created which may then lead to recovery from the eating disorder (Bruch, 1978; Szmukler et al., 1995). The aim of this research was firstly, to explore with participants if and how they experienced the development of interoceptive awareness and insight into their problems during or following treatment. Secondly, the research aimed to discover if and how this had helped participants in the process of recovery.

In an attempt to elicit such information, participants who have received some form(s) of treatment interventions were asked to discuss their personal accounts of their eating disorders and to suggest what helped them to overcome their problems. A personal account, for the purposes of this research, was assumed to be an individual’s ‘story’ of how their eating disorder developed, how it was perpetuated and how it was treated. It was assumed that all participants would have created a personal account, in the light of Harvey et al.’s (1990) work which suggests that following traumatic experiences such accounts are necessary because they perform four psychological functions. These are providing a sense of control over what happened, promoting self-esteem, emotional purging through the telling of the account and, finally, satisfying a need for closure, or bringing things to a proper end.
Research Dossier

Method

Participants

The criteria for participation in the research study were that participants should be adults (over the age of eighteen years) who had suffered with an eating disorder for a significant period of time (at least one year) which had been diagnosed by a medical or psychological practitioner and who had received some form of treatment intervention. Correspondence requesting participants and explaining what the research involved was sent to a University Counselling Service, Eating Disorders Association (EDA) group co-ordinators and Overeaters Anonymous (OA) group co-ordinators. Thus, participants were all receiving some form of treatment intervention and were considered to be involved in a process of 'recovery' from their problems, but were still experiencing difficulties regarding their eating behaviour. Group co-ordinators and counsellors then distributed handouts as they deemed appropriate to potential participants. These contained brief information about the proposed research interview and a means of contacting the researcher if they wished to participate (see Appendix A). By using this method of participant recruitment it was believed that individuals would be less likely to feel pressured into participating than if the researcher had contacted them directly, and could remain anonymous as the researcher was not provided with individuals' names or addresses.

Procedure

Arrangements were made with volunteers to be interviewed for the purposes of the research and whilst speaking to them on the telephone it was confirmed that they had been diagnosed at some point with an eating disorder, had suffered with it for more than a year, were still experiencing difficulties and had received some form of treatment intervention specifically for their eating problems (which could include attendance at an EDA or OA group). It was explained that they would be interviewed for an hour to an hour and a half about their experiences and opinions regarding their
eating disorder and that this would be recorded on audiotape. During the first part of the interview they were asked to describe the nature of their eating disorders which was then cross-referenced with the DSM IV (APA, 1994) diagnostic criteria by the researcher following the interview in order to ascertain that they fulfilled the criteria for either anorexia nervosa, bulimia nervosa or EDNOS which could indicate binge eating disorder.

In accordance with Turpin et al.’s (1997) recommendations regarding sample sizes for qualitative research at doctoral level, a minimum of eight, and a maximum of twenty individuals was required to participate in this interview-based research study. Possibly due to potential participants’ reticence in discussing personal and sensitive issues with a stranger for the purposes of research there was an initial low response rate from the sources targeted. This made it necessary to contact more self-help groups across a broader geographical area which accessed more volunteers. Eventually, due to constraints of time and resources and considering the length of interviews and the depth of analysis required, the first ten volunteers meeting the research criteria were those who formed the research sample.

An appropriate location for each interview was discussed and arranged with participants. A number of interviews took place in the researcher’s home and the others were carried out in participants’ own homes, with the exception of one which was done at a participant’s place of work.

Research Instrument

In research areas relevant to therapeutic practice it seems valid and important to learn from clients, especially those who have benefited from treatment, in a collaborative and mutually beneficial manner, using exploratory qualitative techniques. Hill & Corbett (1993) proposed that having understood what process components are effective, treatment approaches need to be developed and subjected to tests of efficacy. Thus, rather than devising treatment manuals for specific eating disorders it
would be suggested that those involved in the treatment of eating disorders first
determine the effective components from which to build an effective treatment
approach. Although this research is not proposed to be a 'test of efficacy' it is
anticipated that it may generate some useful and relevant experiential data from
which tentative conclusions may be drawn regarding what participants have
experienced as successful components of their therapy interventions.

The narrative richness of participants' self-reports of their experiences provides a
way of gaining access to their perspective on the world which is unavailable to the
quantitative researcher and is of considerable value to practising therapists
(Polkinghorne, 1991; Rennie & Toukmanian, 1992; Hill & Corbett, 1993; Cummings
& Hallberg, 1995). With this in mind the counselling research interview devised by
Coyle (1998) was the approach used for data collection. Due to the potentially
sensitive nature of the material it was believed that using counselling techniques such
as unconditional positive regard and empathy may enable participants to access and
describe in detail emotive (and other) experiences and beliefs. It was hoped that
using such skills as summarising and reflecting would also provoke exploration of
material in order to elicit rich and varied personal accounts and opinions.

Prior to the start of the interview participants were requested to read a consent form
(see Appendix B) explaining how the researcher anticipated maintaining participant
confidentiality and anonymity concerning the research material (audiotape
recordings, transcriptions etc.). Having read and understood the form all participants
signed it indicating their agreement to the terms presented therein.

Participants were then requested to complete a brief demographic questionnaire
specifying gender, age, ethnicity, occupation, marital status and living arrangements,
for example, living with spouse or partner, living with parents etc. (see Appendix C).
It was believed that such data may be useful in describing the research sample as well
as potentially helping to inform the interpretation of the interview material.
A semi-structured interview schedule was devised in order to elicit from participants how they remembered their eating disorder developing; what they believed the background or circumstances were which led up to it; the influence of other individuals and relationships on the development and progression of their eating disorder, and vice versa; the treatment they received for it; their understanding of their eating disorder and finally, if, and how they linked feelings to their disordered eating (see Appendix D).

The interview concluded with participants being given the opportunity to volunteer any other information which they believed may aid further understanding of their experiences or opinions. They were also asked how they felt upon completion of the interview and were offered a follow-up session if they felt it had been helpful discussing such issues or, if they required supportive counselling in response to any distress incurred by participation in the study.

The rationale for such an interview structure was that participants would be guided in a more or less chronological order through the history of their eating disorders and treatment experiences. In so doing, it was anticipated that they would be more likely to provide a comprehensive account than if they were not asked specific open questions about particular stages or aspects of their experiences.

A potential methodological problem concerned with the reliability of retrospective accounts could also be tackled to some extent by structuring interviews in order that each participant was requested to discuss their memories and opinions in as standardised a way as possible (as recommended by Brewin et al., 1993).
Data Analysis - IPA

Data were transcribed and subjected to interpretative phenomenological analysis (IPA) (Smith, 1996a) in an attempt "to explore the participant’s view of the world and to adopt, as far as possible, an ‘insider’s perspective’ (Conrad, 1987)” (Smith et al., 1997, p. 69). This was considered an appropriate approach for the analysis of the interview data which is rich in personal accounts and participants’ perceptions of their own mental health problems (thus, it is phenomenological). The aim of the analysis was to reflect and explore how sufferers perceived they had experienced their problems and treatment interventions and not to objectively measure treatment efficacy.

Another benefit of IPA is that it takes into account the fact that the research interview and analysis are dynamic interactions between participants’ accounts and the researcher’s interpretative framework (Smith, 1996b). In this case this reflects the researcher’s knowledge regarding the subject of eating disorders which has been influenced by relevant literature, counselling psychology training and therapeutic practice.

Following the transcription of all interviews, data analysis involved developing a familiarity with the data through listening to the audiocassette recordings of the interviews and reading the transcriptions several times. Emergent themes of concepts were noted down. These are defined as “patterns of variables involving similarities and differences among categories, and patterns of processes involving connections in time and space within a context” (Miles & Huberman, 1994, p. 246). Where there were similarities between themes within and across individual transcripts they were clustered together to form the main themes described in the analysis. These reflected the interview questions and specific aims of the research as anticipated. The way in which these related to one another was explored by the researcher using ‘spider diagrams’ or flow diagrams in order to graphically represent the links between these themes within the data set.
Considering this was a study of a sample of ten participants and not case study research, it is mainly only shared themes which are presented. These themes were concerned with responses to the research questions or were linked in some way to the literature concerned with the research topic. Thus, the main themes (but not the sub-themes contained within them) were predetermined to a great extent because of the structured nature of the interviews and the aims of the researcher to explore specific topics with participants.

**Epistemological Position**

Due to the occurrence of memory distortions and recall biases in retrospective data (Moss & Goldstein, 1979; Rubin, 1986) it is not possible to justify taking participants' accounts at face value when using this form of research methodology. It is likely that participants' accounts could have been influenced by the context in which they were given (Potter & Wetherell, 1987). For example, they could have given a more psychological account in the knowledge that the interviewer was training be a counselling psychologist than if a lay-person had been asking them about the same experiences. Therefore whilst it is assumed that the accounts reported may bear some relation to the actuality of the events participants were describing, the researcher makes no claims with regard to the exact nature of that relationship. Thus, any conclusions drawn concerning the analysis of participants' accounts of past events are tentative and their validity is dependent upon the extent to which the experiences portrayed are isomorphic with participants' accounts.

**Evaluation of the Analysis**

Following the advice of Smith (1996b) attempts have been made to present the analysis of the data in a 'transparent' form, i.e., raw data in the form of direct quotations from the interview transcripts are presented within the analysis in order that readers may evaluate the persuasiveness of the interpretations being made.
Research Dossier

regarding that data. Readers may check that participants' quotations have not been
taken out of context or are unrepresentative of the main body of data by referring to
an interview transcription which is also provided (see Appendix W in the separate
appendices).

The names of all participants and people referred to by them in the following section
have been altered in order to maintain anonymity and to protect confidentiality.

Participants' quotations are printed in italic script. The omission of material is
indicated by ellipsis points .... Clarificatory material that has been added appears
within [squared brackets].
Demographic Data

Ten female participants aged between 21-43 years with a mean age of 29.6 years (SD = 7.34) took part in this study. None of the participants was married, but one lived with her partner, another lived with her family, five lived with friends or fellow students and three lived alone. According to the International Standard Classification of Occupations (1990) which classifies occupations into ten separate groups, four participants were employed as ‘professionals’, three as ‘associate professionals’, two were students (one undergraduate, one postgraduate) and one was temporarily unemployed, but qualified to work as a ‘professional’.

The mean length of time since the onset of participants’ eating disorders was 13.75 years (range = 7-18 years, SD = 6.52). According to DSM IV diagnostic criteria (1994) four participants had suffered with anorexia nervosa, three with bulimia nervosa, one with binge eating disorder (within the EDNOS category) and two had suffered with all three eating disorders in the above order. At the time of the interviews five participants had recently attended Overeaters Anonymous (OA) meetings on one or more occasions; three were seeing clinical or counselling psychologists for treatment of their eating disorders and two had previously been in treatment (one as an in-patient in both a psychiatric hospital and a specialist treatment centre and the other received weekly counselling at her university), but no longer attended any groups or individual therapy.

Demographic data indicated that in terms of age the sample was older and had had eating disorders for longer than most participants involved in eating disorders research studies (see Fairburn et al., 1993). The impact of the long duration of participants’ eating disorders may have meant that compared to younger participants they had had longer to prepare their accounts of their problems and had been influenced by more life events, therapeutic interventions or eating disorders
literature, rendering their accounts more comprehensive and well-rehearsed. The significance of the data which indicated that none of the participants was married was not clear, but was remarkable considering the mean age of the sample. Whilst analysing the data it was considered that it may have implicated specific issues regarding participants’ interpersonal relationships or difficulties separating from their families of origin (Bruch, 1978). Judging from participants’ stated occupations all were well-educated and successful in their chosen careers. This implied that they were capable of becoming familiar with various theories of eating disorders etiology through reading relevant literature or via other media. Finally, the sample was diverse in terms of the eating disorders diagnoses they had been given and the treatment they had received. This variation did not reflect the relative occurrence of the different eating disorders in a normal population. However, this was unavoidable considering the difficulties in recruiting participants. Consequently, the sample is not to be considered representative of all eating disordered individuals and the conclusions drawn refer to eating disorders in general and not to specific diagnoses.
Theme One:
**Perceived Precipitating Events.**

Theme one was characterised by most participants attributing the start of their eating disorders to specific events that occurred when they were about thirteen years old. They indicated that sociocultural and familial pressures to be slim led them to believe that they would be better accepted and given more attention by others, increase their self-esteem and efficacy if they lost weight.

Most participants identified a specific event to which they had attributed the onset of their eating disorders. For example Beth stated:

"It started with a particular evening .... [a male friend] made a comment about his sister being podgy when I was actually larger than her .... and so I looked in the mirror and decided there and then there was going to be a change and so I started, yes, eating less and just eating less."

It seemed that Beth’s ‘intellectual’ decision to change her body shape following a comment about someone else was indicative of an underlying insecurity regarding her own body image. This type of implied dissatisfaction with physical self-perception is commonly reported as a major risk factor in eating disorders literature (Leon et al., 1993) and is often associated with a sense of ineffectiveness and low self-esteem which was portrayed by other participants in this study.

Several participants’ accounts suggested that the events precipitating their eating disorders were responsible for damaging their self-perceptions and confidence. For example, Gill stated that her will to lose weight was a reaction to "bullying and comments from peers and my own family [which] ruined my self-esteem. As a result I was determined to be thin".

Research Dossier
Accounts suggested that participants perceived that the only way they could re-build a positive self-image was by gaining confidence through changing their physical appearance by losing weight. Helen said “I had just broken up with a boyfriend and to get some esteem and to feel good about myself I thought I’d control my food and lose weight”. Thus there was a perceived causal link between control over dietary intake and an increased sense of self-esteem and confidence.

Participants suggested that they had felt in control again once they had started strict dieting. This links in with eating disorders literature which suggests that prior to the development of controlled eating such individuals feel what Strober (1991) referred to as a ‘sense of inefficacy’. Thus being able to control one’s food intake provides a sense of efficacy, autonomous functioning and mastery over one’s body (Szmukler et al., 1995) that was previously sensed to be lacking.

Common to all participants’ testimonies was that precipitating events were reported to have occurred at the age of about thirteen years, or, this was the age when they claimed they became aware that they had eating problems. This again concurs with research evidence regarding the common age of onset which has been often linked to maturity fears (Crisp, 1978; Rodin et al., 1990; Taylor et al., 1996). However, participants’ accounts did not suggest that they had made links between their age when they developed an eating disorder and fears regarding their increasing maturity. Instead they attributed their change in eating behaviour to their low self-esteem and dissatisfaction with the way they looked as suggested in participants’ accounts of their motivations to lose weight below.

Participants’ accounts reflected an increasing awareness of body image during adolescence and most reported being very sensitive to comments made about them which mirrored the fashion for women to be very slim. Fran grew-up in the 1960s and said that “Twiggy was our role model .... I was just so self-conscious about my figure”. She stated that looking back with hindsight “I don’t think I was even that much overweight”. However, she said she “felt different” from her peer group and
excluded from activities such as “going to Chelsea Girl for trendy gear - I couldn’t get into anything. I remember feeling so miserable and I guess I’ve always tended to blame my weight for all the problems in my life”.

The impact of sociocultural pressures to be slim were what Fran perceived to have influenced her desire to conform with fashionable female stereotypes when she was an adolescent. Her account suggested that she possessed cognitive distortions leading to the belief that her low mood and self-consciousness would be alleviated if she resembled a fashion model. The dysfunctional belief that everything would be better if she lost weight is apparently typical of eating disordered individuals’ dysfunctional thought processes and is frequently mentioned in eating disorders literature. Bruch (1979) suggested that particular deficits in conceptual organisation are responsible for cognitive patterns of ‘egocentric’ thinking (Piaget, 1955) which are characterised by dichotomous thinking, personalisation, rigid morality, viewing correlated events as causal and superstitious thinking (Vitousek & Hollon, 1990; Strober, 1991).

Fran was not the only participant who made the faulty cognition that if she was slim then the way she experienced the world would have been totally different. Familial pressures to be slim were evident in Emma’s account. She attributed this faulty belief to her mother buying fashion magazines when she was a child and “me comparing myself to the model in the magazine .... and thinking ‘why don’t I look like that’ and for years and years I’ve been waiting for that magic wand .... and I’d be thin and I’d look like Kate Moss and it would be great”. She also said “I went to an all girls’ school and it was quite competitive .... wanting to be under a certain weight was a definite thing .... I wasn’t particularly overweight .... it was really sickening”.

Implicit in such statements was a sense of blaming not only sociocultural pressures to be slim for the development of the eating disorder, but also familial pressures. The link between family cultures and eating disorders are documented in Kog & Vandereycken (1983) and Reeves & Johnson (1992) who identified an association
Research Dossier

between eating disorders and family cultures which consistently emphasise concerns about weight, eating, achievements and fitness.

Western cultural associations between thinness and success in all areas of life were also explicit in some participants’ accounts. For example, Fran’s account included the recollection of her mother saying that she “looked like the side of a house and that no one would ever want me”. Believing such comments had ‘made it necessary’ for her to take action to rectify her perceived weight problem, in order that she become slim and therefore more loveable or desirable than before. A few participants believed that those closest to them had reinforced their disordered eating behaviour by condoning these dysfunctional beliefs. This they claimed, explained their feelings of resentment, especially towards their parents. This belief is reflected in Gill’s comment “my family has made me feel very bitter .... they should have accepted me unconditionally”.

Gill suggested that what she thought about herself was partly dependent upon whether she felt her family could accept her no matter what size she was. Her dependence upon others’ opinions and her apparent reliance upon external cues in the need for self-approval rather than relying upon internal ones are documented within the literature as being typical personality characteristics of eating disordered individuals (Johnson & Connors, 1987). They are said to accompany traits of compliance and perfectionism (Guidano, 1987) which were evident in participants’ accounts of how important it was for them to be as thin as models (perfectionism) or to comply exactly with sociocultural ideals (compliance).

Some participants’ accounts suggested that they had construed their eating disorders as a non-verbal cry for help. Clare reported having no concerns about her weight before or during the onset of her eating problems, but she “instinctively” associated her anorexic behaviour with her own “neediness” following what she described as a serious accident:
"I remember feeling very needy and ... not exactly ignored, but people were too busy to sort of respond to my situation which was quite frightening."

Clare perceived there to have been a lack of parental concern for her following her accident. She explained that she had responded to this by letting her weight drop to only four and a half stone in order to elicit her parents’ attention. In some ways Diane’s account of her anorexic behaviour as a young child was construed as a similar kind of plea for attention: "I thought 'how clever I am at keeping myself so small and childlike' .... I just wanted some attention and some protection". Despite this non-verbal communication her anorexia failed to provide Diane with the support and protection she said she needed because she said that no one knew about the abuse until she disclosed about it when she was twenty years old. Her account suggested that what had maintained her anorexia were the psychological benefits of feeling clever and in control of her size which possibly combated the sense of inefficacy she had regarding stopping the abuse.

No matter what event participants attributed to the start of their eating disorders it seemed that being dependent upon other people’s views of them and needing to find a way of escaping feelings of inadequacy or low self-worth were common underlying themes within all participants’ accounts.
Research Dossier

Theme Two:
The Positive Aspects of having an Eating Disorder (Maintaining Factors).

The second theme was concerned with what participants perceived had maintained their eating disorders for several years. Following a precipitating event most participants suggested that they received positive attention mainly from family members when they lost weight which motivated them to continue trying to remain slim. A stark contrast emerged between the way anorexic and binge eating or bulimic participants felt depending on whether they were in control or out of control of their eating and weight. Some (mainly anorexic participants) discussed the sense of self-reliance and independence that they felt when in control of their food and weight. This contrasted with others (binge eaters and bulimics) who experienced swings between a sense of comfort during a binge which they related to being rewarded with food as children and undesirable feelings of guilt and depression following binges.

Emma suggested that being in control of her eating and weight meant that she felt good about herself because of how her mother reacted her:

"My Mum would deliver if I was thin .... I'm like the perfect daughter .... she always knew how much I weighed .... if you are fat you're lazy and you're a failure and if you are thin, you're wonderful and popular and you must be good".

Emma’s parent’s reaction to her when she binged and gained weight reinforced her perception that she was unacceptable when she was not in control of her eating. Thus, dependent upon whether she was bingeing or abstaining from food her self-perception changed dramatically:

"It's like being two different people .... there's a 'thin me' and a 'fat me' and there's never an 'in-between me' "
Emma’s perception of herself as two different people suggested the presence of a dichotomous thinking style which is theorised to be characteristic of eating disorders etiology and is apparently typical of the type of non-abstract thinking more associated with the thinking styles of children (Bruch, 1979). Feeling different depending upon whether she was ‘fat’ or ‘thin’ provided Emma with the desire to always be trying to lose weight because “I suppose in a way it’s attention-seeking because you get positive attention when you lose weight and you do get negative attention when you don’t”.

In contrast to the above case where Emma’s self-esteem was governed by how others perceived her some participants’ accounts (mainly the anorexic participants’) suggested that abstaining provided them with a way becoming less reliant upon others for approval or attention. Beth said that she became:

“a lot more controlling and became very, very self-sufficient in that .... I became very controlled in my homework .... I became unsociable .... I shut out my family a lot .... irritable, a real perfectionist. I hated the thought that I couldn’t do anything well”.

For some participants like Beth abstinence provided the impetus for gaining further control over other areas of their lives, such as academic work. Other participants suggested that food was the only thing in their lives over which they had a sense of efficacy and control. Thus participants’ accounts justified their abstinence from food because it served as a coping mechanism. For example, Helen stated “the only way I could feel good about myself, or the only thing I could control in my life was my food and weight”.

Clare’s account presented the idea that “the more control I had over every aspect of my life the more secure I felt, cos I felt that if I left it in other people’s hands, even my parents’, that I couldn’t sort of trust that, you know?”
Participants who had been diagnosed with anorexic described feelings of superiority through being able to wilfully refuse food. Helen apparently remembered "I felt better than other people and loved being 'special and different'". Diane said that "looking back I was obscenely thin but because people .... thought it was something to aspire to .... I felt great, great". Such comments possibly reflect the extent to which these participants' eating disorders seemed to have served to blank out painful memories and emotions.

In contrast to their anorexic counterparts bulimic participants like Emma stated that they experienced episodes when they believed they were:

"losing control totally and just bingeing absolutely out of control getting very obsessed with it. I can see it happening and I feel very sort of powerless to do anything about it".

The perception that bulimics and binge eaters lose control, are powerless, obsessional or compulsive around food has been suggested by some eating disorder theorists (Slade, 1982; Levy & Adams, 1998) as well as by OA addictions literature. Accounting for their binges in such a way may have served to reduce the amount of responsibility they felt regarding their eating problems. However, this perception probably added to their sense of inefficacy and increased the number of negative feelings they had about themselves.

Participants who binged attributed their relationship with food to early experiences when they said that food was often given to provide a temporary feeling of comfort by their mothers, or given as a reward. Ann reported that she remembered this happening to her and linked it to her current behaviour around food: "I have this sense of entitlement, I don't want to feel pain and if something goes wrong, I compensate myself with a bar of chocolate - 'I have been a very good girl today'".
Research Dossier

Bulimic participants frequently reported a stark contrast between the feeling of comfort provided during a binge and a sense of failure and guilt following it, to which they attributed their low self-esteem. Gill reported noticing a significant change in her mood when she became bulimic: "I became overtly depressed". Negative emotionality is apparently a strong risk factor in the development of eating disorders (Leon et al., 1993) and may account for the frequent low moods reported by nearly all the bulimic participants.

This theme demonstrates how participants perceived their eating disorders to have frequently provided them with a sense of efficacy, self-reliance, self-esteem or comfort. However, it is evident that these feelings were not constant and were often interspersed with feelings of a fear of a loss of control or depression. This leads to the third theme which is concerned with the negative aspects of having an eating disorder.
Research Dossier

Theme Three: The Negative Aspects of having an Eating Disorder.

This theme relates to how participants believed their eating disorders failed to provide them with the positive self-perceptions they initially sought. In spite of becoming secretive, deceitful, self-preoccupied and socially isolated many participants said that they had wanted to be helped but felt ambivalent about admitting to their eating disorders. Some suggested that being seen as a problem and not someone with a problem was the reason for which they were not diagnosed or treated for several years.

Most participants spoke about having become secretive and deceitful in order to hide their eating disorders. For example, Emma said that she lived in close proximity with her partner, but claimed that "he never realised, he never knew I was sick, I was secretive .... you're so preoccupied with yourself all the time". Behaviour which isolated participants from loved ones seemed to contradict their apparent wish for concern and attention, but no one commented upon this. It seemed that whilst being socially isolated they lessened the possibility of discovering a true sense of their own identity in relation to others and became less aware of their own feelings (Bruch, 1973).

By hiding their behaviour and their feelings it seemed that participants perceived that those who were closest to them remained unaware that they were suffering with significant eating disorders. As Fran said "I hid it well. I ate in secret .... my parents never really noticed or cared". Few participants reported being referred for treatment of their problems, which it seemed may have added to any feelings of inefficacy (Strober, 1991) despite their reported efforts to gain their parents' attention. Clare stated that "it was only when I fainted in front of my mother's eyes that she actually started to take me at all seriously". It appeared that with hindsight she perceived herself as having been so angry that her low weight had not been noticed that she had "blocked it all out".
Other participants reported managing to hide their eating disorders so well that as Diane said "I can't remember anyone really worrying about it" even though with hindsight she too believed she was dangerously underweight. The contradiction of hiding one's eating disorder at the same time as wanting it to be noticed seems baffling, but it may explain why many clients are ambivalent about treatment or never seek help (Zerbe, 1993). This same ambivalence is suggested in Gill's account: "I felt it was my way of coping", but she also said she "felt out of control .... I wished I could be noticed so I could be helped". Helen suggested that by being anorexic and extremely thin she had "wanted to attract men that would look after and save" her. This theme of perceiving themselves as wanting to be saved or cared for was fairly common, but participants reported that their needs were not met. For example, Clare frequently reflected on what she perceived as a lack of parental concern and the fact that she believed she "wasn't seen as somebody with a problem, I was seen as a problem and I think that was how it was dealt with". Such comments possibly reflect reliance upon others in the form of dependency, suggested by Guidano (1987) as typical of eating disorders clients, which prevents them from feeling capable and independent as adolescents.

A few participants' accounts suggested other reasons for why they had not sought help, for example, Fran said "for years I didn't realise it was an eating disorder. I just thought I had a weight problem and the treatment was dieting".

It may be that disturbances in perceptual and emotional awareness (Garfinkel & Garner, 1983) were responsible at the time for participants' apparent lack of acknowledgement that they had eating and weight problems. Within several accounts there were expectations that healthcare professionals should have recognised and diagnosed their eating disorders, so that treatment could have been given. Clare attributed the failure of this happening to "always been good at playing it [her eating disorder] down in my mind .... I've always found it easy to argue myself out of it" with the effect that she claimed to feel sometimes that she did not need the help she was apparently receiving at the time of the interview.
Research Dossier

Theme Four:
Participants’ Conclusions regarding the Treatment of their Eating Disorders.

The fourth theme is concerned with how participants eventually acknowledged that they had an eating disorder and sought help in adulthood. Some suggested how labelling their problem enabled them to begin to deal with it although it was sometimes difficult to identify with the diagnosis. Others found that being able to relate to other eating disordered clients had helped them to develop a sense of self by sharing common feelings and thoughts. Participants concluded by discussing how they had changed during their treatment and through seeking help had developed a sense of independence and responsibility.

Most participants reported not being diagnosed or helped until they were adult and had suffered with an eating disorder for several years. Clare apparently perceived that her late diagnosis at the age of twenty, was because “the problem was just sort of glossed over to the extent that because nobody ever called it anorexia, I just thought I had a bit of a thing about food”. Possibly her parents’ reported lack of concern and her own sense of inadequacy led her to believe that her problem was not serious enough to warrant treatment: “I was giving myself a tag [anorexia] which I felt I hadn’t warranted, I didn’t warrant that much attention”. However, Clare said that when the word anorexia was (eventually) mentioned to her she acknowledged that it “just clicked .... and gave me permission to think that” and to “de-mystify” her problems with eating.

Mixed reactions to being diagnosed were reported. Emma said “I know I binge, but I know I am not bulimic .... I still don’t feel I particularly fit the mould”. Despite this she had volunteered to take part in eating disorders research and so her comment may have reflected ambivalence about such a ‘label’. For Clare, being able to meet other people with eating disorders at OA reportedly enabled her to relate “to the struggle with food and the power your mind can have over what you do with it and what it
means”. It may be that in contrast to Emma’s experience, this was a positive step towards her search for a positive identity which she may previously have lacked.

Participants said they believed that no treatment for their eating disorders would have been provided if they had not requested help themselves. The effect of asking for help was perceived by some participants as representing a significant shift in their personality and behavioural functioning. For some previously anorexic participants the reported shift from restricting food intake to eating regularly seemed to be perceived as a positive step towards recovery. Diane said:

“not eating was one of the first things I let go of .... I started eating a lot of food at really odd times, treat food. I think I've overcompensated .... I do have a tendency to comfort eat .... I'm sorting that out now, so it's just finding a balance”.

Nearly all participants reported not receiving any help until they had left home, often during their late teens or early twenties which may coincide with an increased sense of independence having left their families-of-origin (Williams et al., 1990). Alternative theories are that there is something about having an eating disorder which maintains the homeostasis of an ‘anorectic family’ (Minuchin et al., 1978) and so it is no longer maintained after leaving the family unit.

In some circumstances participants explicitly commented upon the increased sense of independence they felt when seeking help for their problems. This may represent a psychological shift from expecting others to provide help to taking personal responsibility and choosing to confront previously hidden difficulties and feelings. Two participants said that they sought counselling whilst at university, Beth commented that it “gave me a tremendous amount of confidence .... because I sought help myself”. Such a comment seemed to reflect a move away from a sense of inefficacy, which may be indicative of a shift away from the eating disordered ‘mindset’ (Goodsitt, 1983). Gill also said she did not seek help until she was away at
Research Dossier

university, but implied that she regretted not having been helped earlier. She stated that:

"counselling has definitely had a significant effect on my life .... I would urge anyone with an eating disorder to seek counselling or join support groups immediately they become aware; then their lives will not be wasted feeling the way I have [wasted mine]".

Participants were unanimous in their conviction that treatment for their eating disorders had helped them to develop a better sense of self and had enabled them enjoy life more. The next theme is concerned what participants believed helped them to do this.
Research Dossier

Theme Five:

Participants’ Understanding of Their Eating Disorders.

This final theme summarises how participants perceived they were helped in their recovery from their eating disorders. Understanding of problems from their outset onward appeared to be influenced primarily by the type of treatment they had received. Some participants whose eating disorders had been treated as addictions perceived them as a disease to be controlled. Exposure to cognitive therapy was evidenced by others who indicated an awareness of faulty thinking styles and consequential identification of their own feelings, thereby becoming less reliant upon others’ opinions of them. Common to all but one participant was the acknowledgement that monitoring feelings and eating disordered behaviour (sometimes using diaries) had helped them to become more open and honest about how they were feeling and to deal with problems more appropriately.

Attending OA or being treated at an addictions treatment centre was reported to have influenced some participants’ understanding of their eating disorders. Ann stated “It’s a disease. It’s possible I was born like that .... I’m always going to have this .... it’s very irrational behaviour, it’s compulsion”. Perceiving an eating disorder as an addiction may have helped participants to feel that its onset was not ‘their fault’ so that they could develop a more positive sense of self and higher self-esteem, whilst perceiving that they need to cope with their difficulties only “one day at a time”. It seemed that Ann had also integrated various theories of eating disorders etiology to form a personal theory which fitted with her experiences: “It’s possibly a symptom of losing this girl [childminder] that I used to love and then lose again the first partner [her first serious boyfriend]”.

In contrast to understanding her eating disorder as an addiction Jane stated that cognitive therapy had helped her to challenge her dysfunctional cognitions (Fairburn et al., 1993):
"My thought processes have slowly been changing over the months .... my thinking was so way out .... [my therapist] helped me put it in perspective .... not worrying about what other people think you should look like".

It seemed that Ingrid too had been helped to change the way she thought and related to the world. She attributed her problems to:

"My personality, sensitivity and the way I looked at life: black or white, good or bad. My low self-esteem and not believing in myself and trusting in life and not reaching out and asking for help, thinking I should know everything. I now realise I am responsible for my thoughts and reactions in life".

Helen said she believed her treatment helped her to see that her eating disorder had been perpetuated by "not saying how I really felt about things. Always thinking people were criticising me. Not doing what I really wanted to do in life". This comment indicated that she was learning to acknowledge her own feelings and acting on them, rather than using food as a way of avoiding them and was thus gaining interoceptive awareness and a stronger sense of self.

Gill said she believed that "therapy helped to clarify my thoughts and their relationship to my experiences. The therapist helped me verbalise it and release these feelings". She stated that she thought that there is a deep-seated reason for all eating disorders and that "therapy has helped me become more aware of this and deal with it". She said that the link between feelings and eating behaviour "became more obvious when I was bulimic due to the fact that life problems or depressive feelings often precipitated binge-purge cycles". This may suggest that bulimics find it easier than anorexics to gain interoceptive awareness because their emotional states in reaction to their bingeing or purging behaviour are clearly differentiated.

A differentiation in self-perception dependent upon whether she was bingeing or dieting was made by Emma in theme two when she stated "there's a 'thin me' and a
'fat me' and never an 'in-between me'”. Despite this clear differentiation she stated that she found it hard to identify her feelings in relation to her eating behaviour and so had been requested by her therapist to try to self-monitor her feelings and eating and purging behaviour as Gill had above by using a diary (this is reported by Rabinor (1991) as being successful, particularly in early therapy). She described how noticing how she feels is alien to her: “It's funny because keeping the diary, I find it quite difficult to write down how I feel, I thought 'I don't know how I feel, I really don't'”.

Beth also said she had self-monitored her feelings and binges during her psychological therapy and described it as a support, almost like a replacement for the weighing scales she had used daily as an anorexic: “I would also recommend a diary keeping track of everything .... what you ate, why and things that went with it and then discussing that .... that really helped me .... it was really a relief writing things out .... it was powerful because I could be completely honest”.

Diane believed her problems had been precipitated by her experiences of being sexually abused as a child and suggested that since forming a long term, trusting relationship with her psychologist she has realised how as an anorexic “I just could not connect with people at all .... I was completely different like I had antenna sticking out of my head .... just not connecting at all with feelings, just relationships with people didn't happen at all”.

In most cases, participants said they could measure their progress by comparing how they behaved previously with current behaviour. For example, Ann said “I was always trying to please people because I needed people so desperately. I am very much self-centred now in a healthy way”. Similarly, Gill had measured her progress by her increased ease in sharing her negative feelings with her close friends: “I do feel more comfortable in expressing my feelings now I have a more realistic perception of my friends’ views and that they want to help”.
Some participants, such as Beth portrayed the impression that they had even managed to construe their eating disorders as something positive in their identity formation:

"I strongly believe that I had to go through that to exorcise it .... to realise that actually being in control the whole time was really unhealthy which is why I'm more laid back now. It's funny how the empowerment of the younger girl came from being thin and now it comes from feeling in control without all of that".

This final theme indicates that participants' understanding of their eating disorders was developing through an increasing awareness of their own needs, thoughts and feelings through analysis of their faulty thinking styles and the development of trusting relationships with others.

Conclusion of the Interview

Following each interview participants reported mixed reactions to the interview, ranging from feeling good, to feeling quite sad. However, no one requested a follow-up session, but nearly all were keen that their experiences should generate useful research data that may aid future sufferers of eating disorders. They also requested copies of the research report, which indicated an interest in the subject and possibly a desire to see how their material has been used within the research study.

A flow diagram indicating how themes linked together should be inserted here (see Appendix E).
Research Dossier

Overview

The extent to which participants' accounts provided an accurate picture of their eating disorders and treatment experiences was not formally assessed. However, the impact of potential memory distortions and recall biases (especially considering the reported length of time since the onset of most participants' eating disorders) is likely to have affected the nature of the relationship between the actuality of events and the accounts which participants gave in the research interviews. It is likely that participants' accounts could have been influenced by the context in which they were given. Thus the impact of telling accounts for the purposes of psychological research may have rendered accounts more psychological in nature or have attributed successful outcomes to psychological interventions in order to comply with what may have been perceived as the researcher's expectations.

It was suggested in the analysis section that due to the high mean age of the sample and the reported long duration of their eating disorders participants had had longer than a younger sample to construct and rehearse their accounts. This may have meant that they were more comprehensive or, conversely were less closely related to the actuality of the events with which they were concerned. Having only interviewed individuals who volunteered to participate in the study it is not known how their accounts differed from those of individuals who did not respond to the request for participants. On the basis of the data collected it seemed that participants were keen for their experiences of successful treatment interventions to be documented and believed that their opinions were valid and may in future influence eating disorders treatments.

The method of participant recruitment by voluntary response to a request for research participants meant that the sample was self-selecting which may have further biased the type of accounts received. Due to difficulties in recruitment the sample was very diverse and was not considered representative of all eating disorders clients. A significant feature of the sample was that each eating disorders diagnosis (anorexia
nervosa, bulimia nervosa or binge eating disorder) was represented by at least one participant in the sample. However, the number of participants diagnosed with each type of eating disorder neither reflected the proportions of these disorders observed in clinical populations (Szmukler et al., 1995), nor were they evenly represented within the sample. Where a sub-theme arose which was not shared by the majority of the sample it was not included within the analysis. Consequently, where there were idiosyncrasies which appeared to be related to a specific type of eating disorder these were omitted. Thus the results presented in the analysis represent findings concerned with the participating eating disordered individuals as a generic group which may not necessarily reflect differentiated eating disorders populations.

Despite the limitations of this study, it appears that the rich narrative data elicited may indicate ways in which eating disorders clients perceive they can be helped that previously were unavailable in such a form from other eating disorders research material. If the research findings in any way reflect the experiences of other eating disorders clients this study suggests what helps such individuals to develop insight and understanding into their problems leading to therapeutic change.

In summarising how the results of the analysis may usefully inform the treatment of eating disorders conclusions are drawn in relation to each of the major themes presented in the previous section. It was felt that the first theme highlighted the importance in treatment of identifying those factors which predispose certain individuals to develop an eating disorder. As Garfinkel & Garner (1982) theorised participants pointed to a wide variety of precipitating events which they believed led to the onset of their eating disorders. However, rather than naively blaming a specific event for the start of their problems, those participants who appeared to have developed the most insight had been helped by recognising the impact of the interaction of the precipitating event with underlying predisposing factors. Sociocultural and familial pressures to be slim combined with body image dissatisfaction, a sense of inefficacy, low self-esteem and the personality traits of compliance, perfectionism and dependency upon external cues for self-acceptance
Research Dossier

seemed to be responsible for the deep impact of events upon these eating disordered individuals. However, most participants seemed only to recognise the presence of these factors with hindsight. For eating disorders treatment to be effective it may be necessary for clients to be helped to acknowledge these factors and the role they play in the development of eating disorders as early in their treatment as possible. This would then help clients to realise that their problems are not concerned with food and weight, but are of a more fundamental nature concerning their self-perceptions and how they interact with the world.

The second theme concerned factors which participants believed had maintained their eating disorders such as positive attention for being slim, a sense of self-reliance, security, feeling comforted and rewarded during binges or feeling special and different for being in control of their food and weight. No one suggested that it was their actual relationship with food which made them feel better about themselves but the feelings they derived for example, from feeling in control of their weight or being able to treat themselves. It seemed that these perceived positive aspects of their eating disorders prolonged their duration and prevented participants from seeking treatment for fear of losing control over the one area of their lives over which they mainly felt effective.

Most participants perceived that there were also negative aspects to some of these behaviours (discussed in theme three), such as feeling guilty, depressed or ambivalent about wanting to be helped. Participants stated that they were ambivalent about acknowledging their eating disorders or were ignorant that they actually had such a problem until adulthood. Consequently, none received any treatment until they sought help themselves after leaving home. It seemed that involvement in the family and familial attitudes regarding food and weight (Kog & Vandereyecken, 1983) had maintained participants’ eating disorders. This may indicate that Minuchin et al.’s (1978) systems theory which states that there is something about an eating disorder which maintains the homeostasis of a family has some salience. However, none of the participants directly related the maintenance of their eating disorders to
family dynamics or functioning. Therefore it may be helpful to clients (especially those still living at home) to explore what it is about their role within the family that maintains their eating disorder. Having left home and sought help to rid themselves of the disordered eating behaviour participants were struck by their increased feelings of confidence and independence. It seems that they had achieved an objective for themselves which gave them a true sense of self-efficacy and self-reliance and represented a major step towards recovery.

Theme four was specifically concerned with participants’ experiences of their treatment. Not seeking help for a long time because they were unaware that they had eating disorders in some cases seemed to indicate the presence of perceptual and cognitive distortions and lack of self-awareness associated with this client group (Bruch, 1973, 1978, 1985; Garfinkel & Garner, 1983). However, this was not acknowledged by any of the participants. It may therefore be useful for therapists trying to engage resistant clients to explain how such distortions are responsible for their difficulties in perceiving themselves as needing eating disorders treatment. As a therapist it is difficult to treat such individuals until they present themselves for therapy. Nevertheless, many participants stated that they thought they would have benefited from starting therapy earlier than they did, which suggests that it is worth persisting with the treatment of clients who may initially be resistant to help.

Being given an eating disorders ‘label’ was perceived by most participants as a positive step which enabled them to start to define a personal identity and to accept that they had specific difficulties with which they could then work. In some cases participants claimed to benefit from relating to other eating disordered clients by identifying and sharing common experiences. This provides support for group interventions in the treatment of eating disorders. It seemed that participants were helped to identify problem areas when in communication with others who shared similar experiences which would then develop their levels of insight into their eating disorders. The benefits of membership of addictions groups such as OA are discussed.
Research Dossier

by Zerbe (1993) who highlights the sense of belonging and group identity which such groups engender.

The final theme indicated how participants' understanding of their eating disorders had helped them to deal with their difficulties. The links made in the analysis between participants' accounts and eating disorders literature may have occurred because the researcher's interpretative framework was influenced by familiarity with certain theories. It was also considered, however, that participants' accounts could have been informed by eating disorders literature through their own reading or learning about certain theories during their therapy. The high proportion of participants who had attended OA may have biased the ways in which the sample as a whole understood their eating disorders. The fact that these participants noted that it had been helpful to construe their eating disorders as addictions suggested that telling clients that they are not solely responsible for being the way they are helped to reduce their feelings of inefficacy, especially if they were binge eaters.

Many participants particularly highlighted the helpfulness of self-monitoring their feelings in relation to their eating disordered behaviour. Using a diary to do this was indicated to provide participants with a sense of support and release for their feelings (Rabinor, 1991). As opposed to focusing on food or weight issues participants highlighted how important it had been learning to recognise and express their feelings (or, develop interoceptive awareness, Bruch, 1973) instead of blanking them out by focusing on weight control. They believed that this had helped them to make sense of their eating disordered behaviour and had helped them to become more self-aware and honest.

Several participants suggested that the process of their recovery was apparent to them when they noticed significant shifts in their behaviour, especially regarding how they interacted with others. They highlighted the importance of learning to trust others with their thoughts and feelings without fear of rejection or humiliation which
emphasises the importance of the therapeutic relationship in work with this client group.

In the course of their treatment some participants seemed to have found it important to learn how to replace dysfunctional behaviours and attitudes with functional ones. This suggests that it may be important in therapy for clients to feel that rather than giving up what may have been perceived as a means of coping (binge eating for example), they are instead working towards replacing it with a better way of coping (such as sharing worries and feelings with close friends who may be relied upon for support). Their accounts suggested that it had been helpful for them to recognise changes they had made during treatment. For example, if they had previously conformed to sociocultural pressures to be slim, it was motivating for them to realise how developing a sense of individuality helped them to value their difference (in comparison to perceived norms) and to rise above pressures to conform. Duker & Slade’s (1988) work which emphasises self-discovery as a mechanism for change bears many similarities to this therapeutic approach and confirms the benefits of working towards a stronger sense of self.

The positive reinforcement participants evidently perceived when their behaviour changed seemed to act as a catalyst for further change, self-exploration and acceptance. It may therefore be therapeutic to encourage clients who are disappointed at their rate of recovery by informing them that even small changes are rewarded and recovery gets easier as time goes on.

It was evident from the accounts that recovery from eating disorders is distinguished by gradual changes in cognitive conceptualisations of the world, personality traits and behaviour, all of which are widely highlighted in existing literature as characteristic of eating disorders etiology (including Szmukler et al., 1995). Considering the length of time that eating disorders are reported to endure, it is understandable that it may take many months, if not years to make these changes.
Research Dossier

Despite its limitations this study provides an insight into how eating disorders participants experience the changes they make in recovering from their problems. It was noteworthy that there was no mention of therapeutic interventions which tackled issues concerning dietary control (Fairburn, 1983; Fairburn et al., 1993) or behaviour modification (Eckert, 1983). Instead the impression was given that what had made a difference to participants’ recovery was addressing issues concerned with challenging dysfunctional thinking styles and developing a stronger sense of self through an increasing awareness of their needs, thoughts and feelings.

Future research which aims to discover how clients are helped to recover from their eating disorders would benefit from studying less diverse samples of participants from which more accurate conclusions could be drawn which relate to specific eating disorders. In addition the methodological difficulties outlined with regard to this study could possibly be minimised by eliciting participants’ accounts whilst they are in therapy or shortly following it. It may also be helpful to re-interview clients several months or years after the end of therapy in order to re-evaluate which aspects of their treatment they perceived had contributed to their continued recovery if this was the case. In light of the fact that participants in this study focused particularly upon those aspects their treatment which addressed their self-perceptions, interoceptive awareness and sense of self it would also be of interest to assess the relative merits of different aspects of treatment from those mentioned above (such as practical issues like monitoring food intake). If certain aspects of treatment are experienced as more effective than others then their relative importance could shape the form of eating disorders interventions so that time spent with clients is used to its maximum benefit.
Bibliography


Research Dossier


Research Dossier

Anorexia Nervosa: Recent Developments in Research, (pp. 3-14). New York: Alan Liss.


Research Dossier


Research Dossier


Research Dossier


Do you or have you ever suffered from an eating disorder/s?

If so, would you be willing to participate in some psychological research? This will be an opportunity to share your experiences and opinions which may help future sufferers receive an improved service of care.

What is the research about?

I am a Counselling Psychologist in my final year of training and am interested in finding out what sufferers of eating disorders believe contributed to their onset of their difficulties and how they could best be helped or what has helped them the most so far.

What does the research involve?

Volunteers for the research will be male and female adults over the age of 18, with or without experience of treatment for their difficulties.

Participants will be asked about their thoughts and opinions by the researcher in a meeting which will last for approximately one hour.
Confidentiality and anonymity will be maintained as described below:

Prior to starting an interview participants will be asked for their consent that it is audio-recorded using a small tape recorder. Following the interview the tape will be transcribed (by the researcher alone) with the recording then being deleted. The anonymity of each participant and any family members or friends mentioned in the interview will be maintained by omitting all names and replacing them with a single letter (i.e. 'D said this to me'). Any details such as place names or other identifying material will also be disguised in a similar way. Transcriptions will be used as material to be qualitatively analysed but will not be included in the research report. However, brief quotations such as illustrative phrases may be included in the report, but only if the participant's anonymity can be definitely guarded. Upon completion, if any participants are interested in reading the final report they may do so by requesting a copy.

If there are any issues arising from the interviews which participants would like to discuss further at another time with the researcher there will be an opportunity for a follow-up session which will not contribute to the research and will obviously not be recorded. Interviews may take place either in participants' own homes, the researcher's home or any other appropriate venue where sufficient privacy can be provided. Depending upon the arrangements made travel expenses will be reimbursed.

If you are interested in participating or know someone who may be, please contact:

[Researcher's name, address and telephone number]
The aim of this research is to investigate how sufferers of eating disorders have come to understand their difficulties. It is hoped that by sharing their beliefs and experiences a better understanding will be gained of how healthcare professionals may best treat these problems.

You will be asked to take part in an informal interview about your experiences of this subject. The interview will be recorded on audiotape so that, in writing up the research people's experiences can be cited accurately. Naturally, to protect confidentiality the researcher will not quote any identifying information such as names and locations. In making transcriptions, therefore, your name will be replaced by a letter and the names of other people or places that may arise during the course of the interview will not be recorded. Once transcribed the audio-tape will be recorded over.

If you have any questions or feel you would like further information about this research please ask the researcher before reading on.

Please read the following paragraph and if you are in agreement, sign where indicated.
I agree that the purposes of this research and what my participation in it may entail have been clearly explained to me in a manner that I understand. I consent to be interviewed about my experiences as someone who has suffered with an eating disorder. I also consent to an audio-tape being made of this discussion and to all parts of this recording being transcribed for the purposes of research.

Signed ..................................... Date ...............................
Research Dossier

Appendix C

Demographic Information Questionnaire

Please tick the appropriate response or write in the spaces provided.

1. Please indicate your gender:

Male ..... Female ..... 

2. How old are you? ..... Years

3. Which of the ethnic groups listed below would you say you belong to? (tick or write in the appropriate answer)

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

4. What is your occupation? .........................................................
5. What is your marital status?

Single  
Living with partner  
Married  
Separated  
Divorced  
Widowed  
Other (please specify: ........................................)

6. What is your living situation?

Living alone  
Living with friends/flatmates  
Living with fellow students  
Living with a partner/spouse  
Living with partner and children  
Living with parents and/or other family  
Other (please specify) ........................................

Thank-you for completing this questionnaire, please let the researcher know that you have finished and are now ready to begin the interview.
Section I: Development of the eating disorder

The subject of this research is concerned with how sufferers of eating disorders understand their difficulties. I would like to start by asking you a few questions about the development of your eating disorder.

1. When would you say your problems with eating first appeared?
   
   Prompt: How old were you?

   How do you remember it so specifically (if appropriate)?

2. What form did these problems with your eating take?
   
   Prompt: Were you bingeing, purging, fasting, using laxatives, exercising to excess, weight loss etc.?

   What form has your eating disorder taken over the years?

3. How long did your eating disorder last?
   
   Prompt: What changed when things started to get better?

4. What differences did you notice in yourself as your problems evolved?
   
   Prompt: How were you different before?

   How would you describe yourself before your problems started?

   How did you realise that you were changing?

   What did you think about what you were doing?

   How do you feel about the changes that occurred?

   In what ways did you stay the same?

Section II: Background to the eating disorder
1. How would you describe your life at the time of the onset of your eating disorder?

*Prompt:* What makes you say that?

If not indicated in question II:1:
Some people develop an eating disorder following a significant event or period such as puberty.

2. Was there any specific event or dramatic change in your life which you attribute in some way to the development of your difficulties?

*Prompt:* What makes you think that that event was related to your subsequent problems?
How did you feel after that?

Section III: The influence of others on the development of the eating disorder

1. What were the reactions of people around you when you developed your eating disorder?

*Prompt:* Did anyone say or do anything when your eating patterns changed?
If so, what was said or done?

2.a If those people did react how did this affect you?

*Prompt:* Were you glad that people had noticed something was wrong? For what reasons?
Were you irritated or annoyed that people seemed to want to stop you from doing what you were doing?
What makes you say that?

2.b If those people did not react how did this affect you?

*Prompt:* Were you glad that people did not notice something had changed? For what reasons?
3. In what ways did those people’s reactions affect your friendships and other close relationships, for example with your parents?  
*Prompt:* How did this make you feel?  
Was there anything good about this?  
Did you ever do anything about the changes you experienced in relation to others?  
If so, what did your do?

4. Did you ever perceive that other people’s relationships or behaviour changed when your eating disorder developed?  
*Prompt:* What makes you say that?  
Why do you think this happened?

**Section IV: Treatment for the eating disorder**

1. Did you or anyone around you seek help for the treatment of your eating disorder?

If yes:
2. What help did you seek and/or receive?

3. What was useful about the help that you received?  
*Prompt:* What was un-useful about it?  
What do you think should have been done differently?

If no:
4. With hindsight what would you have liked to have done about receiving help for your eating disorder?  
*Prompt:* How do you think that would have helped?
Section V: Participant's understanding of the development of their eating disorder

I now want to ask you questions based upon how you think and feel today about the difficulties you have experienced.

1. Do you ever think about what caused you to develop an eating disorder?
   Prompt: What makes you think these things?
   When did you first start to question why you had developed these difficulties?

2. What beliefs have you had in the past concerned with the causes of your eating disorder?
   Prompt: Did anything anyone said influence these ideas?

3. As you are now with your personal experience of an eating disorder and (if appropriate) experience of psychotherapy/EDA meetings etc. (specify according to what the participant stated earlier) what do you feel contributed to the development of your eating disorder?
   Prompt: What makes you say that?

4. Are any of these conclusions influenced by anything said to you by a therapist, anything you have read, a television programme or anything else you have come across?
   Prompt: If so, was this helpful, how?
   If not, would it have been helpful to have heard this from a therapist?

5. In what way/s do you think you could best have been helped through your eating disorder?
   Prompt: What would have had to have been different in your life or relationships to have prevented the development of your eating disorder?
   What advice would you give to someone suffering from an eating disorder today?
Research Dossier

How would that help?

Section V: Closure of the interview

1. Is there anything which you would like to tell me about your experiences which I have not asked you about during the interview?

2. Finally, may I ask how it felt taking part in this interview?

   Prompt: Was there anything which was helpful or unhelpful about the questions I asked?

   In what way was that helpful/unhelpful?

3. How do you feel now?

   If you have found our discussion today helpful I would be pleased to offer you a follow-up session. Also, if you are feeling distressed as a result of this interview or if you feel that it would help you to get some more support regarding what we have talked about today I would be pleased to help you.

   I would now like to end the interview by thanking you for your help in participating and reminding you that all that you have said today will remain anonymous and confidential.
Appendix E

Figure 1: Flow diagram demonstrating how themes link together

-ve Precipitating event: occurred at age of 13, body image dissatisfaction, reliance upon external cues for approval.

Attribution of sense of inefficacy to weight.

Need for sense of control and to feel special and effective.

Development of eating disorder as a coping mechanism.

-ve Effects: obsessional, depressed, isolated, fear of loss of control.

+ve Effects: false sense of self, avoidance of painful feelings.

Desperation and inability to maintain control.

Desire to change in order to improve quality of life.

Sense of independence gained from leaving home.

Treatment: delayed diagnosis and treatment. Signified increased independence. Helped to identify with other E.D. clients to promote +ve identity.

Construction of personal account to perform psychological function of providing a positive sense of self.

Personal theories: based on gaining insight through improved sense of self, interoceptive awareness and esteem.

NB: E.D. = Eating Disorders.