# Current Issues in Clinical Psychology

Volume 3

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## Volume 3

Edited by

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# PREFACE

This is the third volume in the series of books based on the Annual Merseyside Course in Clinical Psychology. In common with its predecessors its aim is to present a number of topics of interest to practitioners, researchers, trainers and trainees in the field, with the intent not only to inform but variously also to question and to guide further enquiry.

Selection for this volume has taken a somewhat different stance to the previous two. Whereas in former volumes an attempt has been made to cover standard areas of general and scientific interest to psychologists and others in related professions, such as anorexia nervosa, forensic issues, long term care, mental handicap, community psychology, anxiety and depression, in this one issues which are of equal relevance but not necessarily of equal prominence in psychological texts, are included. We have not, however, neglected those areas more readily recognized as of major clinical import which are being progressively covered in this series. This year we have the section 'Bereavement and the Care of the Dying'. Although for many this may not be a main focus, it is a subject that few helpers do not encounter either directly or indirectly with their clients. It would be impossible for this subject to not reflect the most human side of the caring professions, and it is perhaps in this field that the objective/subjective dilemma of the clinician can be seen in its most acute form.

The social perspective of roles within relationships is one which historically has received scant attention from clinicians who work with sexual problems or even with broader problems of relationships. It is progressively being suggested that we may not move much further in the development of these therapies unless such a viewpoint is considered. The section 'Social Role Problems in Sexual Relationships' addresses this controversial area both in the theoretical and practical domains.

Inasmuch as social roles have remained in the background in clinical practice, so have they for clinicians themselves. A classic example of such a 'hidden issue' exists in the context of the helping role. This is covered in the section entitled 'The Making of the Clinician'. Even against the tide of financial restriction and reorganization which is pushing the helping professions toward more mechanistic interactions, there can be no justification for ignoring the human processes which operate within helpers themselves. Perhaps it is all the more important for helpers to pay attention to themselves at such times of professional stress. Indeed, it is argued in this section that by not addressing these issues, helpers are both reducing the quality of their service to their clients and devaluing their own humanity.

Until relatively recently, male dominance within the medical profession together with medical dominance within the Health Service has arguably been responsible for the lack of a psychological understanding of those medical problems unique to women. Hopefully, the rapidly developing relationship between physical medicine and psychology as evidenced in the section 'Medical Problems of Women' is indicative of much awaited change in this sphere.

In a different time spectrum, the final section in this book discusses a subject which has raged controversial since the eighteenth century, or even before. This section is entitled 'Hypnosis: Theory and Practice'. Currently hypnosis is put to a wide range of uses by people in a variety of fields, from conventional medical and dental practitioners, who use it for example for anesthetic purposes, to psychic explorers who use it to enhance their mystical experiences. In no field, however, is hypnosis universally accepted and not least so within the psychological therapies. The contributions in this section range over theoretical and practical matters and as a whole show that hypnosis is receiving as serious a consideration from academic and clinical workers as other more commonly practised psychological techniques.

In conclusion, in this volume we have again achieved a range and balance of clinicians and academics expert in their respective fields as contributors and also of psychologists and members of other professions. It is hoped that readers will enjoy and benefit from this selection and take from it ideas which will add to their own understanding in the service of their clients.

Eric Karas

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# BEREAVEMENT AND THE CARE OF THE DYING

# BEREAVEMENT AND THE CARE OF THE DYING

## AN INTRODUCTION

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It would be misleading of me to suggest that this Section intends to cover the area of death and dying. As with so many others the subject is vast, complex and highly specialized. We could not possibly deal with the particular problems of various populations who are approaching death, nor the problems of their relatives. We would also have to consider various models of care including some discussion on the various locations in which such care may be provided. However, it is hoped that these present contributions will provide a clear description of how some Psychologists are attempting to meet the apparent demand in the care of the dying and, to a lesser extent, of the bereaved.

One deviation from this pattern is Dr Richard Landsdown's contribution which addresses the particular problem of communicating with the dying child, from an understanding of the child's conception of death. That it is concerned with such a particular subject, and with children rather than adults, makes it different from the other contributions. It is nonetheless a provocative paper.

Even these reasonably discrete areas of interest provide numerous problems to solve. Indeed, one of the very odd aspects of the psychological care of the terminally ill is the insecurity of our knowledge in this regard. At its most simple, we may wonder why the quality of our care and state of our knowledge is at such a relatively primitive level when death has been such a common occurrence for so long! Moreover, as Kastenbaum (1977) has pointed out, we already have a reasonable understanding of many of the issues pertaining to the psychological care of the dying. Most of us know something at least about the experience of separation, the effect of illness on mood, the nature of institutions and their depersonalizing effect, about anxiety and depression. It would seem then that we are not totally inexperienced when faced with the needs of a dying person. Why then, given this flying start, have the caregivers of the terminally ill failed, with several notable exceptions, to make substantial headway in our knowledge and practice?

There are several obvious answers to this. It is a relatively unglamorous speciality, typically underfunded and based in neglected hospitals for the elderly. Some people may argue that it is more fulfilling to work with the living than with the dying. While these and other answers may be true in part, the one unique feature of the subject matter which may well influence our progress, is the ability it has to elicit very powerful emotions in all concerned. This emotive power seems to remain even for the most hard bitten of caretakers of the dying. Several years ago a colleague and myself became aware of several nurses who, despite many years experience, referred themselves for help in overcoming what, I can only describe as their 'bereavement' following the deaths of elderly patients who they had nursed. One of these nurses was sufficiently insightful to recognize that her behavior towards patients had been substantially influenced by these bereavements. She became aware that she was avoiding some patients and in failing to deal with her own emotions, was also failing in dealing with those of her staff and patients.

As a means of estimating the extent of the demand for our services in this hospital, we arranged to have a notice placed on what was a fairly remote notice board in the hospital. It simply invited interested staff to put their names forward to attend a series of four seminars on 'Dealing with the Dying'. The Nursing Officer informed us that after several hours he was forced to remove the notice as there were so many names on it that he could not afford the overtime payments for staff to cover for those attending the course. Anyone who has had the opportunity to work in a hospital of this kind, a converted work-house, neglected for many years and threatened with closure, will be aware of just how remarkable this response was.

Even more remarkable was the effect of the first seminar. We were seeking to identify the group perceptions of death and the meaning of various kinds of death which they had shared. It also served to help individuals in the group to become aware of their personal perceptions and beliefs with regard to caring for the dying. The first point to make is that these Ward Sisters, despite having very substantial experience, had never discussed this kind of issue previously. Even so, neither myself nor my colleague were prepared for the emotion generated in this first session. Weeks later, we all laughed at ourselves in the safety of an experience shared. One Sister of more than twenty years seniority said 'I was so surprised ... and embarrassed. I couldn't look at the others. I had never allowed myself to think like that'.

There are a number of lessons that could be learned from this, the most obvious being that one should not fall into the trap of believing that experience equals expertise. At the risk of laboring the point, doing a job badly or inefficiently for many years is hardly 'experience' at all. As Peter De Vries wrote, '... we all learn by experience, but some of us have to go to Summer school' (Tunnel of Love, chapter 14). In the case of our Nursing Sisters, although we have no way of knowing how good they actually were at caring for the dying, we do know that this was the first opportunity they had to go to 'Summer school'. It was also the first time that they had been allowed to overcome the enormous barrier to personal and professional development, that was acknowledging the powerful emotions generated in themselves by the death of a patient, emotions which they had all denied in various ways, which directly affected interactions with patients and staff and which prevented careful consideration of nursing practice.

I should point out that nurses are by no means alone in having often failed to carefully consider working practices in the care of the dying. However, this example raises three aspects of the problem which are worthy of note. First is the issue of self awareness, about which much has been written, one example being David Barton (1979, chapter 6) in which he addresses the personal and professional consequences of those emotions generated in caring for the dying. Barton appears to be articulating what is a consensus view of the importance of emotions and beliefs but exceeds the usual by explaining the nature of the effect.

Related to this is the issue of anxiety about death, the manifestation of anxiety in care givers and associated avoidance of patients. P. D. White et al. (1983) has argued that despite numerous education courses designed to improve the quality of psycho-social care of the terminally ill, anxiety and behavior with patients tends not to be influenced by such interventions. Indeed, there is some evidence, reported by Shoemaker et al. (1981), that death education courses actually increase 'death anxiety' of the participants. The work of White, and that of R. L. Peal et al. (1981) is directed towards developing behavioral treatments for death anxiety in nurses and relating such intervention to behavioral outcomes.

The third issue which our example has raised is that of institutional structures which impede the effective development and implementation of high standard psycho-social care of the terminally ill. A great deal has been written of this subject in various guises. Kastenbaum (1977) offers wide ranging comment on the ritualizing of death and typical assumptions and practices of medical facilities in the United States. All of this is provided as evidence and illustration of our failure to meet the challenge of the terminally ill by succumbing to convention and institutionalized tradition. From a nurse's perspective, Ann Hamric (in David Barton, 1979, Chapter 14) provides a clear account of the pressures and expectations placed upon nurses which effectively act as deterrents to therapeutic care of the dying. She includes a discussion of the lack of relevant training provided to nurses who are asked to undertake this task. Drawing on similar sources Knight and Field (1981) make a similar point with regard to appropriate training for those asked to care for the dying. They directly consider the effect of ward structure, organization and communications on the quality of care for dying patients. In another interesting angle, Keith and Castles (1979) considered behavior and expectations of nurses and terminal patients. They conclude that nurses' expectations of themselves varied more widely than the expectations of nurses by patients. This was interpreted as revealing the lack of clarity in the tasks of caring for the terminally ill which contributes to occupational stress and disharmony within clinical teams.

These issues are all useful lessons that can be learned. Even so, I am not convinced that if we were able in some way to improve self awareness, reduce anxiety and emotion related to death and find complete flexibility in institutional structures and expectations, that the quality of care would be enormously different (a conclusion hinted at by Keith and Castles). None of these sources, useful though they are, provides information as to what those who are charged with the task of caring for the dying, should actually do in order to meet the patient's psychological needs.It seems to me that Knight (1981), Hamrick (1979) and others, lead us to conclude that there are large numbers of those caring for the dying who simply do not know what to do. Therefore we should not be surprised if they experience anxiety in the face of having to do <u>something</u> or avoid the problem if they can get away with it. It would seem then that a useful comparison, in terms of behavioral change in care givers and quality of service for patients, would be between the effects of desensitizing nurses to death anxiety which seems to be the thrust of enquiry at St Louis University (Peel et al., 1981; White et al., 1983) and training in the goal orientated contributions to this section.

In some respects, distinguishing between powerful emotions that are elicited by this subject of dying and anxiety which is elicited by task demands which exceed one's competence, does not help us understand the variable nature of what is written about this subject. Kastenbaum (1977) is coy in his explanation for this. Having warned that the various observations and conceptualizations of process or stages of dying may be misleading, he notes that a few studies have been replicated and methodological problems are common. Most significantly, he argues that ' ... the people attracted to this field include some who are unfamiliar with the critical evaluation and application of research findings'. He is also seduced by the notion that it is our anxieties which lead to selective bias in research and application.

Whatever the reasons for this, many of us will have shared an experience of growing unease when reading the literature about models and philosophies of terminal care. It takes on a vagueness or metaphysical quality which leaves me wondering if I have missed the point of what is being said or asking 'what exactly has been done?'

There are, of course, exceptions to this pessimistic picture. In the book 'Home Care: Living with the Dying', edited by Elizabeth R. Pritchard et al. (1979), not only is a research model offered but there is a reasonable description of what the contributors to this model of care actually do and why. Unfortunately there is still another kind of confusion which we must be aware of, having finally overcome the mystique about the care of the dying. At the same time as this may clarify what 'home care' is, it inadvertently contributes to the confusion about what 'hospice care' is. Contrary to popular belief, hospice care does not simply begin at its own front door. If we take St Christopher's Hospice, London, as a model, we will see a very large proportion of their activities directed at the family and home of the patient. There is recognition of high quality care offered by relatives of their patients and the importance of early contact with the family. When used in this way, the hospice becomes a reasonably familiar place into which the next logical step can be taken when the time comes. Only in the sense that there is a possibility of moving to a hospice in the final stage of life are these models different.

Put simply, how can we hope to evaluate a particular service if we have not yet clearly distinguished between the essential components of services which distinguish themselves from each other. We may well be able to compare the effectiveness of one agency/institution with another. Indeed, Colin Murray Parkes (1984) has attempted to do just this. However, it is difficult to know what we are to learn from such a finding, other than one service is 'better' than another. It seems we would have some difficulty applying these results if we had not, a priori, determined the critical differences between them.

What is surprising in this context is not that there are relatively few successful attempts to operationalize the macro perspective of terminal care, embracing philosophy, organizational and institutional features of care, but that there have been relatively few attempts to produce fine-grained, operational descriptions of 'micro' perspectives of terminal care. That is, specific interventions and strategies of intervention which may embody a philosphy or orientation but do not in themselves explain it. In this section each of the contributions has the virtue of providing enough detail for us to understand what it is that the author does when faced with the task of caring for the terminally ill or advising others in that care. Moreover, the ability to compare the methods is enhanced by the detailed description of procedures. At least we can be reasonably sure of what is being tested. We may also conjecture that if those responsible for the care of the dying were to adopt the individually tailored goal orientated approach to their work that is described in this section, they could be reasonably sure of what they were doing. We might speculate still further, by asking, what might be the effect of this on avoidance and anxiety when faced with the dying patients.

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# COUNSELLING PROCESS AND SKILLS

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## INTRODUCTION

In this article, I will describe the model I have devised for training counsellors working with dying and bereaved people in individual rather than group counselling. Some trainees are volunteers attached to bereavement services, others are professional people who want to add counselling skills to their existing abilities. Here I will describe the process and skills of counselling which includes the outline of personality adjustment previously described elsewhere, dealing with the intellectual, psychological, spiritual, physical, emotional, behavioral, social-cultural and practical dimensions of adjustment. This is a general model of counselling which I have also used for training counsellors working with adjustment to disability, separation and divorce, immigration and other major life changes and losses. Here, however, the counselling model will be used specifically in relation to dying patients and people who will be or have been bereaved, before or after a death. The counselling process is most effective when begun before the death and continued afterwards. This article describes the overall pattern of the counselling process. The actual techniques - how to conduct the counselling - are not given here but are covered as training progresses.

## WHAT IS COUNSELLING?

Counselling deals with problems of adjustment. The purpose of counselling is to bring about improvements in how a person thinks, feels, acts or relates to other people. The ultimate aim of counselling is to promote healthy, integrated personality adjustment and to assist a person to fulfill his/her potential.

The method of counselling is through communication, using specific aims and techniques. Counselling is more than conversation: it is a private, confidential relationship in which the focus is on expressing painful thoughts and feelings, making difficult choices or decisions, helping a person to be honest with him or herself about unpleasant reality, and on learning to live more fully, independently and effectively. In the counselling relationship, the counsellor helps the client to discuss, understand and solve adjustment problems. The counsellor has knowledge and skill to help with problems of adjustment; the client wants to change and uses the counsellor's help to do so. Together, they identify particular aims to be achieved, and commit themselves to working together for a specified period of time to try to reach those goals. In the long run, the aim is to feel better and have come through a stressful period better equipped to cope with life and future crises.

## COUNSELLING PROCESS: TEN PHASES

A simple way of describing the counselling process is to think of it in terms of separate parts from the beginning to the end of counselling. In practice, they blend into each other or may occur out of this order. Nonetheless, they are easier to understand if discussed as component parts of the whole. In my model, the process is described in ten phases:

(1) Introduction.
(2) Opening.
(3) Interviewing - Getting the Story.
(4) Assessment - Summarizing Themes.
(5) Setting Goals.
(6) Making the Counselling Decision and 'Contract'.
(7) Working Through Adjustments.
(8) Closing.
(9) Evaluating Outcome.
(10) Feedback into Selection, Training and Practice.

## PHASE 1: INTRODUCTION

In order for counselling to take place, the bereaved person (a) must identify that he or she has a problem relating to bereavement, (b) must know that counselling is available and (c) must be willing to ask for or accept counselling to try to improve his or her situation. This can happen in one of two ways: first, by referral by others: someone recognizes a problem in a bereaved or dying person and suggests that he or she has counselling; or second, by self-referral, the person him or herself discovers through advertisement or personal referral that bereavement counselling exists and makes the first approach to ask for it.

### The First Interview: Assessment and Counselling Decision

The method of introduction has an important bearing on how the first interview goes. If the bereaved person is motivated, has asked for help and knows what counselling is about, counselling can begin straight away. If, however, the counsellor approaches with a 'hidden agenda', i.e., someone else thinks the person needs counselling but has not told the bereaved person that the counsellor will make contact, much of the first meeting is devoted to putting this over to the bereaved in a way he or she can understand and consider to accept or refuse. It is extremely important that the counsellor does not attempt to 'open the person up' and expose raw feelings without the person's knowledge of and expressed agreement to what the counsellor proposes to do. The counsellor should never attempt to break down emotional defences, but to allow the person to lower them once he or she feels safe enough to be honest and open.

## PHASE 2: OPENING

The first fifteen minutes of the first meeting is of critical importance. When first meeting, people sum each other up rapidly, based largely on external appearance which is related to previous experience, and each person decides whether he or she likes the look of the other.

The counsellor's first task is to try to establish rapport with the client to allow them to open up and be honest about painful thoughts and feelings without holding back anything that would help them to see the situation realistically. Therefore, the counsellor must convey particular personal qualities very quickly to give the client the impression that they could confide in the counsellor and that the counsellor would be able to help them.

So the counsellor must develop skills of establishing rapport and of creating an atmosphere conducive to self-disclosure so that people who could benefit from counselling go through with it. If the counsellor fails to establish rapport, no matter how otherwise skilled he or she may be, the person will not be interested. The counsellor must be able to put the person at ease and make it easy to talk openly and honestly.

## Establishing a Counselling Relationship

The counsellor must also rapidly establish that this is to be a purposeful relationship. The relationship between a counsellor and client is not like a usual social relationship between strangers. Especially with a short-term 'contract' model of counselling described here, in which the meetings are limited to between one and ten sessions, the work to be done takes place in a fairly short time, which means that the counsellor must be focused and efficient. He or she must therefore learn new skills of relating to other people. This is especially so in English society, where, in normal behavior between strangers, people are expected not to discuss or show painful thoughts and feelings. Both parties are likely to feel reluctant to bring a subject up which might cause upset reactions, to feel embarrassed if someone cries and quickly to try to make the person stop crying and get control of themselves again. This behavior is based on the learned assumption that people should not get upset, or should not show it if they feel it, and that others should not make them upset by intruding on their privacy by discussing painful or threatening topics. So the topic and the embarrassment are avoided, and the others try to cheer up the person who is sad.

A bereavement counsellor is trained to view and handle the situation differently. Crying is an outward sign of grief, not the emotion itself. If a person does not cry or if he or she is made to stop, he or she will not feel the grief any less, he or she will not get better, he or she simply is not showing it. The natural release of emotional tension is through shouting, wailing or crying. Tears show that a person is freeing him or herself from the sadness, frustration or other tension, and occur because he or she needs to do it. At first, whenever the person recalls the pain of the loss, if he or she feels free to do so, he or she will sob intensely, and this will happen to a lesser extent at other times when he or she thinks or talks about it. But eventually a point is reached when there are usually no more tears, when the emotional tension is released: he or she has worked through grief.

Therefore, the counselling relationship is not initially intended to cheer people up, but to help them to face the reality of life and to explore and express appropriate thoughts and feelings. When a loved one has died, it is appropriate to feel sad - there is something very real to feel sad about. Loving relationships are our greatest treasure, and if that loss is not a source of grief nothing is.

> "Grief is the price we pay for love:
> it is the cost of commitment."
> Colin Murray Parkes (1975).

In a society that fails to give bereaved people realistic support, social expectation creates the adjustment problem: how people feel inside is at variance with the pressure put on them from others to behave as if they did not feel that way. By going to a counsellor, the bereaved person is seeking healthy adjustment in an unhealthy society. By allowing the widower to talk about the death and to react honestly and openly, the counsellor allows him to get upset and to share his upset feelings with another person's support because he feels upset inside. The counsellor does not make the man upset. He already was upset inside because his wife had died - life had changed in a way he did not want. The counsellor simply allows or encourages the upset feelings to come out, to express rather than repress his grief. In discussing and releasing painful thoughts and feelings, he may feel worse at first - more sad, angry, guilty - because he gets in touch with feelings already there, but which society tells him he should not have. But just as lancing a boil is painful for a time, the treatment eventually brings relief from the building pressure. The person had to feel worse before he felt better. But having expressed the hurt, the pain of grief, rather than being obliged to pretend he felt cheerful for the benefit of other people, he can begin to grow from the experience: to face the future with deeper self-knowledge, honesty, compassion and new skills. If society supported bereaved people in a healthy way, there would be no need for counsellors.

Nor is the counselling relationship befriending. Unlike befriending in which a person takes an interest in and may do practical things for another person and hopes they will incidently feel better, the whole purpose of counselling is to bring about improvement using specific aims, skills and techniques. The main differences between the two relationships are in the specific purpose and skill in communication and the expectation of change in thought, feelings and behavior. Befriending may or may not be enough to bring a person relief. If it helps, it is by accident rather than design. It may actually make people worse by pretending it is enough and depriving someone who would benefit from more skilled help from getting it, or by encouraging behavior that will ultimately be unhealthy. It is also not likely to do good with people who are stuck. Friends, family and professionals untrained in bereavement counselling may make people worse by making them hold back thoughts and feeling that they want and need to express, work through and grow more mature from. Family members who know each other well may not evoke expression of the feeling for fear of making each other upset, or may already know how the other feels about the loss and may not ask the kinds of questions that cause the person to reflect and express thoughts and feelings.

> "If you know what I feel, why should I tell you? But unless I say it, how do I know what I think? And unless I work through the thoughts, how will I improve?"

What does a counsellor bring to the relationship that others may not? In bearing the burden of empathy with another person's grief, the counsellor is showing a willingness to get involved, to give time, to give of him or herself. By developing controlled emotional involvement rather than being detached or overwhelmed, he or she is willing and able to allow and encourage others to discuss topics that would evoke such painful feelings in other listeners that they would avoid exposure to protect themselves from being overwhelmed by anxiety or sorrow. The counsellor's realism helps them to face and accept unpleasant reality with honesty. His or her ability to plan and anticipate the consequences of particular courses of action or events helps to prevent or minimize avoidable difficulties. Problems do not go away and inevitable sorrow is not made easier just because they are not discussed. Lack of fear of whatever may emerge stems from confidence in the counsellor's ability to bear and manage others' discharge of emotion without losing control of the situation, even if at times he or she is moved to tears by the tragedy some people experience. Because counsellors cannot take someone further than they have gone themselves, they will usually have successful experience of having come through intensely painful experience themselves, though not necessarily bereavement. Sorrow is the same feeling regardless of its cause. Self-knowledge is most important: the awareness and acceptance of the heights, breadths and depths of emotions and the ability to both express and regain control of one's own feelings. They must believe in the resilience of the human spirit - that people are not irreparably damaged by traumatic experiences, but can actually use them as an opportunity to grow from adversity. Developing the potential to mature is the challenge of counselling. A counsellor must be willing and able to take calculated risks, with the confidence of good backup and supervision as well as inner strengths and outer resources to top themselves up when they give of themselves. And as loss befalls us all, there will be times when a counsellor is more vulnerable because of their own emotional disturbance when life is particularly stressful. They must then be able to·withdraw temporarily from the demands of counselling to nurture their own strengths. Their confidence must be balanced with the humility which stems from the realistic awareness of their own limitations without being inhibited from taking any action because of their own feelings of inadequacy. A counsellor must remain sensitive to the unique impact of each loss, so that although they are desensitized enough through frequent exposure to death and grief to be objective, they do not lose awareness of the deep pain of personal loss and hurt of others inadvertently. Obviously, this combination of qualities is ideal and is achieved only through years of personal development.

In a bereavement counselling relationship, the expectations of how the counsellor and client should behave need to be clearly understood on both sides so that the usual social inhibitions that make people uncomfortable when talking about sad things are lifted. It is up to the counsellor to put the other person at ease and to set the scene for what is allowed to happen in the sessions. This is done both directly and indirectly. The counsellor must somehow give the bereaved person signals and information that say it is all right, even expected, to talk about subjects that are usually not discussed with people until you have known them intimately. But intimacy comes through honest self-disclosure about what you really think and feel inside. You can know someone for years, yet never confide in them, but you can quickly develop the rapport that makes it easy to be direct and open about the secrets of the heart. With some formal relationships, like confessing to a a priest, confidential information is expected to be disclosed. Just as there is a special relationship with a doctor in which within minutes of meeting the patient may take off their clothes and reveal private parts of their body and the doctor tries to put them at ease so that they do not feel embarrassed or ashamed when they are examined, so the counsellor gets the client to reveal the private thoughts of the mind and heart so that pain located there can be treated and healed. Almost everyone has a doctor and it is socially acceptable to go to the doctor for physical illness. Patients know that they are expected to do things they would not usually do with strangers and the doctor makes it clear what is expected of the patient. Likewise, a priest listens to confession and tries to assuage guilt through penance and absolution.

The counselling relationship is more difficult. There is still some stigma about going to a counsellor in this country. Others might think you are 'mad', and admitting that you have emotional or spiritual pain is somehow not as accceptable as a physical pain or illness. People are not allowed to admit that they feel sad, angry, guilty, frustrated or confused, particularly if the pain is so severe that they want to kill themselves.

Yet everyone knows that at times life is difficult, that people have problems and stress during critical periods in life (such as following a death) which sometimes builds up to bursting point, and no matter what they try they do not feel better. Just as there is a point with a physical complaint at which the patient decides to see the doctor for treatment, so you might approach a counsellor when emotions are disturbed and your usual remedies are not adequate. Thoughts and feelings seem more mysterious than physical parts that can be touched and seen to be examined, diagnosed and treated. But with training, the counsellor is able to do that with mental processes.

I do not wish to take the medical analogy too far, because counselling is not only or even primarily for people with mental illnesses in the conventionally used sense. It can be most effective in preventing problems from arising by anticipating and preparing for loss and change before they occur. Or a person may wish to seek a counsellor's help to make the healthiest possible adjustment to loss, as well as those who benefit from counselling by changing and learning different and healthier ways of coping with stress in their lives.

## PHASE 3: INTERVIEWING - GETTING THE STORY

The counsellor must develop skills of interviewing to enable them to extract relevant information in a short period of time about painful and private topics in order to make a balanced assessment of the client's needs without sounding like the Spanish Inquisition.

An interview is an interplay of extracting and volunteering information. There are many skills used by a competent interviewer, although most would be unaware consciously of what they were doing. The characteristics of a skilled interview could be described as follows:

- putting the person at ease so he or she can concentrate on the subject rather than on the strained relationship, and so that he or she will be honest and open;
- the ability to get to the heart of the problem as quickly as possible by having a clear mental frame of reference;
- knowing what to look for;
- asking precisely the right questions to find it but with tact and sensitivity;
- probing when necessary to get more honest, private or seemingly unrelated information;
- getting maximum relevant information from a single question;
- listening out for pertinent clues as they are dropped and remembering them;
- relating different bits of information to each other to see a pattern;
- controlling the amount of information given so that you are not bombarded by irrelevant detail with talkative clients, without rudely cutting them off, but do not fail to get to the point with those who do not volunteer information;
- smoothly changing the subject to get through all the topics to be covered;
- keeping to time;
- paraphrasing after each topic to check that your understanding is correct and clarifying and restating if it is not;
- varying the way in which questions are asked;
- dealing sensitively with emotions aroused from the information given.

There are various ways of asking questions: with open-ended or closed-ended questions; using direct or indirect questions; and making statements which encourage the person to respond or to acknowledge that the interviewer is aware of particular feelings so that they may come up in conversation later. An open-ended question gets more information than a closed question which gets a yes or no answer. Many people shy away from asking direct questions, yet there is no faster way to get through to the heart of a subject than to ask about it directly but sensitively and without embarrassment. Many people have not learned the ability to volunteer information, and may wish to withhold it, but are not likely to hold back or to lie if asked directly. With embarrassing subjects, they may well want to talk about it, but not know how to bring it up in conversation and will welcome the counsellor taking the initiative.

The counsellor must have the ability to start, maintain and terminate a conversation, and to feel comfortable talking about and bringing up painful topics.

This model of counselling uses a framework of interview questions, based on the model of personality adjustment previously described. The purpose is to get a brief but overall description of the whole person's adjustment, identifying a balance of strengths and problem areas. The model includes eight parts of personality - intellectual, psychological, spiritual, physical, emotional, behavioral, social-cultural and practical. It also covers adjustment over time, from (1) previous life-events relevant to this particular loss, (2) adjustment before the death, (3) adjustment at the time of death, (4) adjustment since the death, and (5) how the bereaved person sees the future. These topics are incorporated into the first interview, and the counsellor must be able to switch smoothly from one to the other, leading on and connecting the subject-matter so that it is coherent. This requires considerable conversational skill.

As I mentioned at the outset of this article, the actual techniques of how to conduct an interview will not be dealt with here, but here is an outline of how the interview works in practice.

The client or counsellor comes in. They introduce themselves. They make small talk for a moment to get comfortable with each other. The counsellor then gives a lead into the subject which they have come together to discuss - the bereaved person's grief. The counsellor asks a question. The better the question the more relevant the answer, and the more information can be given by the client. The client thinks about the question, may reflect quite deeply, then answers, perhaps only answering the question exactly as it was asked, or volunteering more information. The counsellor then processes the answer, either by paraphrasing to show he or she has understood, by linking the answer with something said earlier, which he or she must remember and associate, or by asking another question for clarification or to lead into a new topic. At times, the counsellor must feel comfortable with considerable periods of silence without feeling the need to jump in and say something, while the client reflects. This sense of inner stillness is in itself therapeutic. Throughout the interview, the counsellor bears in mind the structure of personality adjustment mentioned above, so that the dimensions of personality and time are covered. This model must either preferably be recalled from memory, or read from an assessment form. Obviously, the more familiar the framework or checklist is, the more smoothly the interview will flow, and the more the counsellor will be able to recognize relevant information. If the counsellor works from memory, while the client answers, he or she listens, analyzes the answer, stores relevant information in the memory and disregards trivial detail, or (on paper) condenses the answer and writes it down.

Working from memory, the counsellor must remember which areas have been covered and which have not, so that they can be asked about. If he or she is skilled and is able to control the amount and type of information given by the client in the first interview, he or she should have covered most relevant details of all the areas of adjustment. This allows an assessment to be made.

Before I go on to describe how that is done, more should be said about the interview. The kind of question asked and the way it is asked are the key to the information given, which forms the basis of assessment, goal-setting, making the 'contract' and working through adjustments. If the right information is not given, the counselling will not make the person feel better because the real issues will not be identified.

Difficulties in getting the right information stem from three sources: (1) the counsellor; (2) the client; and (3)the relationship.

## (1) Barriers in the Counsellor

The counsellor may lack sufficient knowledge or may not have developed skills of recall or association. Or his or her judgement may be distorted by over-identifying with the client's situation because it is too close to his or her own. Those are intellectual barriers.

The counsellor's own defences against being overwhelmed by anxiety may inhibit him or her from asking the right questions because he or she is afraid. They may be afraid of evoking a response that they cannot handle, or of being overwhelmed by the response that emerges or of getting upset themselves by being the cause of upset to the client. Those are emotional barriers.

Cultural inhibitions which the counsellor has learnt about not expressing grief or intruding on privacy are the most common barriers to opening painful topics. Unless and until the subject is brought up it cannot be discussed and worked through. Being afraid to ask upsetting questions because the counsellor needs to be liked and does not wish to jeopardize the relationship again means that painful reality will not be confronted, and people who are stuck will not make progress.

Occasionally, something about the client (e.g., a mannerism) reminds the counsellor of someone significant to them. If the counsellor relates to the client as if they were that person, without being able to identify and control and isolate the associated characteristics, that would impede the counsellor's objectivity.

All these barriers should be lowered by good training and supervision.

The importance of helping the client to ask him or herself the right questions rather than thinking he or she has to be able to produce profound answers is beautifully illustrated by a mass murderer, who told the prison psychiatrist:

> "No-one is ever going to be able to help me."
> "Oh? Why not?"
> "Because no-one has ever asked me the kinds of questions I have to ask myself in order to give myself the right answers."

## (2) Barriers in the Client

These are mainly due to the client's perception of the counsellor which inhibits the ability to let go, so the client holds back information that would be relevant. This is due to the following:

(a) Habit: it may be that the client is reserved by nature and does not confide easily in others, or is not used to disclosing private thoughts and feelings or simply does not know how to volunteer information spontaneously in communication.

(b) Anticipation of criticism: whether or not clients themselves feel ashamed, they may believe that the information or show of feeling would be unacceptable to the counsellor who would be critical or shocked; disloyalty to the deceased, sexual taboos, previous mental illness, and murder are all topics that spring to mind as having been causes of concern to clients.

(c) Desire to impress the counsellor: the client may not wish to lose face by revealing information that he or she anticipates may disappoint or disillusion the counsellor; macho male clients with attractive female counsellors may be inhibited by the male-female attraction, or professional people who feel they should be able to cope, such as nurses or social workers, may feel inhibited if the counsellor is perceived as a colleague. Professional people often find it difficult because others do not allow them the humanity to grieve.

(d) Need to protect the counsellor: the client may feel paternal if the counsellor is perceived as naive or vulnerable, and hold back feelings or thoughts he or she thinks will shock, frighten or overwhelm the counsellor.

(e) Futility due to incompetence: what is the point of revealing very personal details if the client thinks the counsellor lacks the skill to help?

(f) Mistrust and confidentiality: the client does not feel able or willing to entrust secrets to the counsellor, fearing he or she will tell someone else, especially in a small, enclosed community where the client may find themselves sitting next to the counsellor at dinner, knowing that he or she knows their darkest secrets.

(g) Lack of respect: due to the counsellor's inability or failure to instill confidence. Respect and acceptance are more important than liking the other person.

(h) Fear of letting go: many people fear loss of control, thinking that if Pandora's box is opened, the contents will be overwhelming and that permanent or irreparable damage will be done. The counsellor's ability to contain an outburst and put the person back together after each session communicates confidence and encouragement to let go.

### (3) Barriers in the Relationship

The main difficulty is in establishing rapport. The counsellor and client cannot get on the same wavelength, or have a personality clash. Lack of rapport is due to the inability to communicate effectively with each other, to establish understanding and to feel comfortable together. With new acquaintances, you would say that there was nothing in common. All the factors previously mentioned contribute to such difficulties.

Because counselling is a process conducted by two or more people communicating with each other in a particular way about sensitive topics, how they get on with each other is of the utmost importance. For that reason, the matching of client to counsellor is vital, and is a good reason for referral to another counsellor if rapport is not and cannot be established.

## PHASE 4: ASSESSMENT

Having elicited information from the client in the interview, the next step is for the counsellor to group together the disparate things the client has said into a summary of themes to make an objective and descriptive assessment of the client's adjustment in different areas of personality.

The counsellor must be able to remember what was said over the 60 to 90 minutes of the interview and cluster facts together into their categories. This is where paraphrasing and summarizing throughout the interview helps to recall relevant facts.

By assessing each personality dimension, rather than focusing only on problem areas, the counsellor presents a more balanced picture to the client of their adjustment to the situation, identifying strengths as well as problems. To focus only on problem areas presents a warped view of the personality, and gives undue emphasis to the counsellor on helping with adjustment problems. Reinforcing and mobilizing the client's own strengths and existing coping capacities and resources is a most powerful source of self-healing and self-esteem.

The accuracy of the assessment depends on the honesty and completeness of information. Almost invariably, as the client trusts the counsellor more, additional factors come to light that alter the assessment.

Accuracy of assessment depends not only on superficial facts but on the counsellor's deeper ability to interpret what events or feelings mean to the client. The depth of understanding varies according to the counsellor's knowledge and experience. At a basic level of understanding, the counsellor simply paraphrases or puts into other words what the client him or herself has said. That requires good listening skills but little analytical ability. At a deeper level of understanding, the counsellor seeks to analyze what particular events or behavior mean, including unconscious motivation and defences as well as reasons which are apparent. The counsellor's analysis depends largely on the theoretical school in which he or she has been trained, and his or her life experience which allows him or her to apply theory to practice.

A critical point to remember is this: analysis of personality adjustment is only the preliminary step to treatment and improvement. Simply describing, labelling or categorizing are not enough and will not improve the situation in most cases. The counsellor must be able to translate the assessment into a strategy for change,through short-, medium-, and long-term aims and particular techniques for reaching them; and the strategy becomes the basis for the counselling program in working through adjustments. So the next step is to set goals.

## PHASE 5: SETTING GOALS

The counsellor and client jointly consider the assessment of each area of personality and the long-term aims of healthy adjustment or resolution of grief and they translate problems into goals specific to the client's situation. They state what the client wants to achieve in each area of his or her life, looking first at the long-term aim, the ultimate goal, then identifying intermediate aims to reach it.

If the problem of emotional adjustment included feelings of sadness, guilt and loneliness, the long-term aims would be defined as:

(1) to reduce sadness, to increase feelings of well-being;
(2) to assuage guilt, to forgive oneself;
(3) to reduce loneliness.

In the last example, one of the aims is to reduce loneliness. But a variety of intermediate short-term goals could be set to reach the long-term aim. For example:

(a) to go out more;
(b) to improve social skills;
(c) to enjoy being alone;
(d) to form a confiding relationship;
(e) to remarry as soon as possible.

Each intermediate goal should be worded as far as possible in terms of clearly observable, specific behavior. Instead of stating vaguely that the aim is 'to feel better', it is preferable to define the desired action to be achieved as clearly as possible, e.g.,

> "to reduce the amount of time each day I spend crying about the death".

The aims to be achieved are not absolute but relative, and there are a number of alternative approaches to achieving a particular aim. Some of them are not likely to bring improvement, and some of them may actually be harmful in the long run. For example, "to go out more" sounds a reasonable way to achieve reduction of loneliness, but one can feel desolately lonely surrounded by people, so that aim will not necessarily achieve the desired result. "To remarry as soon as possible" is certainly one way of reducing loneliness, but prematurely formed attachments often end in regret or separation. Therefore, the ability of the counsellor to foresee the likely consequences of a particular course of action is important. Aims must be reasonable and achievable.

Defining aims for each area of adjustment provides a framework for the counselling program, and is a necessary step before making the counselling decision and contract described in the next section.

## PHASE 6: THE COUNSELLING DECISION AND CONTRACT

Having made an assessment and identified what needs to be achieved to bring improvement, the counsellor and client are in a position to make the counselling decision. The questions to be decided are: (1) does he or she need it? (2) does he or she want it? (3) will it help? (4) from me or, if not from me, from whom?

The first two questions highlight the difference between objective need and felt need. The counsellor may well feel that the person has problems which could be alleviated by counselling, or that the client's habitual way of dealing with stress is likely to lead to an unhealthy outcome, such as physical or mental illness. The client objectively needs counselling. But he or she may not want it. Motivation is the essential factor in contributing to success of counselling. It is a waste of time to try to counsel someone who does not want it. The counsellor then sees that someone who could benefit is likely to refuse help. This requires salesmanship to enable the client to make an informed choice. The counsellor must be able to inform the client about what the counselling would entail, what could be achieved, what the risks are both of having and of not having counselling, all in an objective way without putting pressure on the client to accept it. Belief in the need for and benefit of expressing grief and belief in the opportunity to grow from the challenge of loss and change are two attitudes that the counsellor should convey. Having clearly presented the possibility, it is up to the client to accept or refuse help. Each person has responsibility for his or her own life and the right to make choices that may lead to an unhealthy outcome or one the counsellor would not like. We can but offer.

The third question in the counselling decision is "will it help?". The question refers to this particular model of short-term counselling with this particular person or family in these special circumstances. Some people, for example, would benefit from group counselling or from a longer-term or more specialized therapy than that being offered. Also, some people and some situations are highly resistant to change. Especially when resources are scarce, it is most effective to give them where they will actually make a difference.

Fourth, the counsellor must ask him or herself: "should he or she have counselling from me or from someone else, and if so, from whom?" Only after having identified the scope of the counselling program can the counsellor decide whether he or she is competent enough to provide what is required so that the level of need is matched by an appropriate level of skill in the counsellor. So it is partly a question of competence and of recognizing when more skilled help is required. But chemistry between the counsellor and client also plays a large part in the success of outcome, and a failure to establish rapport, trust, or the ability to confide will sabotage the outcome and the counsellor may need to refer the client to someone else. If people do not click, it will not work.

Referral to another counsellor or agency requires skill and knowledge of local resources, so that the client does not feel as if he or she is being passed from pillar to post. It should be done as rapidly as possible and to a suitable person. The client should be kept fully informed of what is being done on his or her behalf.

## The Contract.

If the counsellor and client decide to go ahead together, a contract is made. This is an oral or written commitment on both sides to work together on a specific program of a fixed number of sessions of sixty to ninety minutes. A short-term, goal-directed counselling model was devised for a number of reasons.

With a limited number of counsellors and potentially unlimited demand, more people could be helped. Research had shown this type of counselling to be effective. The purpose of a fixed number of sessions is to concentrate time and attention on a specific number of areas which are most relevant and to avoid random wandering. One reason why so much counselling and psychotherapy is not successful is because the counsellor and client are unclear where they are going, so how can they know if they get there?

The contract lets both parties know where they stand before a situation arises. A limited number of session prevents the client from becoming dependent on the counsellor and reassures him or her that he or she is not entering into an open-ended relationship that may begin to pall. This is vital as a main aim of counselling is to help to build independence and a new life for the client. The counsellor is also able to control the demands made upon them. The counsellor's own need to be needed might otherwise extend the number of sessions indefinitely, as in other befriending or counselling models.

What should the contract include?

(1) The assessment of needs in each dimension of adjustment.

(2) Aims which are written down to serve as guidelines for the counselling program and to evaluate later the success of counselling in achieving previously specified goals.

(3) The estimated number of sessions, which should be re-evaluated halfway through the program. The number of sessions varies according to the aims to be achieved and how much relearning of new skills the client needs to do, as defined by the assessment of needs. For counselling begun before a death takes place, the number of sessions with the patient or family members or both and the amount of time available will vary, so that sessions may be spaced closer together. The purpose is to tie up unfinished business and to anticipate and prepare for changes and losses that will take place after the death so that preventable difficulties can be avoided or minimized. Counselling then continues after the death. The better the preparation before the event, the better you are able to prevent avoidable difficulties afterwards, which may change the very nature of the adjustment the family would have made had counselling not been available. For counselling begun after a death, the contract usually covers six to ten sessions over the first three months, with quarterly checks over the first year to monitor progress.

(4) Techniques to be used, particularly if these involve cathartic techniques for releasing powerful, repressed emotions.

(5) Expected progress and outcome. Several points need to be made about the progress from grief work to growth work. Almost invariably, there is a period of time, about a third to half way through the sessions, when the client reports feeling worse than he or she did before the counselling. This is to be expected and is easily understandable. During the counselling sessions, the thoughts and feelings about the loss and changed circumstances are brought to the surface, expressed and explored. Painful emotions often erupt that the client may have struggled until then to suppress or avoid. Although the counsellor should help the client to regain control before leaving the session, thoughts and feelings are still processed during the intervals between sessions. If the client had maintained balance by avoiding painful reminders, encouraging him or her actively to uncover and reveal other memories, longings and worries may make them feel worse for a while. That is an appropriate reaction to an unpleasant situation. However, as time progresses, and they work through the adjustments to their altered circumstances and take greater control of their lives, changes must take place. That is what adaptation means. Whether the changes are harmful, neutral or beneficial is largely a matter of planning and of how they perceive the situation, but can also be measured objectively. So, feeling worse before getting better is not a problem unless the client terminates counselling prematurely, or is overwhelmed by the intensity of reactions between sessions and attempts to harm him or herself. Dealing with that is discussed below. But the progress described here should be spelled out to the client.

(6) Measures of success, which will be described in the section on evaluating outcome.

(7) The risks of having and not having counselling, particularly the increased risk of developing physical illness as the result of the increased stress of bereavement, particularly if there is no adequate outlet for the release of emotional tension. Counselling attempts to reduce that risk.

(8) Some counsellors, myself included, also seek agreement from clients who are particularly depressed or in despair not to commit suicide for the duration of the counselling program, and not to harm themselves, the setting or the counsellor during sessions when powerful feelings are being expressed. This sounds extreme. But most clients fear loss of control and welcome defined boundaries. It makes it clear that they have responsibility for their own lives which conveys respect and the expectation that they will be able to cope with whatever happens in the counselling or as a result of it.

(9) Arrangements for how to contact the counsellor outside sessions: there may be times between sessions when the client wants or needs to make contact with the counsellor. It is recommended that the counsellor's home telephone number is not given to the client, but that he contact the bereavement service which then contacts the counsellor who contacts the client. This prevents abuse of the counsellor's privacy outside designated sessions. It is preferable to deal with the situation before the counsellor is awakened in the middle of the night by a client who simply wants someone to talk to and the counsellor finds he or she is setting a precedent for the pattern of their relationship.

(10) The fee, if any, should be agreed and when payment will be made.

## PHASE 7: WORKING THROUGH ADJUSTMENTS

This phase actually constitutes the bulk of the time taken up in counselling, during which the work of exploring and working through the problems of adjustment is accomplished, using the specified aims agreed in the first, and often the second, sessions. For this to take place, the counsellor develops and uses a variety of techniques to bring about changes in how the client thinks, feels or acts and to help them to make decisions or solve problems . He or she strives to maintain balance between head and heart, between grief work and growth work, and to act as a neutral sounding board for the client to explore his or her situation. The client is given work to do between sessions which makes best use of the limited time spent together, and which gives the client responsibility for his or her own recovery. The counsellor plays many roles, but in part acts as a catalyst for the client's self-discovery and development, helping him or her to have the courage and clarity to ask themselves the right questions, to face unpleasant reality with honesty and to begin to rebuild a changed future. It means striving to accept the things that cannot be changed and to make the best of them, and to take a systematic approach in dealing with the reorganizations that must be made in the gradual process of realization of and reconciliation to the loss.

### Balancing the Program During Sessions.

In order to attempt to achieve balanced adjustment, the counsellor and client must keep a continual eye on all the dimensions of adjustment being worked on simultaneously and keep short-, medium-, and long-term aims in view. Otherwise, so much time is spent working on one or two problems of adjustment that the others are forgotten and go by the board, only to raise their ugly heads later on. This is largely solved by good recording in written records in which one can see at a glance the total program set out at the beginning and the changes over time. Also, halfway through the number of sessions agreed in the contract, the counsellor should review with the client all the aims identified at the outset and if necessary modify them and the number of sessions required to reach them. Rigidity is not to be encouraged, but any temptation to keep extending the number of sessions indefinitely should be resisted. Often, a clear perception of the situation only occurs after several sessions when the facts cluster into a different pattern. There is nothing to gain from terminating the program before a result is achieved because the first assessment of the time needed was inaccurate.

## PHASE 8: CLOSING

You are working towards closing from the opening of counselling, for the counsellor's achievement is in making him or herself redundant through the planned withdrawal of help gradually throughout the later sessions. This prevents the client from being suddenly dropped and gradually builds the client's resources to cope alone. There is always the understanding that if the situation changes and new problems arise, a new contract can be negotiated.

As it takes two to five years without intervention to make an integrated adjustment to a major life crisis, of which bereavement is one example, the counsellor does not see the client through to the completion of mourning and rebuilding a new life. The counsellor's role is more one of preventing pathology by early intervention, by altering the course of unhealthy reactions that are established and by helping the client to learn new ways of coping with future stresses.

Like the adage "Give a man a fish and you feed him for one meal, teach a man to fish and you feed him for life", the best outcome you can hope for is not to solve one problem for the client but to teach him or her to take control of his or her own life, not only to restore balance to the previous status quo but actually to enrich and enhance life so that he or she matures from the experience of crisis. Having re-evaluated life in light of the opportunity necessitated by changed circumstances, the client can strive to reach potential abilities that were previously unidentified and untapped.

A widow who had been overprotected throughout a marriage, may, upon finding herself alone, initially feel panic about facing the future without the security of past habits and shared roles, and without someone to take decisions and responsibility for her. Gradually, through necessity, she gets through the challenges and the aims one day at a time and eventually finds she has developed new skills not previously needed and an independent identity, not as a wife or widow but as a woman in her own right. Her enhanced self-esteem from the satisfaction of knowing she has emerged from the loss not only a whole person but a better person gives new courage to face future changes and challenges, and to take calculated risks better able to cope.

## PHASE 9: EVALUATING THE OUTCOME OF BEREAVEMENT COUNSELLING

Does bereavement counselling work? Do people get better or worse, or does it make no difference whether they have it or not? These are important questions for a counsellor and for a bereavement service to attempt to answer, in order to modify and improve training and practice.

In reality, the most likely outcome of counselling with almost everyone is not any absolute extreme of success, failure or no impact, but of partial success, either in achieving some aims but not others or in having some degree of change within different areas of adjustment, or change in areas or ways that were not anticipated. So outcome is a balanced picture.

## Progress During Counselling

Counselling strategy and particular techniques are evaluated throughout the counselling program in several ways:

(1) During sessions: by monitoring progress at each session using the aims specified in the counselling contract,the counsellor and client can assess whether they are achieving what they intend to as they go along. By asking "what changes have taken place since we last met" the client can first mention spontaneously changes for the better or worse or whether nothing has shifted. This may be something value like "I don't know why, but I feel better than I have for ages", or more specifically, "I spend less time during the day crying and I went out to dinner with friends last night for the first time."

(2) Written records: the counsellor has a progress form on which is written the problems identified, aims,methods used to reach aims and outcome. During or after each session, the counsellor fills in the final two columns and also afterwards does a brief report on the counselling session, using an outline called 'The Supervision Monitoring Form' so that standard information is recorded for each client. The purpose of this is to make it easy to supervise and evaluate the counselling. The counsellor attends fortnightly group supervision meetings at which the reports are read, progress evaluated, and suggestions made by the supervisor and other counsellors about further intervention. The supervisor ia also available at any time between meetings. Thus peer evaluation and guidance takes place along with monitoring and evaluating progress with the client.

## Difficulties in Evaluating Outcome

There are several factors that make it difficult to evaluate outcome:

(1) Some clients are unable or unwilling to acknowledge that they are improving. The reasons for this are basically:

(i) Some people do not want to relinquish the pain of grief. When they lose that, they will have given up the last link with their loved one who is gone;
(ii) They feel guilty that they are alive while the loved one is dead, perhaps feeling responsible in some way for the death, and may feel the need to punish themselves by never again enjoying life. To improve, to feel better, even to grow more mature or whole from the death would seem a sacrilege; and
(iii) some people have a re-existing tendency to devalue their positive qualities or successes which is made worse when they are grieving.

Thus one bereaved mother whose son had died eighteen months earlier and who had not been out of the house alone since then said "I've only been out twice this week" during the session after her first solo venture. She devalued her achievement. All three reasons given here applied to her.

The counsellor must understand the motives behind the actions, which may well be unconscious, in order to define the problem correctly and treat it.

(2) A further difficulty in evaluating the effectiveness of counselling stems from the opposite tendency. The client may want to see and report improvement to avoid disappointing the counsellor. He or she tells the counsellor what he or she thinks the counsellor wants to hear. Indeed, one element of what brings improvement is the client's confidence in the counsellor's ability to help regardless of what technique is used.

For evaluation to be most useful, objective measures need to be used of adjustment before and after counselling at specific time intervals. There are several measures of successful outcome:

(a) counselling accelerated the rate of improvement, or people got better faster than they would have without it;
(b) it brought a better overall adjustment than the individual had before the death; or
(c) a better adjustment was achieved compared with bereaved people who were not counselled.

From the outset, the counsellor has a built-in disadvantage. He or she cannot give back the person who has died, which is all the bereaved person wants, and everything else seems second best. It is only with hindsight that the client can see that he or she made the best of an inevitably and unavoidably painful situation, which is also the counsellor's reward in what many would consider to be a potentially depressing subject for work or leisure time in voluntary work.

## PHASE 10: FEEDBACK INTO SELECTION? TRAINING AND PRACTICE

It is vital that a bereavement service of which the counsellors are agents attempts to make use of the evaluations of outcome to modify the selection, training and practice of future counsellors. By learning from our successes and failures, we can identify more precisely those factors in the counsellor's personality and technique and in the counselling process which are most likely to lead to healthy outcome for bereaved people.

## CONCLUSION

Thus we come full circle in the ten phases of the counselling process: introduction, opening, interview, assessment, setting goals, making the counselling decision and contract, working through adjustments, closing, evaluation and feedback.

In addition to understanding the overall pattern of the counselling process, the counsellor must develop skills within each of these phases which will be developed over time in training. Those form the subject of separate papers.

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# TERMINAL CARE: GOAL SETTING - HOSPICE PHILOSOPHY IN PRACTICE

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A variety of services specializing in the care of the dying, dealing mostly with cancer patients, have recently expanded rapidly in the UK and the USA (Lunt and Hillier, 1981; Buckingham and Lupa, 1982). Whilst domiciliary and hospital teams, working in an advisory capacity and supplementing existing provision, continue to multiply (Lunt, in press) further major expansion of inpatient hospice units seems unlikely, at least in the UK. Instead, hospices are urged to disseminate the principles and techniques of terminal care to improve the care provided by other existing services (Wilkes et al., 1980). There has been surprisingly little research to demonstrate the effectiveness of hospice care, though more is under way. All published evaluative studies in Britain refer to St Christopher's Hospice (Parkes, Part 1 and 2, 1979; Hinton, 1979; Parkes, 1984). Home care services have been subject to even less study (Parkes, 1980). There has to date been no evidence that education and training in terminal care skills for staff in non-specialist settings, by itself produces improvements in care, though recent research at St Christopher's shows that standards of pain control have improved in nearby hospitals since the hospice opened (Parkes, 1984).

For the specialist principles of hospice care to be disseminated and taught, they must first be fully described and found to be effective. The "hospice movement" is beginning to attend to these questions in a systematic way, though at present only in relation to symptom control and bereavement support. Yet even the most superficial reading of the hospice literature, or encounter with hospice care, shows that "the hospice philosophy" encompasses a great deal more than these aspects. This paper reports an attempt to describe the hospice philosophy in operational terms, so that its practice can be measured, evaluated and taught.

## THE GOAL SETTING MODEL

Considerable progress has been made in the management of the mentally ill (Goldiamond, 1974), the elderly and infirm (Kastenbaum, 1968), and mentally handicapped (Shearer and Shearer, 1972) by setting short team treatment goals aimed at achieving longer term goals set by the person and his or her family. The characteristics of this approach to treatment include: first, that these goals arise from a careful analysis of the person's present problems and what they hope to achieve; second, the treatment builds on whatever abilities, strengths and resources are possessed by them and their family; and third, the goals are positive rather than negative, building new patterns of activity and behavior within the limits of the person's disabilities.

In looking at the work of Countess Mountbatten House (CMH), a hospice in Southampton, and reading about the activities of hospices, it appeared that successful hospice care was perhaps achieved in a similar way. In general terms this can be described as:

1. Looking systematically and in detail at the patient's problems, their abilities and strengths, and those of their family, the resources they have to call on and the history of their problems and the ways they have found of dealing with them in the past;
2. Identifying together with the patient and family, aspects of their life in which change is wanted from what is currently happening;
3. Deciding which of these have the highest priority;
4. Working out with the patient and family specific goals to be worked on and in what order. (By the term "goal" is meant what the person will be doing as a result of care and treatment which is different, and better than at present.);
5. Breaking down distant goals into manageable parts or short-term goals which build on the strength and abilities of the person or their family;
6. Planning and carrying out the treatment program;
7. Regularly assessing progress in relation to the goals and changing treatment accordingly;
8. Reviewing goals frequently as the illness progresses and as the patient's and staff's understanding of the patient's abilities change, or the family's reactions change.

This description is rather different from the description of the care of the dying patient usually found in the medical, nursing and social work literature. It does not describe how to select appropriate treatment, how to implement it, which drugs to use under particular circumstances, and what side effects to look out for. Nor does it describe the philosophy of care in broad generalizations such as "treating the whole person", "considering the family as the unit of care", "making the most of life", "living, not dying". Such descriptions are to be found frequently in the hospice literature, and give the flavor of a broad philosophy, but do not indicate how this is to be translated into practice. The goal setting model, on the other hand, describes the framework within which decisions are made, treatment is planned and care is given, in terms of the specific tasks undertaken by the care givers.

However, these steps are not being carried out overtly in hospice care. Rather, it is suggested that this model provides an explicit, operational account of an approach adopted informally, implicitly or intuitively by hospice staff. The fact that the model is explicit means that it can be tested against the reality of hospice practice. A series of studies were undertaken to investigate the applicability of the goal setting model in hospice care. In a number of case studies, goals were set explicitly by the author in collaboration with staff, patient and family (Hillier and Lunt, 1980). Examples from these cases will be used to illustrate and expand on the goal setting model in terminal care.

How do you identify a terminally ill person's goal areas (step 2) and short term goals within these areas (step 4)? You start by doing what you always have done: talk to the patient and the family; find out the history of the illness; about the family; and so on (step 1). Enquire about the things which presently concern them. It is helpful to have a checklist of aspects of a person's life, or situation, or functioning in which problems or goals may appear and to structure the discussion around this checklist. Initially the checklist used in the case studies included: symptoms; self care; mobility; sleep; recreation/leisure; social activities; family relationships; work; financial; information about illness. This has since been extended as a result of later empirical studies. All doctors and nurses have checklists of areas which need to be covered. They are usually not written down. It helps to have an explicit list to prompt the discussion of issues which might otherwise be forgotten or avoided. The content of the checklist may well be one of the key factors affecting the kind of care given. "Treating the whole person" can perhaps be partly translated into "Using an adequate checklist of areas to discuss with the patient".

People are usually rather good at telling you their problems (step 1), so you might well get problems described in many or all of these areas. Some will be very general: "I've never felt so ill in my life". Others will be insoluble anyway: "I've got terminal cancer". Many will be quite specific and potentially soluble. However, the crucial step is to turn discussion away from negatives (problems) and on to the positives (goals).

The patient is ill, and probably dwelling on their problems and difficulties because they are important and may well seem to dominate their life. The task (steps, 2, 3, 4) is to help this person clarify the kind of changes they want in their life as it is at the moment, so that you know how to help them, and how to assess the effectiveness of your help. The process of setting goals is not just as a matter of getting information from the patient or their family. It is part of the therapeutic process and should leave all parties feeling that there is something positive to work on: all hope is not lost. The staff will probably be in a good position to judge what it is possible to achieve tomorrow, the next day, in a week, and so on. The patient and family is in the best position to decide which direction to go in and the importance of each goal area.

A man was admitted to the hospice having been told he had incurable cancer of the pancreas and might live "3 days, 3 weeks, or 3 months". He was extremely depressed and had not bothered to eat, dress, wash, or get up before lunch time for several days. A discussion took place between this man, his wife, one of the hospice doctors and myself. Asked to describe what we would see him doing if he felt less depressed (step 2), he described himself waking, getting up, washing, dressing, going for a walk, going home, taking the dog out, arranging his financial affairs and replacing his car with a newer one his wife could cope with better. The process of describing his own image of himself as not depressed, and setting modest goals derived from that description for the next day, seemed in itself to put this man in a frame of mind in which these things could happen. He achieved all these short term goals and went on to achieve the long term goals before dying six months later. After this discussion he commented that he was surprised to find the doctor talking about these positive things rather than about his illness. As far as this doctor was concerned he <u>was</u> talking about the man's illness - about its impact on his life and how <u>he</u> was coping with it.

In response to an initial question of the sort of changes they would like to see, people will often say "I want to be better", "To feel happier", or "To feel less depressed". These words can mean many different things to different people and some clarification is needed. "What would you be doing if you were better, happier, or less depressed?" For one man, who had just gone home, "independence" meant washing and dressing without his wife's help and helping to prepare the vegetables for the evening meal. By setting these goals explicitly and discussing them with his wife, Mr G hoped to prevent his wife "making an invalid" of him as he thought she had done each time he went home from hospital in the past. His wife joined in keeping a diary of his success in achieving these goals and celebrated that success with him. This stay at home was the longest he had had in many months.

The husband of a lady who was dying at home of cancer of the colon was doing almost all the nursing care his wife required, but they were both becoming increasingly unhappy about their relationship. Their only contact with each other was when she rang the buzzer to summon him and he left her as soon as he had done what she demanded. For him, "getting on better with his wife", meant among other things talking together. He felt unable to talk about their past together or about plans for the future, for fear of upsetting his wife, who knew she was becoming increasingly ill. He therefore thought there was nothing he could safely talk about with her. But his wife enjoyed talking about holidays they had had in the past, and wondered why her husband was becoming so uncommunicative. A short term goal for this couple was to talk for a few minutes about past holidays when he took her evening meal upstairs.

Many goals will be distant. Some may seem quite unattainable. After finding out what the goal areas are, one has to agree with the people involved what is a realistic short term goal to set within each of the goal areas (step 5). For this one needs to know the current state. One also needs to know the resources the person has to call upon, what related abilities they have and what support they have from their relatives for attaining goals, i.e., their strengths.

It is better to aim for a short term goal which is too low than too high, since the patient has probably had their fill of failure in the recent past as their illness has progressed, and an important part of maintaining morale (for everyone) is to get some success, even if on a modest scale. In addition to describing who will do what, goals should also state the criterion of success which the patient finds acceptable, e.g., go home by Friday, walk to the bathroom without pain.

One aspect of goal setting with terminally ill people appears paradoxical at first. Goal setting clearly has a place in training or rehabilitation. But with people who are deteriorating physically, it might seem they will always be failing to achieve whatever goals are set. However, much hospice care _is_ rehabilitation, enabling people to overcome their disabling condition and to live in whatever way they wish. Rehabilitation goals will often aim to re-equip a person with a skill such as walking, eating, dressing, which they will be able to use to function effectively in their day to day living. The rehabilitation aspect of terminal care might also include helping a person to deal with their emotional response to their illness. For one patient such a goal was that he would be able to talk to the doctor about his illness without becoming distressed.

However, at some time rehabilitation loses significance. When someone's physical condition is deteriorating rapidly, that person may be losing skills and abilities. This does not mean, however, that they have no aims or aspirations. A key part of hospice care is identifying what the patient wants to do and is capable of doing (maybe with much assistance) and helping them to do just that, perhaps within a very short time scale - now, today, or in the next hour. Again, the goals may relate to emotional or spiritual matters. Whatever it might be one has to find out specifically what the patient wants to do.

Goals are not necessarily the opposite side of the coin to problems. If you ask someone "What would you like to be doing this afternoon?", they may say "I'd like to go to Mass and then sit in the garden with my wife". There may well be things it is necessary to do or not do to allow this to happen. However, if you ask that same person what their problems are, you are unlikely to receive the reply "I anticipate having difficulty in attending Mass and then going outside to sit in the garden with my wife". Focusing on problems alone will miss many important ways of helping patients. A second reason to focus on goals rather than problems is that people produce very long lists of problems. When you ask them instead to describe their aims, or what they would be doing if the problems were solved, they often produce quite a short list. Here are one lady's numerous problems and difficulties:

Pain in right shoulder
Stiff right arm
Weight loss
Difficulty in swallowing
Poor appetite
Cataract in right eye
Cannot get dressed
Difficulty in walking
Bored all day
Drowsy during the day
Insomnia
Cannot concentrate
Unable to knit

Her list of goal areas was relatively short, simple and positive:

Pain control (right shoulder)*
Improve movement in shoulder*
Start knitting*
Write letters*
Get dressed
Go home*
Cook own meals

The asterisks indicate goals which immediate efforts were made to work on. The very distant goal of going home was broken down into a sequence of steps, the first of which was to go home for an afternoon with some relatives. The main point of this example is to illustrate the difference, in number and in kind, between the problems and the goal areas identified by simply asking the questions "What are your problems?" and "What do you want to do, what improvements do you want to see?"

The exploratory case studies were encouraging. The goal setting approach did seem to fit in with the approach used at this hospice. Furthermore, the model provided a framework within which a number of commonly experienced problems of care planning and coordination could be clarified.

The first common problem: a week after Mr Brown's admission someone asks in a ward round, "Now, what are we doing for Mr Brown?" No answer is forthcoming. A search through the notes begins to look for the reason for admission and to make a plan. No one has set any goals with the Brown family - explicitly or tacitly.

The second common problem arises when one member of staff (often the admitting doctor) knows what they are trying to do for Mr Brown, and are happy with progress, but a colleague has very little idea of why they are treating him this way, or how they are supposed to tell if they are making progress. The goal setting was implicit, and it left others in the dark.

The third problem arises when a patient's goals and the family's goals appear to be in conflict. Because these goals are not discussed explicitly, the conflict is deepened rather than resolved. This often comes to light in connection with a patient's discharge home. Mr Brown wants to go home. The Brown family think he should stay in the hospice. Why?

Mr Brown has things he wants to do which he thinks can only be done at home. The Brown family are anxious that they will not be able to cope with caring for him, or they have things they want to do which they think will be impossible if Mr Brown is at home. Clarifying the specific goals often points the way to a resolution. The issue becomes how the hospice team can help Mr Brown and the Brown family to achieve their various goals rather than one of whether or not he goes home.

It seems, then, that not only does the goal setting model fit in well with the existing hospice approach, but also that some of the difficulties faced by the hospice team arose from their failure to set explicit goals.

A second study (Lunt and Jenkins, 1983) was carried out to investigate the following hypotheses:

1. A system of explicit goal setting could be incorporated into the routine work of a hospice.
2. Such a system would be helpful to staff in planning and reviewing care.
3. The goals set would cover a wide range of areas of patient and family functioning.

The third hypothesis relates to the importance attached in hospice literature to "treating the whole person" and considering "the family as the unit of care". If goal setting provides a model of the hospice philosophy in practice, then the goals set should illustrate this breadth of approach. The study took place over thirty eight weeks. All patients were eligible for inclusion, regardless of diagnosis, condition or prognosis. The admitting doctor and the senior nurse on duty were to draw up a list of goals as soon as possible after admission. This would include as much direct involvement of the patient as possible. The senior nurse would have seen the family. The goals set would reflect priority needs of the patient and family, would be written in precise, preferably behavioral terms, and would be designed to be realistic (attainable rather than impractical). The goal list would be discussed in a ward round by staff of all disciplines, and would be written in the nursing notes. The list would be updated according to whether goals were attained, progress was being made, or the patient's illness or other life events indicated some other goal was more appropriate. At various stages the system was modified to take account of practical problems as they became clear.

Was explicit goal setting relevant and helpful to staff? The staff set goals with 166 (64%) of the 266 patients admitted during the study. The system was used equally for those patients who were to die in the unit during the admission and for "rehabilitation" patients who went home. Goals were rarely set for those who were to die within three days of admission, but this was only 13% of all admissions.

More notable then, is the high rate of use with the large majority of patients who survived more than three days. The staff did not have to use the goal setting system with any patient. Though a number of practical difficulties arose, the staff made persistent efforts to resolve them and there were seldom any problems of principle. On the other hand, the use of the system was discontinued within six months of the end of the study. Though senior staff still held the view that it would be valuable, the benefits were clearly not enough to outweigh the costs (time involved) when considered as a regular working tool. Explicit goal setting was said to be used when difficulties arose with a particular patient.

The evidence from this study appears to support the hypotheses: (1) that the goal setting model is compatible with existing terminal care practices in this hospice; and (2) that explicit goal setting is helpful to the staff. But it is also time consuming, and staff do not make their goals explicit unless specifically asked to. It is reasonable to suppose that explicit goal setting is helpful <ins>because</ins> the model corresponds to some important aspect of the hospice approach, though there is no data to support this directly.

What issues were covered by the goals set? Figure 1 shows the results of a content analysis of the goals set in initial lists, standardized to one patient for the purposes of comparison. A wide range of issues were addressed. Goals dealing with the control of discomfort and particularly pain occurred frequently. There was also an emphasis on helping the patient to make the most of life either in terms of functional capacity or how time was spent. The goals covered a wide range of issues besides purely medical matters. Thus, using explicit goal setting, attention is being directed to the very issues which hospice philosophy indicates.

The two studies described so far were exploratory and descriptive. No comparison or experimental manipulation took place. To test the validity of the goal setting model as a description of how hospice philosophy is translated into hospice practice, requires a comparison between hospice care and other terminal care. The last study (Lunt, in preparation) to be reported here investigated the following hypothesis:

Goals of care (explicit or implicit) will differ between practising hospice philosophy (hospices) and other settings. In hospices:

1) goals will cover a wider range of issues;
2) more goals will be attained;
3) more of the goals will be the patient's and family's rather than the staff's.

This study was conducted as part of a larger comparative study of hospice and hospital care. Random samples of 60 new admissions were selected in each of two hospices. One was where the earlier studies had been done. The other was similar in terms of its size, facilities, staffing, administrative arrangements (both being NHS services) and broad objectives. A comparable sample of terminally ill patients were selected from five wards of a general hospital. For a random half of each sample, the staff's care goals were identified. Once a week a doctor and a nurse familiar with the patient were interviewed separately using a standard procedure based on Kiresuk's Goal Attainment Scaling technique (Kiresuk and Sherman, 1968) modified for use in terminal care. Using a checklist of possible areas of concern a list of specific goals of care and treatment were obtained. At all interviews in all settings, the doctor or nurse received the same set of prompts to elicit their care goals for the patient and family. For each goal identified, a five point scale was devised according to which outcome at the end of the week could be rated by other members of staff. These scales ranged from "much worse than expected" through to "much better than expected", with the midpoint of the scale describing the situation which was expected to prevail in one week's time. Each goal scale was decided by the doctor or nurse and would be unique to that patient or that family for that week. The outcome score therefore indicates the level of success in reaching the staff's own care goals, using their own criteria of success. At the end of each interview the doctor or nurse gave the relative priority of each goal scale, and distinguished those scales which were patient's or family's goals from those which were the staff's. This method was designed to interfere as little as possible with normal care processes (Lunt and Jenkins, 1983). The staff were not asked to discuss the goals with the patient or family. This was an attempt to measure the end product of whatever process the staff normally went through in these settings to decide what they were aiming to do for their patients.

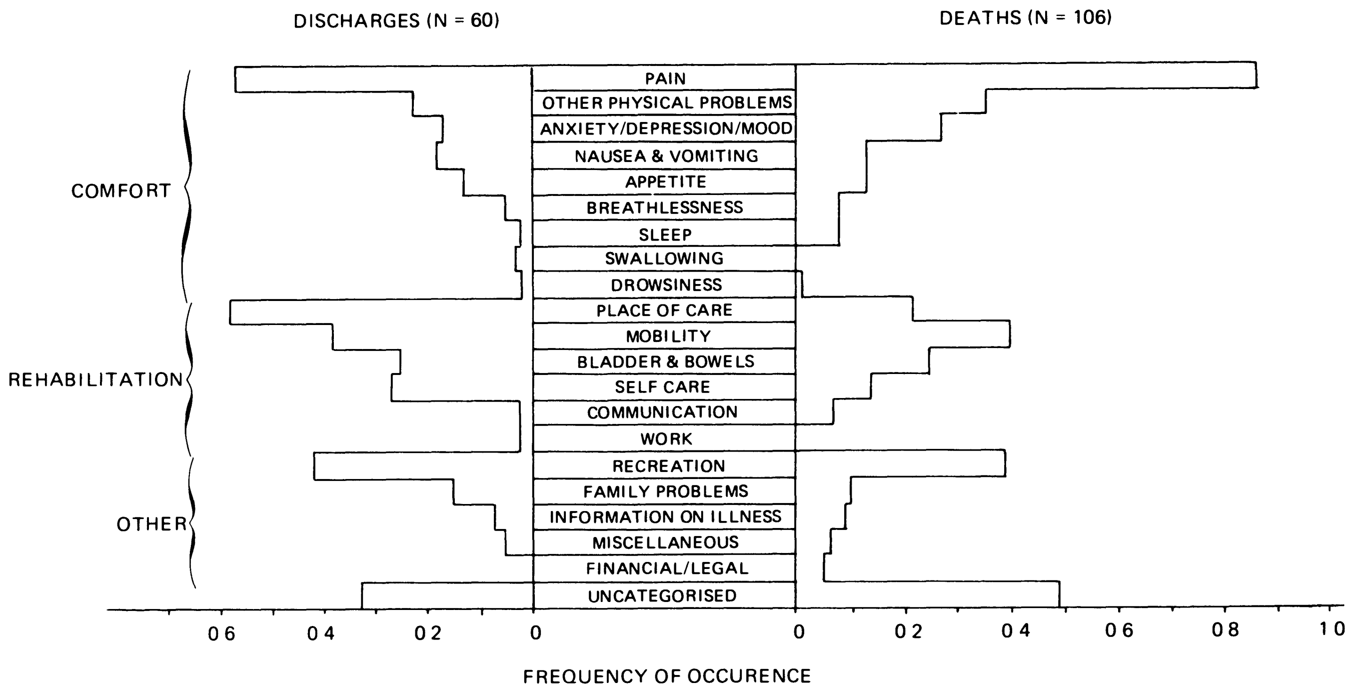

Fig. 1. Contents of initial goal lists: mean frequency of occurrence.

The full results of this study are yet to be analyzed. However, the results of preliminary content analysis of the data available are presented in Tables 1 and 2. These early results suggest that there are differences between the hospices and the hospital in the sort of goals being set. A greater proportion, and a greater absolute number, of "comfort" goals were set by hospital nurses compared with the hospice nurses. The hospital doctors were setting fewer goals in all categories than the hospital nurses or the hospice doctors and nurses. Most of the "other" goals are to do with family problems or family relationships. Thus the difference which seems to be emerging is of the sort predicted. Table 2 shows considerably poorer outcome by the end of each week in the hospital compared with the hospices, in relation to "rehabilitation" and "other" goals. By their own criteria, then, the hospital staff are having less success in these areas. Again, this is a difference in the predicted direction.

These early results of the comparative study lend further support to the goal setting model. If the final results of this study are similar then the question which immediately arises is whether the use of explicit goal setting in the hospital setting could be used as a method by which the hospice approach to care could be taught or replicated.

## IMPLICATIONS: A POSSIBLE ROLE FOR THE CLINICAL PSYCHOLOGIST

There is a clear role for the clinical psychologist in psychological intervention with patients, for symptom control and anxiety management. In so far as there has been psychological input to hospice care, it has been in these areas. Another possible role is indicated by the approach out-

Table 1. Preliminary Content Analysis of Goals (part sample only): Mean Frequency of Goals Set Each Week, Averaged Across Patients

| | Nurses' goals | | Doctors' goals | |
|---|---|---|---|---|
| | Hospice | Hospital | Hospice | Hospital |
| Comfort goals | 2.17 | 3.29 | 2.47 | 1.99 |
| Rehabilitation goals | 1.16 | 1.11 | 1.17 | 0.60 |
| Other goals | 0.85 | 0.98 | 0.88 | 0.48 |

Table 2. Follow up Ratings on Goal Scales (part sample only)

| | No. of goal scales with outcome rated:- | | |
|---|---|---|---|
| | Worse than expected | As expected | Better than expected |
| Comfort goals | | | |
| Hospice | 41 | 94 | 40 |
| Hospital | 40 | 87 | 38 |
| Rehabilitation goals | | | |
| Hospice | 42 | 57 | 37 |
| Hospital | 23 | 20 | 8 |
| Other goals | | | |
| Hospice | 23 | 33 | 28 |
| Hospital | 28 | 18 | 11 |

lined in this paper. This is to work with staff to help them to set appropriate care goals, explicitly, and in collaboration with patients and their families. This may involve the psychologist working with patients and their families directly, but would primarily be an opportunity to teach staff goal setting skills. The arguments set out in this Chapter suggest that hospice and hospital staff alike would benefit themselves, their patients, and their patients' families by acquiring these skills.

Many clinical psychologists are already highly skilled in goal setting with many other types of patients and with staff. They are also experienced in teaching these skills to their professional colleagues. It is my hope that clinical psychologists will soon find opportunities to deploy these skills in this hitherto neglected area.

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# THE DEVELOPMENT OF THE CONCEPT OF DEATH AND ITS RELATIONSHIP TO COMMUNICATING WITH DYING CHILDREN

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## INTRODUCTION

In 1973 Claire Mulholland published a collection of poems written to and about her child who had died of leukaemia. The shortest said simply:

Worst of all was the agony
Of not knowing
What you knew.

In this paper' I will consider some of the ways that psychologists have tried to examine the development of the concept of death and I will conclude that a careful evaluation of the results of these studies throws us back firmly to the individual child. An understanding of general findings is undoubtedly necessary for those working with very sick children, but it is not sufficient. I hope, though, that what I am about to discuss is not relevant exclusively to the sick child. Children who die, from whatever cause, leave behind siblings and friends and their subsequent adjustment to another's death is not without importance.

To some extent the current interest in children's attitudes to, and concepts of, death has increased in proportion to the reduction in child mortality. An illustration of the decline in infant deaths is given in Table 1.

How different it was in the 19th century when a clergyman could write for children thus:

> My dear children, the whooping cough is spreading fast; several little ones have died of it. Day after day I hear the bell tolling, and one little child after another has been buried here; as I walk out into the villages and the lanes and go into the schools, I see your little faces swelled and hear you coughing; but I am pained to think how few of you would be found ready were you children to die of it.

"The Childrens' Friend".

This quotation raises an immediate point of context. The well brought up five year old Victorian was likely to be taught about death, and heaven or hell directly or indirectly. Today the Indian child is taught that we

Table 1. Infant Mortality, England and Wales per 1,000 Live Births

| | |
|---|---|
| 1906-1910 | 117.1 |
| 1911-1915 | 108.7 |
| 1916-1920 | 90.9 |
| 1921-1925 | 74.9 |
| 1926-1930 | 67.6 |
| 1931-1935 | 61.9 |
| 1936-1940 | 55.3 |
| 1941-1945 | 49.8 |
| 1946-1950 | 36.3 |
| 1960 | 21.8 |
| 1970 | 18.2 |
| 1974 | 16.3 |

From Registrar General's Statistical Review.

will be reborn; the British child learns, if anything, that our spirit goes to heaven. But the British child may also learn that talking about real death is not quite nice. Most of the work I shall be quoting in this paper is based on work done in America or Europe; I know of only one study carried out elsewhere.

## THE AWARENESS OF DEATH

There is ample evidence that children under the age of five are aware of death. Kastenbaum (1974) reported that a 16 month old was observed to watch in alarm as an adult trod on a caterpillar. The child studied the remains and after a pause said "No more." Last year I worked with the parents of a boy who died of cancer just before his fifth birthday. Shortly before his death he told his parents that he did not want to be an angel and to go Jesus and he went on as follows:

> "People do die, don't they mummy?"
> "Yes everybody dies sometime."
> "Doctors can't save all the people can they?"
> "No, but doctors try very hard."
> "The doctors can't make me better, mummy, and neither can you, can you? But Jesus can make me better. Jesus will make me better with love and kisses because Jesus doesn't give pricks. And then he'll send me home."

Just a few weeks before he died, he told his mother that he did not like going to sleep because he dreamt about horrible things:

> "I dream about dying."
> "About you dying?"
> "Yes."
> "Does that frighten you?"
> "Yes, I know I'm going to miss you and daddy."

At a less anecdotal level Kane (1979), studying 122 mainly middle class children in America, reported that all the three year olds she interviewed were able to distinguish a picture of a dead rabbit from one merely sleeping. Maurer (1966) is one of several writers who have argued that experimentation with an awareness of alternating states of being and not being can be dated from the infant's first game of "peek-a-boo."

So far, then, we can be reasonably sure that children are familiar with the word 'dead' before they enter school. We know that some of them may associate it with immobility and with separation. But we are still a long way from understanding in detail what it is that a child understands.

## THE CONCEPT OF LIFE

As Anthony (1971) pointed out, living is not the sole antithesis of death; nevertheless, an understanding of animism and the notion of life in general is assumed, if not to precede that of death, at least to go hand in hand with it. Animism has a long history. Anaxagoras, a philosopher and friend of Pericles, was prosecuted for impiety for teaching that the sun and moon were not alive and it was not until Newton that all traces of animism were removed from the laws of motion.

In more recent years, though, Piaget is the name most often associated with children's concepts of life. In the first Piagetian stage, up to the age of about seven, life and will are attributed to inanimate objects generally. In the second stage, anything that moves is seen to have life and in the third, life is reserved for anything that appears to move of its own volition. Workers other than Piaget, e.g. Russell (1940), have tended to confirm the sequence that he outlined, without necessarily supporting the ages reported in his studies.

An interesting complication was thrown up by Huang and Lee (1945) when they questioned Chinese children. The children were more likely to attribute 'living' than 'life' to objects both animate and inanimate. This reminds me of a misconception encountered in an English child who illustrated a peculiarly English semantic pitfall when she said to a friend:

> "When you die your body is buried, not your head, just your body."

As Anthony has indicated, the adult observed is generally not aware of the misleading nature of much traditional usage. A child will hear of a live wire, a telephone which is dead, and hills that are alive with the sound of music.

## THE CONCEPT OF DEATH

When writing on the concept of life Wallon (1945) noted that there is a distinction between adults' concepts, which may be unitary, and children's which may not be. The earliest students of the development of the concept of death in children soon discovered that we are not talking of something a child has or does not have. Children do not go to bed one night with no concept of death and wake up next morning with one. A more accurate way of considering the topic is to look at components of the concept and stages of acquisition.

The notion of stages is exemplified in the pioneering work of Anthony. Originally published in 1940, her work was based on a study of 128 children, mainly from London, aged 4 to 12 years. Three methods were used to assess each child's concept:

a) Records made systematically by parents.
b) Definitions of the word 'dead' inserted into the vocabulary scale of the Stanford Binet Intelligence Scale.
c) A story completion test, translated from one used in Geneva.

Anthony used the second technique to assess age related stages in concept formation. She found responses falling into five categories:

A. Apparent ignorance of the word.
B. Interest in the word combined with limited or erroneous concept.
C. No evidence of non-comprehension but definition by reference to:
   a) associated phenomena not biologically or logically essential, e.g., the ritual surrounding a funeral;
   b) humanity specifically.
D. Correct, essential but limited reference.
E. General, logical or biological definition or description.

Table 2 shows the mean ages and age range of the children in each category, excluding 58 who were mentally subnormal.

Table 2. Meaning Given to the Word 'Dead' by Age

| Category | A | B | C | D | E |
|---|---|---|---|---|---|
| Under 5 | 1 | 3 | | | |
| 5 - 5.11 | 1 | 3 | 6 | | |
| 6 - 6.11 | 1 | 1 | 6 | | |
| 7 - 7.11 | | | 14 | | |
| 8 - 8.11 | | 1 | 6 | 1 | 1 |
| 9 - 9.11 | | | 8 | 1 | 1 |
| 10- 10.11 | | | 4 | 3 | 3 |
| 11- 11.11 | | | 2 | 1 | 1 |
| mean age | 5.6 | 5.8 | 8.0 | 10.2 | 10.4 |

From S. Anthony (1971), The Discovery of Death, The Penguin Press.

The age of 7 to 8 appears to Anthony to be the pivot of change, a finding, she asserts, that is fully in accord with psychological theory. The story completion test consists of a series of sentences to be completed by the children. Of 98 children responding, 45 made some reference to death, funerals, killing or ghosts.

Both chronologically and methodologically the next major investigation to be published was that of Nagy (1948) who had a sample of 378 Hungarian children aged 3 to 10 years. She, too, used three techniques:

a) Written compositions for the 7+ group with the instructions, "Write down everything that comes into your mind about death." The children were given one hour for this, a commentary on the stamina or patience of Hungarian children of this era.
b) Drawings for the 6+ age group.
c) Discussions for all, starting with a definition of death, then: "Tell me all you can think about death." "Why do people die?" "How can one recognize death?" "Tell me a dream about death." Nagy, like Anthony, used stages to categorize her respondents.

Stage 1 (3-5 years). Denial of death as a regular and final process. Death is a departure, a further existence in changed circumstances.

Stage 2 (5-9 years). Death is personified, one is carried off by the death man.

Stage 3 (9-10 years). Recognition of death as the inevitable dissolution of bodily life.

Commenting on her results Nagy noted that probe questions were of the utmost importance in revealing the true extent of understanding. She quoted one girl of 5 who appeared to know much but in fact was quite hazy. She mentioned also that death and sleep were closely related and reflected in a West African language that has no single word for sleep, the phrase used being "half dead."

The use of probe questions and a flexible, open ended discussion has given rise to an alternative to the stage related approach of the early workers, namely the notion of the component. As an illustration we can turn to an account of a conversation in a class of young children given by Rudolph (1978). The following is a slightly abbreviated version of the original.

The teacher discovers one morning that one of the two frogs she has recently acquired is dead; but before discarding it she leaves it in a bowl next to the enclosed live one. She knows the children would miss the frog and would ask to see it, in whatever state.

Roger, three and a half, comes up to the frog and asks:

"Why is this frog here?"
"This frog is dead," the teacher answers.

| | |
|---|---|
| Roger | Who deaded him? |
| Teacher | Nobody did anything to him. He died by himself. |
| Roger | Why did he die? |
| Teacher | He jumped out of the mud pan and we couldn't find him; so he had no mud or water, and he dried up and died. |
| Roger | Is this frog dead? |
| Teacher | Yes. |
| Roger | Put him in water. |
| Teacher | It won't do him any good. |
| Roger | Will he bite? |
| Teacher | No. |
| Roger | Why is the frog dead? |
| Teacher | He dried up and died. |
| Roger | Can I put him on the table? Isn't the frog dead? |
| Teacher | Yes. |
| Roger | Can he turn over? |
| Teacher | The frog is dead so he can't do anything. |
| Roger | Give him some food. |
| Teacher | No, the frog can't eat - he's dead. |
| Roger | Why is he dead? |
| Teacher | He had not water or mud, so he dried up. |
| Roger | I'll turn him over. |

As he does so, Roger seems to realize that the frog is incapable of resistance or reaction (certainly different from the jumpy live one he had finally made himself touch). But he pokes the dead frog and seems to be watching for reaction and asks still again: "Is the frog dead?"

After almost half an hour of studying the dead frog, Roger picks it up and brings it to the children at another table. Roger says to them: "See this frog is dead." "See Albert, this frog is dead because he didn't have any water." Several children ask: "who deaded him?"

From this account it is possible to discern at least three components of the concept. Roger is aware of causality but he and his peers turn first to an external agent who deaded the frog. He is hazy on dysfunctionality and seems unsure on irrevocability. The component approach was used by Koocher (1974) when he studied 75 mainly middle class children aged between 6 and 15. Four questions were asked of them about their perceptions of the meaning of death and about their expectations in regard to their own death. As well as these, Koocher gave the Similarities subtest from the Wechsler Intelligence Scale for Children, excluding all those who scored below 50% ile. He had, therefore, a biased sample. The battery was completed with three conservation tasks, enabling each child to be placed in a Piagetian category: pre-operational; concrete-operational; or formal-operational.

The results are given by question:

### What Makes Things Die?

| | |
|---|---|
| Category 1: | Magical thinking, egocentric reasoning. Typical of the pre-operational child. |
| Category 2: | Specific means of inflicting death. Most typical of the concrete-operational child. |
| Category 3: | Ability to abstract clusters of more specific possibilities, including physical deterioration. Typical of the formal-operational child. |

### How Do You Make Dead Things Come Back To Life?

Piagetian thought argues that children at the pre-operational stage of cognitive development, generally aged 7 and below, would not realise that death is irreversible. The child is still animistic in thought and cannot share the experiences of others. Since he has not died he might not be expected to regard death as permanent.

Eight children suggested ways in which the dead might come back, all eight being in the predicted pre-operational stage. An example was "Give them hot food."

### When Will You Die?

All but one made an estimate, the guesses ranging from 7 (from a 6 year old) to 300 by a 9 year old. The mean for the whole group was just over 80.

### What will happen When You Die?

There was a wide response to this, with 52% giving 'being buried' and 21% making some reference to an after life.

Kane (1979) considered components in some detail. She, too, saw middle class children aged 3 to 12 (N=122) and used an open ended interview. Her results by component are given in Table 3.

A word about personification: only 4% mentioned it and more admitted to believing in it. Similar findings have been reported by Koocher (1973) and Zweig (1976). Perhaps Nagy's results reflected something of Hungarian folk lore. Kane followed Koocher in finding the Piagetian framework valid.

Several subsequent studies have supported the general notions of a gradual accumulation of components and a move from the concrete to the abstract. Working once more with middle class children, in India, Misra and Mewara (1980) asked children aged 6 to 13 a series of eleven questions similar to those used by Koocher. They classified responses by age, with a

Table 3. Components of the Concept of Death

| | | Average Age Attained |
|---|---|---|
| 1. | Realization | all 3 year olds |
| 2. | Separation | 5 |
| 3. | Immobility | 5 |
| 4. | Irrevocability | 6 |
| 5. | Causality | 6 |
| 6. | Dysfunctionality | 6 |
| 7. | Universality | 7 |
| 8. | Insensitivity | 8 |
| 9. | Appearance | 12 |
| 10. | Personification | --- |

From B. Kane (1979), Children's Concepts of Death, Journal of Genetic Psychology, 134:141-153.

steady increase in generalization and abstraction and, at 9 years, a notable increase in an interest in ghosts. (This interest is discussed further below.)

The most recent general studies are those of Reilly et al., (1983) in America, and myself and Benjamin in England. The former, working within a Piagetian framework, asked questions of 60 children aged 5 to 10, mostly from "middle income" families. Children's understanding of personal mortality, judged by their response to the question: "Do you believe that some day you will die?" was related to their general cognitive level, assessed by a conservation task. The positive replies found by age are given in Table 4.

Table 4. Declared Belief in Personal Mortality

In answer to the question: Do you believe that some day you will die?

| Age | 5 | 6 | 7 | 8 - 10 |
|---|---|---|---|---|
| Percent replying yes | 50 | 73 | 82 | 100 |

From T. P. Reilly et al. (1983), Children's Conceptions of Death and Personal Mortality, Journal of Pediatric Psychology, 8:21-31.

My own study, carried out with my colleague Gail Benjamin, used a story about an old lady who died as a basis for discussion, with a heavy emphasis on probe questions. The responses of 83 children aged 5 to 8 have so far been analyzed in a preliminary fashion and these results suggest that 7-8 remains the nodal point in conceptual development. However, of 17 children aged 5, almost one third of the age group had a virtually complete concept, that is they gave several causes of death, they did not see it as reversible and, perhaps most surprising in the light of Kane's work, they had a good idea of the appearance of the dead person. Clearly it would be most unwise slavishly to follow the conclusion that 8 or 9 is the key age at which one can discuss death.

## EXPERIENCE AND CONCEPTUAL DEVELOPMENT

If the development of a concept is related to factors other than simple chronological age then one would predict that children's experience of death related topics will affect the rate at which various components of the concept are acquired. Kohlberg (1968) however, disagrees. Concepts of death and birth, he argues, develop naturally through Piaget type stages, "regardless of pre school scientific informational input." Possibly the experience of the death of a pet or a parent do not fall within Kohlberg's compass of scientific input. Several studies have addressed themselves to this topic, not with total agreement.

The most obvious experience to take into account is death itself: it could be predicted that children who have themselves experienced the death of a relative, close friend or a pet would have an accelerated concept. Kane (1979) found this to be so for children up to the age of 6 only, and Bolduc (1972) also supported this notion when children aged 9 to 14 were considered. Tallmer et al. (1974), looking at 3 to 9 year olds, did not find the same effect.

Closely related to family or pet deaths is experience of war or civil war. McWhirter (1980) studied children in Northern Ireland and found that a more advanced definition was indeed given by 4 to 5 year olds living in the areas of the troubles.

Little attention has been paid to social class as such. One study by Tallmer (1974) found that children from lower social classes had a more advanced concept possibly because they have more contact with death on the streets or because they are in greater danger themselves. This study was carried out in America.

Religious belief has been shown to have some influence; Blum (1975) found that Roman Catholics believed more in the after life than did Jews. Swain (1975) and Zweig (1976) however, found no difference between the religious groups they studied; the latter asserted that the media teach more than families or the church.

## IMPLICATIONS FOR COMMUNICATION WITH THE DYING CHILD

The first point to make here is that by no means all children with life threatening diseases are dying. I may walk onto a ward tomorrow and see twenty five children - I know that half of them are likely to be dead within five years if treatment continues with its present success rate. On another day the figure may be more or less half; there is no need to quibble about percentages. But it is equally possible that of those twenty five all but one or two will still be alive in a year's time. A primary question, then, is to ask whereabouts on the sequence of concepts about one's illness the child is.

Bluebond-Langner (1978) has discussed this topic and has suggested that there are five stages in the sequence. Table 5 shows these sequences.

Table 5. Self Concepts of the Dying Child

| | |
|---|---|
| 1. | Seriously ill |
| 2. | Seriously ill and will get better |
| 3. | Always ill and will get better |
| 4. | Always ill and will never get better |
| 5. | Dying |

From M. Bluebond-Langner (1978), The Private Worlds of Dying Children, Princeton University Press.

While I do not disagree with Bluebond-Langner I would like us to consider five more, shown in Table 6.

Table 6. Stages in the Concept of Illness

1. I am ill but I will get better.
2. I am very ill but I will get better.
3. I have an illness that can kill but I will get better.
4. My illness can kill my contemporaries.
5. I may die very soon.

The crucial stage, in my experience, is number three. Healthy children tend to use death references as a metaphor: "I could kill you" is rarely meant literally. When they hear their parents say that they must take their tablets or they will die, I suspect they take this threat in the same metaphor-like way. But when they hear of the death of someone of their age, or younger, perhaps a child they had seen up and about only recently, the full realization of the possibility of their own impending death comes home. I remember telling a 13 year old that another child on the ward, a boy of 7, had died the night before. She burst into tears, saying over and over again "I didn't want him to die." What she was also saying was, "I don't want to die."

Following this outburst I went on, not surprisingly, to talk with this girl about her own death. She made me promise to tell her when it was imminent. Given that she was 13 years old I was happy to do this. I was less happy when confronted with the obvious distress of a 3 year old, dying in hospital, with no family to support him. His mother knew how ill he was but was unable, for various reasons, to be with him. I did not talk to him about his death; I reflected that for a child of this age the greatest fear is separation and so I stroked him and told him that there would always be someone with him. If I were not there (and I am rarely on the ward for more than a couple of hours) then a playleader would be, or a nurse, or a doctor, or the ward clerk, or someone. Fortunately the organization of psychosocial support on our ward is such that I could promise this knowing that it would be arranged.

The three year old and the thirteen year old are easy. Much harder is the 6 to 8 year old and I hope that the research outlined in this paper has both emphasized the difficulties and outlined some guidelines.

I would, however, like to end on a plea that one should remember that communication is a two way process and one should listen as well as talk. Several years ago I worked with an eight year old girl with cancer. She was very sick indeed and although her parents had told her that she had cancer they had also told her that this was not a serious illness. She was having nightmares and a recurring theme was a monster which chased and sometimes caught children. The monster never caught my patient but the threat was ever present. Personification may not be apparent in research reports but we should not be blind to its possible presence.

Ghosts, too, appear in children's stories and fantasies. They appeared in the Indian children's stories already mentioned and they are discussed by Ferrari (1979). Ghosts, it is suggested, are transitional objects between one and not one and also between the living and the dead. They still participate in the life of the living and yet they are already dead, they go beyond and transcend the real and the unreal, the true and the false.

It is no accident that I begin with Piagetian cognitive stages and end with the ghost as a transitional object. A ghost, by definition, is beyond the descriptive powers of the conventional scientist.

We all have our own versions of hell, some of us have a version of heaven. The children with whom we work have their own ideas of life and death and if we are to communicate effectively with them we must start wherever they are.

I will conclude with an illustration from a child, a tape recording of an interview I had with a five year old boy with cancer. His father, who was present at this session, had asked to see a psychologist because he wanted advice on how best to talk to his son about death, should it be appropriate to do so.

| | |
|---|---|
| R.L. | What happens when someone's dead? |
| Christopher | Its body goes away. |
| R.L. | And what makes people die? |
| Christopher | Illness. |
| R.L. | Any other reasons? |
| Christopher | Battles. |
| R.L. | Can anybody die? |
| Christopher | Yes, at the end of their lives. |
| R.L. | And can they come back once they have died? |
| Christopher | Yes, they go up to heaven where there is more life. |
| R.L. | But can they come back to earth again? |
| Christopher | Well, a little bit of heaven can float down to earth but you can't see the people any more; their bodies have changed... They are invisible. |
| R.L. | So they can see us but we can't see them? |
| Christopher | Yes. |

Christopher was very ill when this tape was made but he was not dying. I took the conversation a little further but, perhaps most important of all, his father was able to store away some notion of what he, Christopher, knew. We might return to the poem with which we began:

> Worst of all was the agony
> Of not knowing
> What you knew.

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# WORKING WITH THE TERMINALLY ILL

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The focus of this paper is working with people with fatal illnesses as a clinical psychologist operating from a community health center. I am not at all sure that general practitioners readily see psychologists as being relevant to their needs when managing patients with terminal illnesses. However, as it becomes apparent through routine clinical practice that psychologists contribute usefully to problems in living other than traditional, more psychiatric problems, extrapolation to the problems of dying people and their families becomes more obvious. It is probably inevitable that if District psychology services continue to provide services to community health centers we are increasingly likely to be asked for help in instances where GPs have difficulty with the emotional and behavioral problems of fatally ill patients and their families. Also, as GPs become more informed about the research on terminal illness and more aware of the possibilities of reducing distress, help will be sought more frequently.

As a background to these trends which are information based, there is a further trend in the care of the fatally ill which also is likely to increase the demand for psychological intervention. The trend is that of more patients, particularly cancer patients, being cared for at home and being cared for longer at home. Although almost two-thirds of patients with terminal cancer die in hospital the past six years has seen a trend for shorter hospital episodes for symptomatic treatment and longer home care even though, eventually, the person may die in hospital. Also, the advent of the Wilkes' Report (1980) has prompted many Health Authorities to look more to the provision of community services and less readily towards the further provision of in-patient care. There is every reason to suppose that involvement of clinical psychologists in the care of the terminally ill in the community is likely to increase. The size of the demand is difficult to estimate but we can remind ourselves that in the UK about 120,000 people each year die with cancer, this being the main group of people comprising the terminally ill, and 31% of this group die at home at the moment. A significant minority of terminal cancer patients experience pain, nausea, incontinence, anorexia, anxiety or depression. About one-fifth of fatally ill people and one-fifth of their next of kin become moderately or severely depressed and between a quarter and a half of fatally ill people experience moderate anxiety (Carr, 1980). Table 1 reminds us that distress is by no means confined to the person who is ill. Given some capacity for empathy, it is clear that there is little that the terminally ill person must endure that his or her survivors can avoid.

Table 1. Common Sources of Distress

| Fatally ill person (P) | Those who love P |
|---|---|
| Awareness of impending death | Awareness of impending bereavement |
| Anticipation of loss | Anticipation of loss |
| Physical sequelae of disease process, e.g. tumors, lesions, nausea, incontinence, breathlessness, unpleasant smells | Empathic concern, aversion, etc. |
| Frustration and helplessness as disease progresses | Frustration and helplessness as disease progresses |
| Uncertainty about the future welfare of the family | Uncertainty about the future welfare of the family |
| Anticipation of pain | Empathic concern |
| Empathic concern | Caring for P, night-sitting, tiredness, etc. |
| Changes in roles with family, friends, etc. | Changes in roles with family, friends, etc. |
| Changes in abilities as illness progresses | Empathic concern |
| Changes in appearance as illness progresses | Empathic concern, aversion, etc. |
| Uncertainties about dying | Empathic concern |
| Dying | Empathic concern |
| | Discovery of death, directly or indirectly |
| | Practicalities, funeral, etc. |
| | Grief |
| | Role Changes |
| | Reconstruction of life |

Reproduced from Psychology and Medicine by Griffiths, D. (ed.), BPS/Macmillan, 1981.

This underlines the need to attend to the patient's family as well as to the patient, both for their welfare and in respect of their potential role in the support and care of the patient. Because of the almost inevitable distress of families, the adverse effects their distress will have on the patient and the fact that most patients express a wish, if possible, to be cared for at home, the focus of effective care has to be the patient and his or her family. Ideally, this means home care with effective support and backup services which, of course, may not always be available. In this context it must be stressed that the lack of in-patient accommodation which can guarantee a bed should it become necessary can be a severe disadvantage to and, in fact, a deterrent to home care. It can be extremely difficult or impossible to reassure families and patients if in-patient care for brief periods cannot be effectively guaranteed either for symptomatic treatment or for the relief of carers. Overall, I would argue that caring for the terminally ill at home is not only likely to increase but it is also desirable. What is important, is that appropriate provision is made both in terms of personnel and training.

In the context of a fatal illness, communication problems abound. The major difficulty is caused by discrepancies in knowledge of the patient's prognosis. Probably no more than 18% of terminally ill people are told explicitly of their prognosis by their GP or hospital doctor: current estimates vary between 12% and 96% which indicates that the situation may be improving. Almost 90% of close relatives are told of the prognosis (Cartwright et al., 1973). This discrepancy is set against clear evidence that about 80% of people want to know about a fatal prognosis (Samp and Curreri, 1957). Of course most patients realize at some point that they are not going to recover. The late discovery of the truth can have disastrous consequences for mood and health. When there is no mutual awareness of what is happening, the support that can be obtained from sharing anxieties and sadness is denied to the people involved. There is little doubt that the quality of life and home care is maximised when all concerned share a common understanding of the future and of each others problems. Although talking about dying can be difficult and painful at first, in practice most people cope well and experience relief when the topic is openly, sensitively and gradually discussed. Nor is the work always grim and morbid, far from it. Patients are typically more courageous, supportive and perceptive than one had ever anticipated.

A patient's awareness of impending death usually develops unevenly, with apparent progressions and retrogressions. He or she may one day appear fully to understand the implications of the illness and yet, the next day, to behave as if the previous day's awareness had never existed. Understanding may reappear some days later to be followed by dejection and anguish or by anger and bitterness at what is happening. Days or weeks later, the person may again appear to be unaware of the seriousness of their illness: and so it goes on, with the person showing a wide range of emotional responses in varying sequences over time. Conversely, another individual may have suspected the seriousness of their illness before this was confirmed and may subsequently set about finishing their life tasks with calmness and determination, never showing significant variability in emotional response. It is important that we view patient's emotional states as responses to their situations and not as <u>necessary</u> steps or phases in adjustment to impending death. It is important that those who are involved in caring for the patient are kept informed of his or her emotional reactions and apparent understanding. A useful practice is to record patients' relevant comments and behavior in addition to their usual medical notes and to make these accessible to all involved. Against this background of effective communication most communication problems within the family can be resolved in a manner, and to a level, that is acceptable and beneficial to all.

Effective and appropriate communication ameliorates many types of distress for the fatally ill and their families and is the background against which specific action may be implemented. Much relief is obtained through the application of high levels of pharmacological expertise and one role for the psychologist is to augment these beneficial effects of chemotherapy. The amelioration of anxiety or depression not only reduces these miseries but also pain and other discomforts. The goal here is to help the patient to escape from the adverse cycle of pain, deterioration of mood and worsening of pain into the beneficial cycle of improvement of mood, lessening of pain and further improvement of mood.

Although there are many physical problems experienced by people with fatal illnesses that lie outside the direct range of action of psychological approaches there are also many problems to which existing approaches and techniques may be readily applied. This requires <u>first</u> that we view the patient as living rather than dying and <u>second</u> that we set our goal as helping the patient to live as fully as they are able for as long as they are able. This orientation leads one back to the familiar psychological approach that is problem and goal orientated and away from the global and useless notions that are so prevalent e.g. people get depressed _because_ they are dying, and people are frightened of dying so one would _expect_ them to be anxious.

Just as it is not useful to say, in the general context, that anxiety and depression occur because the patient is living so, in terminal care, it is useless to say that they occur because the patient is dying. Provided that we place the same emphasis upon specificity and detail and upon the patient's perceptions and anticipations as we do in the context of general clinical work, the problems of the fatally ill person become amenable to intervention. The majority of people do not fear death in an existential sense: they fear unbearable pain, dependence and so on and they worry greatly about such things as pensions and childrens' schooling. Their losses are more tangible than the anticipated loss of life: they lose social involvement; the opportunity to complete long-term tasks; the opportunity to perform pleasurable or anticipated activities. With care and ingenuity the usual range of assessment and therapeutic skills is sufficient to help patients manage most of the problems they face. However, those of us brought up in the more behavioral traditions will find that this work calls for more thoughtful verbal activity than we may be used to, with more careful listening, reflection and effective management of a wide range of emotions such as resentment and anger.

Working with the fatally ill and their families in a community context has generated a reasonably consistent approach in which specific and general preparation are as important as the more active stages of involvement. Although the approach in any particular instance is inevitably tailored to the characteristics of that instance, there are sufficient consistencies to allow a broad strategy to emerge. For the sake of brevity, the essentials of this strategy are summarized in Table 2.

In the assessment phase, it is helpful to use a simple check list of common concerns to clarify the patient's specific sources of distress. Detailed description of concerns and problems leads to specification, with the patient and family, of achievable goals and thus to intervention strategies. Of course, this also identifies unrealistic hopes which can then be the focus for discussion, negotiation and information giving to find alternative, achievable goals. A check list is currently being used to collect data on first and subsequent assessments from a sample of terminal cancer patients being cared for at home: it is shown in Table 3.

Relevant intervention strategies to date are, generally, broadly behavioral and cognitive-behavioral with discussion, reflection and information giving to increase understanding and communication and to help patients and families to cope with separation and unachievable goals. Negotiation plays a large part in the improvement of communication and a good deal of effort goes into alleviating helplessness on the part of patients and families. Encouraging patients and families to express anger and sensitive concerns occupies a lot of time as does training in anxiety management. On the whole, work in this field involves a degree of befriending which is not commonly found with many other clinical problems. It arises most typically through the reciprocal sharing of concerns about death and through implicit or explicit understandings to guard against fears of abandonment on the part of the patient or the family. Also, there are many occasions when it is profitable to involve other people such as social workers, friends, trade union officials etc. who are more knowledgeable and effective in issues of pensions, benefits and related problems.

Table 2. Observations on Strategy

A. Preparatory

1. Be informed:
   - (a) in general, about dying and bereavement;
   - (b) in particular, about this person and family;
   - (c) identify other care-givers involved.
2. Be comfortable:
   - (a) with the vocabulary of dying and bereavement;
   - (b) with talking and thinking about own death;
   - (c) with talking to other people about their thoughts and feelings about their deaths.
3. Identify a confidante for oneself for support and to share grief, anger, etc.
4. Do not get involved if one cannot be reasonably 'available', at least *in extremis*.

B. Involvement

5. Offer help and be prepared to withdraw.
6. Stress confidentiality:
   - (a) within the family;
   - (b) between self and other involved professionals.
7. Assess:
   - (a) familial resources;
   - (b) patient;
   - (c) family members.
8. Identify problems.
9. Negotiate goals and strategies.
10. Work towards agreed goals.
11. Subject to confidentiality agreement, keep other professionals informed appropriately and review events/progress.
12. Contact family:
    - (a) soon after death;
    - (b) soon after funeral;
    - (c) c. fortnightly/monthly as necessary. (6-12 months).
13. Withdraw explicitly 'leaving door open.'

Despite the apparent relevance of psychological expertise to the problems that arise in the management of terminal illness we must recognize the relative inefficiency of single case work in this field as in many others and that there are other involved professionals with more routine contact with these families and patients than we might have as clinical psychologists. Hence, another major role for the clinical psychologist is that of staff training, particularly the training of GPs, nurses and social

Table 3. Checklist of Concerns

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A. Discomfort:
  - type
  - location
  - frequency
  - duration
  - intensity
  - resulting problem(s) (repeat if necessary)

B. Eating
Sleeping
Washing
Toilet
Mobility
Reading/TV/Radio
Car/Caravan/Boat etc.
Work/Jobs
Activities/Hobbies
Financial:
  - Cash/bills
  - rent/mortgage
  - loans/debts/hire purchase/credit cards
  - pension
  - fees/subscriptions
  - wills/gifts

House
Garden
Pet(s)

C. Present and future well-being of, and relationship with:
  - parent(s)
  - sibs
  - spouse
  - children
  - friends

D. The Future:
  - pain
  - treatment
  - abilities
  - appearance
  - control/dependency/isolation/abandonment
  - sig. others

E. Dying:
  - Unfinished business: practical and functional/achievement/ actualising/experiential/relationship/emotional
  - Funeral/cremation/burial/ashes
  - God/heaven/hell/religion/spiritual life etc. (punishment, reward/undeserving)
  - Non-existence/non-experiencing/unknowing etc.

  (Life review)

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workers. In one sense this is a familiar role in terms of the provision of information about psychological responses to imminent death, bereavement and pain. However, professionals often are uncomfortable with the subject of death, finding it difficult to talk about with patients and families and with colleagues and, thus, compounding and creating problems in communication, uncertainty and anxiety. It seems that people need to come to terms with their own mortality if they are to be able effectively and empathically to communicate with the fatally ill. Although information is important in this respect, structured role-play and other experiential exercises are a necessary part of such teaching. Perhaps the GPs are the most important as a first stage in this education process and the best point of contact would seem to be vocational training schemes and particularly the designated trainers in these schemes.

Although we must take great care not to professionalise dying and to force care upon those who do not want it, the last weeks and months of the lives of many people and their families are more uncomfortable, anxious, miserable and helpless than anyone would wish.

To help a person to live as fully as possible for as long as possible is a goal that can be interpreted sensibly and, above all, practically for most individuals at home.

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# SOCIAL ROLE PROBLEMS IN SEXUAL RELATIONSHIPS

# SOCIAL ROLE PROBLEMS IN SEXUAL RELATIONSHIPS

## AN INTRODUCTION

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## INTRODUCTION

Patients rather expect psychologists to ask them about their sex lives.

Clinical psychologists, whether they intend to concentrate on this aspect of patients' functioning or to gather background information, question patients about their sex lives.

Psychologists and patients alike are influenced by prevailing theories and assumptions about sexual functioning.

Sex therapists have proliferated in the past 10-15 years since Masters and Johnson published their work. Much research has been conducted on patient and therapist variables and treatment outcome. There has been less emphasis on examining and evaluating the underlying theories accounting for sexual dysfunction.

In the last few decades human sexuality has emerged as a respectable discipline. This has resulted in a broad range of analytical approaches to understanding sexuality, all of which have impact upon therapeutic approaches to sexual dysfunction. The three papers presented here represent different schools of thought about sexual behavior; this difference is reflected in their clinical approach. A brief review of some current trends in sex and gender research will serve to place these papers in context.

In most known cultures sexual behavior is a markedly private affair. The same pattern is true of most of the great apes. The consequence of this has been a remarkable paucity of what might be called hard data. Assumptions rather than facts about the nature of sexuality have therefore guided most theory. This is particularily evident in theories of female sexuality where a nineteenth century legacy of females as normatively sexually passive continues to reverberate. A normative assumption, it must be added, that is in direct contradiction to the eighteenth century when women were thought to be sexually insatiable. With the emergence of the Feminist Movement, beginning in the early sixties, many of these assumptions have been questioned. Glen Wilson, in his paper, derives his theoretical perspective from evolutionary biology, a field in which a feminist rethinking has had some influence.

Since Darwin evolutionary biologists have sought to answer those most vexing and refractory of questions about the nature of human sexuality - why does the human female, unlike her primate ancestors, possess breasts, protruding buttocks, continuous receptivity to intercourse, concealed oestrus, and multiple orgasm? A popular explanation contends that female sexual traits have been selected for over time, in order to reinforce a monogamous pair-bond and consequently to reduce competition between males (e.g. Beach, 1978; Campbell 1970; Morris 1967). Monogamous bonding is thought to be adaptive since females, limited by infant raising, needed help from males in order to reproduce successfully, so they developed breasts, buttocks and continuous receptivity in order to entice and tie males into mother-offspring groups. Lovejoy (1981) takes this argument a step further and contends that monogamous pair bonding led to bi-pedalism in that males, as they became more invested in infant care, needed the use of their hands to forage and bring the food home to mother and baby, so they stood up. Continuous receptivity kept them motivated and on the job.

These arguments have been criticised on a number of grounds. Hamilton, (1984) for example points out that evolutionary biologists assume female sexuality has evolved through selection by males and moreover, that all men everywhere have similar tastes in female attractiveness. The pair-bond hypothesis, additionally, is not particularly well supported by primate evidence. Research on monogamously mated primates shows a poor correlation between the existence of pair-bonds and sexual activity; monogamously mated gibbons for instance, are fortunate to mate every two or three years. In the primate world monogamously mated species tend to be around the same size. Humans, in contrast, are moderately dimorphic. Dimorphism, as Darwin noted more than a hundred years ago, is associated with polygynous mating systems. Since 80% of the world's societies have polygynous marriage systems it seems unlikely that we can assume an evolutionary history of monogamy for humans. Both the pair-bond hypothesis and the Lovejoy hypothesis depend upon an assumption that females relied upon males as providers of food necessary for survival; sex being the pay-off. Yet evidence from a number of hunter-gatherer societies repeatedly shows that females, through gathering, provide more than 80% of the total diet consumed, while hunted meat is more a prestige food than a powerful evolutionary force (see Zihlman and Tanner, 1978). Finally, and possibly most compelling, recent observations of sexual behavior in monkeys and apes throw into question the supposedly uniquely human attributes of concealed ovulation, nonreproductive sexual activity and female orgasm (see for example, Burton, 1971; Chevalier-Skolnikoff, 1974; Lancaster, 1979; Zumpe, 1968; Mitchell, 1966; Goldfoot, 1980; Hardy, 1981).

Glen Wilson, in his paper, draws heavily on the work of sociobiologist Donald Symonds. Symonds, in contrast to the foregoing "group" oriented hypothesis, suggests an hypothesis about female sexuality that is couched in terms of evolutionary advantage to the individual.

Essentially Symonds is contending that since, under natural conditions, females do not vary greatly in the number of offspring they produce, female productive success will be constant in a given environment and not much affected by her sexual conduct. Female sexuality therefore, is immaterial to her evolutionary history. That females do experience sexual desire and orgasm is because humans share an embryonic anlagen; female orgasms occur as a by-product of mammalian bisexual potential hence females may experience orgasm because it is adaptive for males.

Wilson has taken this argument and applied it in a very creative way to the clinical problem of anorgasmia. Pointing out that this particular "symptom" of sexual dysfunction is generally diagnosed as a by-product of guilt and anxiety, Wilson uses Symonds theory to argue that it is simply due to the different natures of men and women. Because orgasm is not "natural" to women, they must learn how to achieve it. Put in this light anorgasmia can be seen as a problem of teaching and practice rather than something of a personal failure.

Symonds' theory, however, has not gone uncriticised by other sociobiologists. Hardy (1984) regards this approach as "evolutionary utilitarianism". Evolution, she argues, is always a compromise between preexisting structures and selection favouring improvement. To believe that female sexuality is "invisible" to natural selection, she contends, is to ignore her very high stakes in reproductive success through her role in reproduction. And, parenthetically, from a societal point of view, Hardy observes that women's readiness to engage in sexual activity is great enough that the majority of the world's cultures have made efforts to control it.

Hardy theorises (1984) that female primates evolved a strategy that played upon male paternity insecurity. The shift to situation-dependent receptivity, concealed ovulation and assertive sexuality allowed females to manipulate male paternity confidence such that males would tolerate infants, even care for them, and by so doing increase the likelihood of infant survival.

For the most part evolutionary biology, with its emphasis on the differing reproductive interests of men and women, marks difference between the sexes. This stress on difference is central to Freud and to the more sociological approaches to understanding human sexuality taken by, for example, Kinsey, and Martin Pomeroy (1948, 1953) and Hité (1976). But it took the Women's Movement to really raise the question of the extent to which the differences are biological or political. The problem of the extent to which the sexes are the same or different, equal or oppressed, dominated much feminist sholarship of the 60's and 70's, and indeed the debate continues to this day. Sidney Crown acknowledges this debate in his paper on the impact of feminism on women's sexuality. While Glen Wilson views men and women as products of bio-evolutionary divergence, Crown accepts some biological differences, but his accent is on social equality between the sexes and the consequences of this equality for human sexual functioning. Reporting from his clinical practice, he shows us that while some women have benefitted from a growing personal autonomy, others are left feeling guilty and inadequate in the housewife's role. Men, on the other hand, faced with the contemporary blurring of sex roles, sometimes respond by erectile impotency and premature ejaculation as unconscious means of punishing competitive females.

Neither Wilson nor Crown introduce the construct of "gender". Increasingly scholarly work on human sexual behavior is analyzed within a "gender" framework. It seems timely therefore, to introduce this construct, particularly as it has relevance, on the one hand, to Wilson's stress on sex differences, and on the other, to Crown's concern with status issues and the effect of status on sexual functioning. The term "gender-identity" was first introduced by Robert Stoller (Katchadourian, 1978) to distinguish between sex as anatomy and physiology, and sex as behaviors, feelings, thoughts and fantasies. In other words, while sex refers to being a genetic male or female and is usually ascribed at birth, gender refers to a sense of maleness or femaleness and implies nothing about biological sex. Discriminating between female and feminine, male and masculine, has allowed for a much finer grained and interesting analysis of sexual difference than was previously possible.

Among the most interesting developments in gender studies are those centering upon the problem of the acquisition of gender-identity, a central question being to what extent is a sense of "femaleness" or "maleness" learned or inherited through biological principles. Money and Ehrhardt (1972) break down gender-identity into three components: (1) core gender-identity; (2) the gender-role of public behavior; (3) sexual orientation - or the private expression of sexual preference. Until quite recently there has been wide agreement that gender-identity was not determined by biological principles of chromosomes, and gonadal and pre-natal hormone influence, rather it was determined by ascribed sex of rearing. This has had significant implications for those children born with indeterminate genitalia since a surgical decision about sex assignment could be made that did not depend upon the chromosomal make-up of the child in question. Money et al., also proposed a "critical period", from 19 months to 2 years, during which this decision must be made. Gender-identity, they maintain, is fixed by age four. In contrast to gender-identity, it is thought that gender-role behavior is influenced by the pre-natal hormone environment. For example, chromosomal females subjected to high androgen levels in utero, are reported to demonstrate more "rough and tumble" patterns of play than female control samples.

These conclusions have been widely criticised. Maccoby (1979) for instance, while she accepts the social ascription of gender-identity argues that hermaphrodites, who form the data base for these conclusions, have been exposed to abnormal pre-natal situations. If gender-identity depended at all on pre-natal hormone sensitization then hermaphrodytes would be in an intermediary position, hence they might be more malleable to social reassignment than children whose pre-natal environment predisposes them more definitely to the characteristics of one sex or another. Another source of evidence that argues against the social ascription of maleness and femaleness comes from the Imperato-McGinley (1979) studies. Based on evidence from two villages in the Dominican Republic, Imperato-McGinley et al. found that genetic males, suffering from 5 alpha reductase deficiency and unambiguously reared as females, changed without much difficulty to a male identity and male gender-role at puberty. Thus these authors concluded that the relationship between gender-identity and biology is at best inconclusive. They suggest that gender-identity is not fixed in early childhood, instead it evolves, becoming fixed at puberty.

The illumination that a gendered perspective can provide is not limited to the study of sex differences. Contemporary scholarship has, for example, decomposed "The Family" into differing units of analysis and subjected them to a gendered social and historical examination. Among the first to attempt this was Juliet Mitchell (1966) who argues that "The Family" cannot be seen as a monolithic "haven in a heartless world" (Lasch, 1977) rather, that it is necessary to analyze its underlying structure. The kind of structural analysis she recommends shows that "The Family" means very different things to different family members depending not only on gender but also on generation, class and ethnicity. Destructuring "The Family" has significant implications for the study of sexuality. It is within the confines of the family, through the avenues of marriage and pregnancy, that women's sexuality reaches its full social, political and psychological significance. The often paradoxical consequences to women of this institution are clearly delineated in Sidney Crown's paper.

Myfanwy Scott Brown's paper on the treatment of incest reflects the growing awareness of these structural differences within the family and the effect of this upon family members. According to Breines and Gordon (1983) child abuse, wife-beating, and incest, while known to occur, have only recently been recognized as serious social problems. Breines and Gordon are of the opinion that these forms of what might be called family violence are only comprehensible if seen in the context of wider social relationships of power. Furthermore, that there are patterns to violence between intimates that can only be fully understood through an analysis of gender and generation within the family.

Breines and Gordon's stress on relations of power, gender, and generation as central to an understanding of incest is not reflected in the classical clinical literature on the problem. Here the daughter, in cases of father-daughter incest, is likely to be described as seductive, the mother as collusive, while the father is subtly absolved of responsibility by virtue of diminished capacity of one sort of another. In a radical departure from this position, the treatment program described by Brown advocates the removal of the offending father from the home. This strategy prevents the child victim from suffering a two-fold trauma - incest and alientation from mother and family. But it also requires that the father "earn" his way back into the home. This restructuring of traditional familial relations of hierarchy provides an interesting example of how changing societal mores are reflected in a clinical therapeutic approach.

Incest takes place in a situation where issues of power, gender and generation exist but these may be less relevant to an understanding of the perpetrator's behavior than his personal psychosexual history. Several workers (Berliner, 1983 and Abel, 1979) believe there to be no automatic difference between incestuous and paedophile offenders. If this can be shown to be the case there are obvious implications for treatment. The treatment program Brown describes has been adopted in many parts of the US and has strongly influenced treatment initiatives currently developing in the UK. Research into the aetiology of sexual offending may shift the treatment focus from the family dynamics to the perpetrator's sexual deviancy.

How we proceed clinically depends on our knowledge of human sexual behavior derived from scientific enquiry and our attitudes, beliefs and values absorbed from the zeitgeist. The following papers contribute to the informed debate on the nature of human sexuality.

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# BIOLOGICAL AND SOCIAL ASPECTS OF FEMALE SEXUAL FUNCTIONING

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Perhaps the most common problem tackled by sex therapists is what used to be called frigidity and is now called anorgasmia (a merciful abbreviation of the more grandiose "female orgasmic dysfunction"). This is often viewed as a pathological condition, due mainly to excessive guilt and anxiety in the woman, or to clumsy, ham-fisted love-making by the man. There maybe some truth in these ideas, but they obscure the real basis of the problem which can only be understood in terms of the differing nature of men and women.

The female orgasm is notoriously unreliable, varying from woman to woman and from occasion to occasion. The Redbook survey of 100,000 U.S. women (Tavris and Sadd, 1977) gave the following figures: 15% of women "always" had orgasm during intercourse; 48% "most of the time"; 19% "sometimes"; 11% "once in a while"; and 7% "never". Since the sample was probably biased towards "sexy" women, these figures might err on the optimistic side.

Fisher's (1973) study highlights the importance of clitoral stimulation in producing orgasm. Of the 38% of women who "always or nearly always" had orgasm, 63% used clitoral stimulation before intercourse and 35% during or after. A high proportion of women reported that intercourse alone was not sufficient for orgasm; direct manual stimulation was also necessary. Of Hite's (1976) sample of 3000 (mainly feminist) women, 30% attained orgasm during intercourse without manual stimulation, 19% reached orgasm during intercourse but only with additional manual stimulation, 22% rarely had orgasm, and 29% never had orgasm during intercourse. The 30% who were orgasmic without manual assistance generally used techniques that provided clitoral stimulation (e.g., from the partner's pelvic area) in addition to penile thrusting.

Western people use a lot of foreplay in their love-making. 10-15 minutes is typical compared with intercourse itself which lasts another 2-10 minutes. This shows recognition of the fact that a woman's response is usually slower than that of the man and that sustained stimulation of the clitoris is required for the woman to achieve orgasm. Even so, surveys show that "insufficient foreplay" is the most common complaint that women have to make about their partner's sexual performance.

## OTHER CULTURES

Anthropological observation reveals great cultural variation in the occurrence of women's orgasm. In a few cultures, all the women are said to have orgasm while in others none of the women are believed to have orgasm and the very concept of female orgasm may be absent (e.g., some of the Irish bog peoples). Symons (1979) suggests that the critical factors mediating the occurrence of female orgasm within a culture are the extent of sexual permissiveness and the level of male skill in love-making. A high degree of both are necessary (though not sufficient) conditions for women to be orgasmic.

One of the most female-orgasmic places in the world is Mangaia, in the Cook Islands. Here teenage boys are given instruction in sexual techniques including breast kissing and cunnilingus and taught the importance of delaying ejaculation until the girl has had several orgasms (Marshall, 1971). Practical exercise in intercouse follows, with an older, experienced woman who teaches the boy how to delay ejaculation and time it so that it occurs simultaneously with the partner's climax. Girls are instructed by older women in how to take active control of intercourse in order to ensure their own orgasm. The Mangaians believe that orgasm must be learned by a woman with the help of a good man. A man who fails to bring his partner to orgasm risks losing her to another man and his reputation may be ruined with other women.

The "East Bay" community of Melanesia is another culture where female orgasm is expected as a matter of course. This is achieved by extended mutual masturbation with insertion of the penis occurring just before the female orgasm (Davenport, 1965). However, these Pacific peoples are exceptional. In the vast majority of societies men take the sexual initiative and proceed rapidly to their own orgasm with little regard for the satisfaction of their partner (Ford and Beach, 1951). The result is that women in these societies seldom experience orgasm. As Margaret Mead (1967) observes, "that whole societies can ignore climax as an aspect of female sexuality must be related to a very much lesser need for such climax".

## OTHER ANIMALS

The animal evidence is also illuminating. Many female mammals display what Beach calls proceptivity, seeking and presumably enjoying sex, but there is no compelling evidence that they experience orgasm. Primates do not have orgasm in the wild, though they occasionally do so in zoos and laboratories following a degree of stimulation that does not occur naturally.

Burton (1970) harnessed three female rhesus monkeys on a frame and fed and groomed them until they presented. He then gave them five minutes of clitoral stimulation, five minutes vaginal stimulation with an artificial penis, four minutes rest, and another five minutes of vaginal stimulation. As a result of this treatment, two out of the three monkeys showed vaginal spasms indicative of orgasm. This compares with usual rhesus copulation which lasts 3-4 seconds - obviously much too quick for female orgasm to occur. It appears, then, that non-human female animals have a capacity for orgasm but that it may be realized only with prolonged clitoral stimulation of a kind that seldom occurs in the wild. Even then, it is highly unreliable, not all animals experience it, and those that do are not consistent.

Interestingly, orgasm in captive female monkeys has been observed to occur as a result of lesbian contact. Occasionally, when a female stump-tail monkey mounts another female she makes pelvic thrusts which culminate in muscular spasms, facial expressions and vocalizations like those of an ejaculating male (Chevalier-Skolnikoff, 1974). The same does not happen when the female is mounted, whether by a female or male. The parallel with Hite's finding that lesbian sex produces more orgasms than heterosexual intercourse is striking.

## THEORIES OF FEMALE ORGASM

This evidence concerning female orgasm in humans and animals is pertinent to several theories that have been put forward to account for the evolution of the female orgasm (Wilson, 1981a).

The first is repression theory, stated most explicitly by Sherfey (1972), although similar ideas have been expressed by philosophers such as Marcuse and Reich. According to repression theory, female orgasm occurs easily in animals and primitive peoples and the difficulties experienced in our society are due to the repressive forces of civilization. Women are supposed to be naturally very sexy and responsive creatures but inhibitory control has been imposed upon them by political and religious agents in the interest of social stability and family life. This viewpoint is appealing to some feminists because it blames sex roles for women's difficulties and it has thus gained quite a widespread following in recent decades. However, it conflicts fatally with the known facts. Female orgasms are actually less common in animals than humans and, with the exception of a few Pacific Islands, women in primitive societies fare worse than modern Europeans. Attempts to link orgasm difficulty with type of religion or devoutness have always failed to implicate this aspect of upbringing. In my own survey of nearly 3000 women, for example (Wilson, 1981b), the following percentages of orgasm difficulties were reported: Catholics 41%; Protestants 43%; and Agnostics 46%. Despite this and many similar findings (Fisher, 1973), sex therapists in the Masters and Johnson tradition persist in the belief that religious guilt-induction is a major cause of anorgasmia.

A second theory of female orgasm, proposed by Elkan (1948), may be called come and get it theory. Elkan's argument is that female orgasm is unnecessary in any species in which the male has a mechanism for restraining the female in a copulatory position until he has ejaculated. This implies that rape is the natural order of the animal kingdom and that emancipation of the human female produced a need to evolve a new sexual incentive system - the reward provided by orgasm. Few ethologists take this theory seriously because the human male's superiority in strength over the female is equivalent to that of many species which are not female-orgasmic. Elkan would have to argue that the evolutionary need for female orgasm arose out of a uniquely human convention of requiring female consent before proceeding to intercourse. This is not very persuasive because female consent is necessary for copulation in a great many non-human, non-orgasmic species. Also, it does not explain why the phenomenon of female orgasm is so elusive.

A more widely held and plausible theory of female orgasm is that of pair-bond consolidation. This has been mooted by many psychologists and ethologists such as Beach, Wickler, and Eibl-Eibesfeldt, and has recently become popular through the writings of Desmond Morris. As with Elkan's theory, female orgasm is presumed to be a late development in evolution, serving a function exclusive to humans - in this case, the function of promoting monogamy and making family life more rewarding. Female orgasm and loss of estrus are both construed as evolutionary channels by which the human ape has returned to a bird-like pair-bonding arrangement so that the usually dependent human infant is helped by two parents rather than just one. The pleasure of sex, therefore, is used not just for reproduction but for social purposes almost as important. If a woman is sexy at all times in the cycle (even when not fertile) and has highly rewarding orgasms along with her man, this will cause a couple to fall deeply in love, the better to cooperate in the task of child-rearing.

At the social level there might be some truth in this. Women may stay with men who give them good orgasms, but the argument could be circular in that women usually have more orgasms with men they love. From the biological point of view there is a greater problem with pair-bond theory. If female orgasm evolved to serve an important function (i.e., to enhance survival), why would its occurrence be so sporadic and unreliable? Evolved mechanisms, whether anatomical, physiological or behavioral, are characterized by sure-fire operation - they are never half-hearted. The failure to find any evidence that orgasmic women have a breeding advantage over non-orgasmic women is detrimental to any theory of female orgasm which assumes it to have evolved to serve a biological function.

The next theory of female orgasm, which has been floating around in various forms for many years, I have called jackpot theory. This supposes that a female orgasm identical in speed and ease of occurrence to that of the male would be reproductively disadvantageous because intercourse would be terminated 50% of the time before ejaculation. On the other hand, a total absence of orgasm would mean that sex would be unrewarding to the female and therefore avoided. A compromise has thus been arrived at whereby women have orgasms (sometimes even multiple orgasms) but seldom so quickly that the man has not ejaculated at least once in the meantime. In Skinnerian terms, women are on a variable reinforcement schedule which is known to be particularly resistant to extinction of behaviors preceding it. This theory accounts for the equilibrium that seems to have been arrived at in the human female, but it does not adequately explain the late evolutionary appearance of female orgasms. Like pair-bonding theory, it stumbles on the fact that female orgasms do not seem to have occurred often enough in our ancestors for any selective advantage to have taken hold. It is unnecessary to postulate any sudden anatomical change from ape to human since the physiological apparatus for orgasm is already present in female apes. And if enjoyment of orgasms is unnecessary for the successful reproduction of female apes, why should women be any different? The problem is not so much in explaining why women's orgasms are slow and unreliable, but in explaining why they occur at all.

The theory that is most convincing to me is artifact theory (Symons, 1979). Symons argues that the female orgasm has no evolutionary function at all. The potential is there simply as a spin-off of the fact that females have most of their neurology in common with males - it is neither natural nor necessary. For the sake of embryological simplicity, the neurological blueprints of male and female are left as similar as possible without incurring reproductive disadvantage. A female canary has all the mechanisms for singing but does not do so unless injected with male hormones. The human male has vestigial nipples which are quite useless to him and not erotically sensitive unless he is given estrogen. Likewise, a woman's clitoris is a vestigial penis. As such it is rather small and not located in such a place that intercourse is the optimal method of stimulation. If sufficient clitoral stimulation is given orgasm will occur, but a great deal of mechanical or chemical attention may be necessary in addition to, or instead of, intercourse.

This theory puts new light on the Masters and Johnson observation that the vaginal spasms of female orgasm are timed at 0.8 of a second, the same as the muscular contractions that pump ejaculate through the urethra of the male penis. This is not because male and female genitalia are designed for the ultimate compatibility of simultaneous orgasm but simply because the wiring of nerve to muscle is the same for the two sexes. Multiple orgasm is possible for women because they do not actually ejaculate and, for the same reason, is a capacity that exists in some prepubertal boys.

## THE ROLE OF ANXIETY

If orgasm is not natural for women, then its absence is not pathological. Emotional inhibitions such as guilt and anxiety would not then be expected to be of major significance. This, indeed, is what all of the research suggests. Comparisons of orgasmic women with those who are sexually experienced but non-orgasmic (Shope, 1968; Fisher, 1973) find little difference in personality between the two groups. If anything, the orgasmic women are more emotional, not less. They also tend to show more persistence and endurance than non-orgasmic women, which is what might be expected if orgasm is a task that has to be worked at for a woman. It is also interesting that such research has failed to implicate the personality or behavior of the husband, or traumatic experiences in earlier life, such as rape or assault. Survey research also suggests that guilt and anxiety are not of major etiological significance. Table 1 shows results from my own survey of 4,767 readers of a national newspaper, a sample that is roughly representative of the occupational structure of Britain (Wilson, 1981b). While orgasm difficulty, painful intercourse and boredom are commonly reported by women, inhibitions such as disgust, guilt and anxiety are relatively minor impediments.

Table 1. Percentages of Men and Women, Under and Over 30 Years Old, Reporting Various Sexual Difficulties

| | Male | | Female | |
|---|---|---|---|---|
| | <30 | >30 | <30 | >30 |
| Impotence | 25 | 29 | 6 | 7 |
| Orgasm too quick | 59 | 53 | 12 | 14 |
| Inability to have orgasm | 23 | 23 | 44 | 41 |
| Painful intercourse | 18 | 13 | 45 | 37 |
| Disgust | 5 | 4 | 8 | 9 |
| Guilt | 15 | 13 | 19 | 18 |
| Anxiety/fear | 14 | 14 | 19 | 16 |
| Boredom/disinterest | 21 | 17 | 35 | 36 |

The hypothesis that things are changing with the advent of women's liberation is not supported by a comparison of today's women with their mothers' generation. Splitting the sample into two groups of above and below 30 years old yields virtually identical figures. Although raised in a much more liberated social climate, the under 30s (averaging 23 years old) have exactly the same problems as the over 30s (averaging 40). If permissiveness promotes female orgasm, as Symons believes, then other changes occurring in Western Society, such as the higher expectations created by feminism, must be offsetting its effect. There is evidence that feminists are less happy in their marital relationships, both generally and sexually, than traditional women (Wilson, 1982) though the direction of cause and effect is not clear.

I mentioned that religion cannot be demonstrated to impede orgasm even though it does appear to reduce some forms of sexual behavior (e.g., premarital and extramarital). Another hypothesis concerning the role of the social environment is examined in Table 2 which divides the sample according to whether they recalled being punished for sex play as a child and whether their parents kept a special instrument for punishment, such as a strap or cane, in the house. Although frequently implicated by both analytic and behavioral therapists as a source of sexual inhibition, the impact of parental strictness and corporal punishment is minimal.

Table 2. Punishment History Related to Sexual Difficulties (percentages reporting)

| | Punished for sex play | | Special instrument | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Impotence | 22 | 14 | 17 | 14 |
| Orgasm too quick | 38 | 29 | 33 | 29 |
| Inability to have orgasm | 33 | 35 | 34 | 36 |
| Painful intercourse | 30 | 32 | 36 | 31 |
| Disgust | 11 | 7 | 8 | 7 |
| Guilt | 22 | 17 | 15 | 18 |
| Anxiety/fear | 19 | 17 | 15 | 17 |
| Boredom/disinterest | 25 | 29 | 28 | 29 |

## TREATMENT IMPLICATIONS

Artifact theory predicts that anti-anxiety drugs would not be effective in the treatment of anorgasmia whereas male hormones might well be helpful. This is exactly what has been found by Carney, Bancroft and Matthews (1978). Figure 1 shows that testosterone significantly improved sexual responsiveness, but another group of women treated with an anxiolytic drug derived little benefit. Presumably, the testosterone works by sensitizing the clitoris, making the woman more man-like. There is a slight danger of general masculinization (e.g., hair on the chin), but the body reacts by adjusting its own internal secretions so as to restore the original hormone balance as far as possible. For both these reasons, the topical application of testosterone specifically to the region of the clitoris is more promising than systemic intervention. And even if hormone treatment for anorgasmia turns out to be totally impractical, the research results are of great theoretical interest. The fact that it is male hormone that promotes female orgasm, not estrogen, is powerful support for artifact theory.

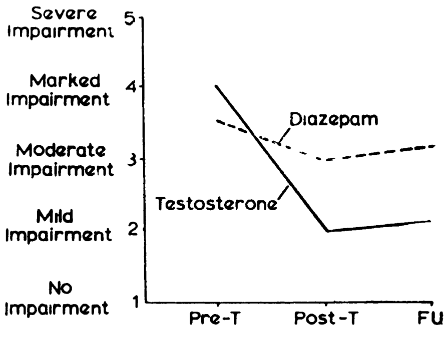

Fig. 1

On the basis of artifact theory, one can also make behavioral suggestions as to how female orgasm can best be obtained. These may be summarized as raising libido, allowing sufficient time, and engaging in forms of stimulation that are as masculine as possible.

1. Increase background arousal by fantasy-type stimulation as may be provided by verbal and visual erotica or role-playing games. Scenarios in which the woman achieves some form of social or sexual dominance might be expected to enhance natural secretion of androgens.

2. Make allowance for the fact that the female response is normally slower than that of the male. Since men tend to lose motivation, if not consciousness, after their own orgasm, it is best to provide extra stimulation in the form of foreplay (manual, oral, etc.). An alternative that may work for some couples is for the woman to learn how to re-arouse her male partner for a repeat performance soon after his first ejaculation - he is almost certain to last much longer the second time around.

3. Since women's orgasm is mediated by the clitoris (the penis analogue), stimulation around this area is likely to be more effective than internal manipulation. This is easy enough during manual and oral foreplay but during intercourse itself more ingenuity is required. Certain sexual positions, such as flanquette and the female superior, allow more clitoral stimulation than others. (Face-to-face positions are generally better than front-to-back (doggy-style) positions, which might help explain why human females are more orgasmic than animals.)

4. Active participation on the part of the woman, especially man-like thrusting of the pelvis and tensing of upper leg muscles, will also enhance the likelihood of orgasm. Again, this is much easier when the woman is on top than when she is crushed by the weight of her partner.

Most of these suggestions are recognized as useful by practising sex therapists regardless of theoretical persuasion (e.g., Gillan and Gillan, 1976). But it is worth noting that none of them assume anxiety to be a major factor and none of them assume that orthodox intercourse should provide sufficient stimulation for the woman to experience orgasm.

To say that orgasm is, biologically-speaking, a male function, should not be taken to devalue the female orgasm in any way, or the efforts made by sex therapists to help women achieve it. Fingers have not evolved for playing the piano, but we can learn to do so, giving ourselves and others a great deal of pleasure in the process. Likewise, many women who have not experienced orgasm can learn the skill and their male partners can learn to help. To this end it would help if we abandoned the myth that men and women are "made for each other" - constructed in such a way that in the absence of any pathology they will both naturally have orgasm during intercourse. Orgasm is natural for men, but for women it is a variable capacity that can be developed with appropriate training and experience.

It hardly seems earth-shattering to assert that men and women are different, yet this basic biological fact is often lost sight of by scientists raised within the recent environmentalist zeitgeist. For the best of political motives, social learning theorists and feminists have sought to minimize the role of genetic differences in human behavior and promote the belief that social conditions can be adjusted to make us more alike. This viewpoint has resulted in the correction of many injustices, but it has also added some confusion to the theory and practice of psychology.

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# PSYCHOLOGICAL ASPECTS OF FEMALE SEXUALITY:

# THE IMPACT OF FEMINISM

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As a psychotherapist with a special interest in relationships, including sexual relationships, and a major subsidiary interest in feminism, it is with the person to whom everything happens that I am concerned. Others have concentrated on the biological and the social.

## IMPACT OF FEMINISM

The impact of feminism has been profound and has led to major, positive psychological and social changes. I say this because, inevitably, I will be spending part of the rest of this paper in areas where feminism has become involved in controversy and conflict.

Another preliminary statement, obvious enough perhaps, is that my remarks are limited to urban Great Britain, the only milieu I know well. I know nothing directly of the Third World or of the Far or Middle East. Even in Europe I was tartly reminded when attending an Eastern European Psychotherapy Conference in Warsaw earlier this year that when women queued in the morning for shoes for their children and in the afternoon for food there was little time or energy for feminism.

Because of the achievements of feminism girls, including thankfully my daughter, grow and develop in a world that is prepared for the fact that women are, and are expected to be, the equal of men. Previously restricted fields such as medicine, the law, engineering and technology encourage women as potential practitioners. At a more general level there seems acceptance of women as individuals not just as one of, say, an exhibition of "Six Female Artists". I have to admit that being of an age where "progressive", co-educational, education was the vogue in the trendy Hampstead of the Thirties and Forties where I was brought up it has never been particularly remarkable to me to accept women as more talented than myself!

At the present the feminist movement seems to express itself as radical, conservative or middle-of-the road. Radical feminism is necessarily assertive as the first line of any significant movement is, the butt of a competition for "feminist nonsense" in the satirical magazine "Private Eye". It may also provide a refuge of cliche-ridden slogans for emotionally disturbed people. Sometimes the rejection of men is pathological. In at least one American city it leads to violence to men and even to murder. At the other extreme are those women who affect to despise feminism and what it has achieved - though benefiting from it! They are as contemptuous of feminism as the most mindless and virulent male critic. The majority of women accept with dignity, pleasure and gratification what the feminist pioneers have done to improve female involvement at work as well as in personal and emotional relationships. They are neither overwhelmed by their "rights", nor are they willing to be overawed or ignored by male conventions and attitudes.

To the radicals an inevitable backlash has accrued, reinforcing some men's non-acceptance and condemnation of women in their developing role in society. On the female side too the backlash has manifested itself in one group of women as a paradoxical guilt reaction. These women say, rather sadly, to psychotherapists "I just want to be at home, to look after my husband and my children ... I have no desire to have a job ... Is this wrong?"

Before developing these ideas I would like to make a brief biological digression because the implication of everything said so far is that it is all learned. The female child is "socialized" to conform to sex role stereotypes. Are there any inborn differences between men and women?

## A BRIEF BIOLOGICAL DIGRESSION

It is, surely, not remarkable that physical and mental characteristics and traits should differ between different human groups? Also, at least in part, that these differences might be inborn. The psychosocial pendulum has swung so far that hardly anyone dares even to talk about inborn differences let alone study them or publicize their findings. Witness the problems of Eysenck and Jenson in their writings on possible inborn ethnic differences in mental ability.

Is it likely that differences between men and women, if they exist (as I believe they do), are at least in part related to inborn differences? If the question was about physical qualities, for example, that the fastest woman marathon runners are about 20 minutes slower over 26 miles than the fastest men, no one would seem to find that fact very remarkable. They would explain it as likely to be due to differences in muscular strength or other physical qualities rather than to differences in "socialization". After all, serious women athletes practise as hard as men.

In the psychosexual field the idea of constitutional differences seems unacceptable to many. Yet, it is a fact that women have a profoundly altered hormonal balance each month; that a baby gestates within them for 9 months; that they go through the mind-blowing experience of giving birth, followed by the emotional impact of lactation and bonding - surely these events must exert a profound effect on women's sexuality? I think there are inborn differences between men and women and the combined impact of these differences may express themselves in the platitude - but nevertheless true - that female sexuality is a great deal more complicated than male sexuality.

I would now like to consider the impact of feminism on three important aspects of our lives: work, social relationships and sexuality. In all three of these areas there is overspill from feminism to sexuality.

## FEMINISM AND WORK

From regarding women as being incapable of sustaining a "man's job", the impact of feminism has altered the situation but in some ways complicated it. The psychological problems women may present to psychotherapists often relate to fixed male attitudes, such as wives or girlfriends earning more than they do. Some of these attitudes seem class-based, the working-class man being less tolerant than the middle-class man. Certainly if there is a clash, it appears far less amenable to discussion with working-class than with middle-class couples. A dogmatic statement prohibiting work is an end to it. However, there are many middle-class men, especially business and professional men, who are just as dogmatic and just as intolerant. What these men psychologically seem to have in common is a vulnerability to competition with females which may rationalize or excuse itself in non-sexual ways. For example, such men may complain that women are "unreliable", "always going off and having babies", etc. But there is also an unrecognized spill-over from competition at work to sexual vulnerability. The Freudian might think in terms of a concept such as castration anxiety. Another example with a different socio-political background is the Trade Unions. These male dominated groups seem threatened by female vocational competence and just as unwilling to let women generally acquire equality with men. These clashes spill over into sexuality. There may develop the common male sexual dysfunctions, erectile impotency and premature ejaculation, either of which may unconsciously seek to "punish" the female partner for successfully competing vocationally. By failing to develop sexual competence or, at an unconscious level, by withdrawing established sexual competence, male sexual dysfunction may limit female sexual fulfilment.

Another route for a vulnerable man to reach the same goal is to transfer his affection and sexuality from the effective and - as he sees it - competing partner with whom he is sexually impotent to the less competitive woman, possibly intellectually, vocationally or socially inferior to him, with whom he can be sexually potent.

Another Machiavellian kick-back is men putting on to women with whom they work a complicated double or even triple-standard. Women are expected to be equally or more competent than the men with whom they work and little subject to illness or the reverberations from home such as illness in their children. At the same time they are expected to remain sexually desirable as women and are often subject to verbal and even to physical harassment which they are expected to laugh off or deal with in a sophisticated "grown-up" way. It is inconceivable that these pressures are not transmitted back to sexuality with the husband or to irritability and impatience in the family.

## FEMINISM AND PERSONAL FULFILMENT

An attractive, lively and basically conventional middle-class lady in her thirties, married to a successful lawyer, and now living in the USA wrote to me. I had, 6 years previously, done individual psychotherapy and marital therapy because of their difficulties in establishing worthwhile and meaningful discussions, mutual emotional support and communication and this had seemed successful. She now writes: "... everything on the 'domestic' front is fine. D and I are very happy indeed and we now have 3 children, all boys. My problem is that I am increasingly haunted by the fact that I have never really done anything and with every year that passes I feel quite consumed by regret for all the wasted years, for having taken so long to 'see' myself in a job, let alone a career. Now I panic that it may be too late. It is so difficult to know in what direction to point myself ..."

Such a letter would have been unthinkable prior to the advent of feminism and feminism's power to raise women's awareness about themselves. I have become increasingly interested in this group of women who cross class barriers: similar problems are present in my East End NHS practice. One of my working-class woman's problems was that she liked to read books and to listen to Radio Four. Her intelligent and equally nice male partner found such solitary pursuits "peculiar", out of line with his class-based ideas of how people should be. Couple therapy helped them towards a gratifying resolution.

Failure in self-fulfilment spreads into, and blocks, sexuality because of resentment at the male partner's inability to "understand". The female response may be to "switch-off" sexual arousal or to develop orgasmic difficulties. A crucial aspect of all this is that the primary aim is personal; it is not necessarily related to excessive control by a male. Thus it may concern a woman without a permanent or even a semi-permanent relationship.

Relationships have two underlying and partially conflicting dynamics. A balancing or homeostatic dynamic keeps the relationship as it is and has always been. There is, however, also an ongoing, developing changing dynamic whereby these partners grow and develop both as individuals and in the relationship itself. The developmental dynamic has the effect of a threat because it is a process, albeit healthy, leading to change. Both processes are necessary for a good relationship. The ongoing process expresses itself in what might be called a "healthy abrasiveness" and this needs the involvement of both partners. It is here that the impact of feminism has been most profound because to be healthily abrasive both partners need to be involved and, until relatively recently, women tended to allow themselves to be overlooked. Obviously this process involves all aspects of the relationship: the practical or so-called "instrumental" aspects, who does what; and the emotional expressive aspects including sexuality.

Both individual and couple psychotherapy or the combination of these may be aimed at initiating, certainly, or catalyzing, this ongoing process.

## FEMINISM AND SEXUALITY

One outcome of feminism has been to make women more assertive in relation to sexuality. The classical Freudian model stressed three aspects of female sexuality: narcissism or self-love; masochism or self-punishment; and passivity rather than activity. These ideas are anathema to contemporary feminism and certainly narcissism, whether or not it is valid for female sexuality, has strikingly spread to males! Attention paid to hair, clothes and make-up hardly differentiate the sexes in 1983! The masochism dimension too seems to be one along which both men and women differ. So that, in sexual problems, the psychotherapist sees masochistic women but also masochistic men.

One interesting sub-group of women that come into psychotherapy with difficulties in this broad area are those who publicly proclaim, and are identified with, active feminism but privately, in their sexual expression, take up the conventional "female" role. Thus there is a conflict between their private and their public personalities. The activity- passivity dimension also relates in sex-role terms to the development of so-called "masculinity-feminity". Psychologically there are certain measurable differences between the sexes although these are group average differences, not necessarily true of individuals. Men are more mathematical, women more verbal and there are differences in the way these abilities unfold during childhood and adolescence. Boys also show greater assertiveness and aggressiveness than girls in their games. Some of these differences may be inborn but differences in expectation and social training are significantly involved.

In sexuality the "masculine" role has implied activity rather than passivity so that men expect to lead in sexual matters - frequency of intercourse, method of foreplay, sexual positioning. The male sexual role has also traditionally been self-centered rather than equal or other-centered. Promiscuity has also been, at least until recently, regarded as a male pattern of sexual expression; women have been regarded as psychologically monogamous. By the same token, interest in pornography has traditionally been regarded as exclusively male, but recent experiments in the USA have shown that women may become equally physically aroused by pornography. Verbally they may deny interest - perhaps to conform to the sexual stereotype.

What in the USA has been called the "new impotency" in young men seems possibly one outcome of this blurring of sex roles and greater assertiveness of women. Again in classical psychodynamic terms many men seem easily threatened by sexually active women: this may be literally what is meant by castration anxiety.

## MODELS OF MARRIAGE

This follows from what has gone before. The egalitarian model of marriage with equal partners seems more prevalent and acceptable than it has ever been. Not only does this include the possibility of both partners having equally responsible jobs and earning power, but it involves the expectation of sharing traditionally assigned "female" tasks such as care of children, cooking, shopping, chores in the house and time-out for separate interests. This model of marriage seems workable so long as both partners accept it and really accept it. When this is not so, disagreements can easily spread into sexuality and so lead to sexual dysfunction in either partner.

"Open" and "closed" models of marriage are another choice with sexual expression either restricted to the marriage or encouraged outside it. My psychotherapeutic experience suggests that it is relatively rare for both partners to be equally accepting of extra-marital relations. Usually the situation is more equal for one partner than for the other!

One interesting extension of this closed-open model of relationships is the apparently increasing mid-life practice of couples deciding to terminate a marriage by mutual agreement and to begin with another partner. It is difficult to judge how far this is an escape for people too lazy to work on relationships to another equally passively accepted relationship and therefore likely to be illusory in the prospect of happiness and fulfilment. Or whether, for a number of couples, weary of each other and with the sameness of their lives and needing new emotional input, change can offer a genuine possibility of sought-after fulfilment. It is too early to say - experience will build up over the next ten years.

## THE NEXT GENERATION

Finally, what is there for succeeding generations in the social and sexual changes I have discussed? Children are necessarily affected in that they internalize the models of relationships they see and know. It seems to me likely that exposing children to an egalitarian marriage with a sharing of most things will be wholly constructive. What seems to me much less certain is whether fashionable models of relationships, particularly those that underrate or even denigrate commitment, are likely to be equally healthy. Mutual self-respect, love and commitment represent permanent values possibly of far greater significance than the changing and developing values with which we are so preoccupied.

## SUMMARY

Feminism has made the Western Industrial World a better place for a woman to grow up in. Women can compete in previously male dominated professions and can also enter previously forbidden areas such as technology.

There may be an over-spill from feminism to sexuality. Work competitiveness between men and women may mean unfair pressure being put on women, particularly to compete as equals at the same time maintaining a traditional sexual attractiveness. Also many men seem psychologically vulnerable to what they see as female competitiveness and this vulnerability may spill over into sexuality leading to sexual dysfunction unconsciously to "punish" the female partner.

Feminism has led to a desire to achieve personal fulfilment so that many women present to psychotherapists with this as the reason and not the usual anxiety, phobias or somatic symptoms. Individual and couple psychotherapy may be used to catalyze this process of fulfilment.

Feminism has also had an impact on sexuality encouraging female expectations in the initiating of love-making, choice of position, need for orgasm and so on. A "new impotency" has arisen when young men cannot face up to these demands.

Previously supposed aspects of "female" sexuality, narcissism, masochism and passivity can now be seen as shared human traits: either partner may possess them; with either partner they may lead to sexual difficulties if in excess.

Feminism has spread into models of marriage, especially the "open" marriage including sexual openness versus the monogamous or "closed" model. While acceptable in theory it seems that one partner usually tolerates such an arrangement less well than the other.

An interesting further extension is to the change-partner model, increasingly prevalent in mid-life not because of wholly negative attitudes to each other but to seek new marital enrichment with another partner.

What will be the effect of social and sexual changes upon children's development? So far experience is too limited to say.

# FATHER-DAUGHTER INCEST:

# A MODEL FOR TREATMENT

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## INTRODUCTION

The past ten years has witnessed a remarkable proliferation of papers in the clinical and social science literature on the topic of incest. For example, a computer citation search from 1970 to 1982 showed more than 260 papers that discussed incest from a variety of medical, social, and socio-legal perspectives. Remarkably absent in this literature, however, are reports on how to treat the problem. The purpose of this paper is to describe a model for the treatment of incestuous families. This model, developed in 1971 by Hank Giarretto* for the Child Sex Abuse Treatment Program in San Jose, California, has been used successfully to treat more than 4000 families in the San Jose area; it is also in use in 105 satellite child sexual abuse treatment programs in the United States, Canada, and Australia.

Before describing the program I would like to briefly discuss what exactly I mean by "incest" and how much of a problem does it constitute in our society. Incest, narrowly defined, refers to sexual intercourse between consanguineous family members. For the purpose of describing the sexual abuse of children within the home, incest is more generally defined to include any sexual activity between family members when one of the partners to the relationship is sexually exploited - either by virtue of age or of psycho-social maturity. Therefore, included within this definition are sexual acts that may or may not culminate in sexual intercourse and which occur between family members who may or may not be blood related - stepfathers and mother's live-in boyfriend would be examples in this category. Hard-line scientists who would seek to explain the universal trend towards human inbreeding avoidance take a dim view of this broad definition, a definition they suggest that is clouded by overtones of feminism and moral disapproval. From a clinical perspective, however, it seems essential that we maintain this admittedly broad definition of incest since, at this time, we simply do not know if the extent of sexual involvement by the victim is correlated with the severity of emotional consequences. In other words, we do not know if the child who has engaged in

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* For a manual for treatment, see Integrated Treatment of Child Sexual Abuse: A Treatment and Training Manual, Henry Giarretto, 1982, Science & Behavior Books Inc., Palo Alto, California.

sexual intercourse with her father suffers greater consequences than the child who has engaged in oral copulation with her stepfather. Increasingly in the United States, incest is being defined under the rubric of "child sex abuse". The effect of this is to remove some of the stigma associated with the word "incest". "Child sexual abuse" is a category that is seen as part of a general family dysfunction - a category that is treatable by means of therapy. Realistically, however, intra-familial child abuse, while no longer seen as simply a disgusting crime or as the act of a very sick man, seems to occupy a middle position on the axis of criminal vs. irrational behavior since violaters, while they are referred to treatment programs, are also sent to jail.

There is growing evidence that the long-term consequences of intra-familial sexual abuse can be devastating. Silverson (quoted in Weber, 1977), for example, found that of 500 adolescent victims treated for drug addiction more than 70 percent had been sexually abused at home. Similarly, Densen-Gerber (Bernard and Densen-Gerber, 1975) found that 44 percent of her sample of 118 female drug abusers were also victims of incest. The clinical literature increasingly reports the negative effects of incest, these ranging from non-orgasmia (Becker et al., 1982) to hyper-orgasmia (Yates, 1982), hyster epilepsy (Goodwin, 1979), chronic pelvic pain (Gross, 1980), and filicidal impulses (Green, 1982). In a survey of 200 child psychiatrists, La Barbera et al. (1980) found that of the 64 who responded to the questionnaire they all agreed that incest almost always leads to psychopathology.

Given then, that incest is destructive to the victims, the question becomes: how serious a problem is incest in our society? What sort of incidence figures are we talking about? Weinberg (1955), in his classic study, estimated 1.2 to 1.9 cases of incest per million in English-speaking countries - hardly a serious incidence problem. In 1967 the American Humane Society (De Francis, 1967) estimated that a minimum of 80,000 to 100,000 children were sexually molested annually in the United States of whom, it was figured, at least 25 percent occurred in the home. Based on recent population figures this would represent approximately 25,000 cases of incest per year. It is impossible to determine from these two very different figures if this represents an alarming increase in sexual abuse or an increase in reported cases. More recently, Diana Russell (1983) conducted the first random sampling of the general population in an effort to determine the prevalence of intra- and extra-familial abuse of female children. Based on data obtained from 940 adult women in San Francisco, she found that 16 percent of these women reported at least one experience of sexual abuse within the home before age 18 (31 percent reported at least one experience of extra-familial abuse before age 18). Only two percent of these cases of intra-familial sexual abuse were ever reported to the police. If one was to generalize these figures for the entire population they would indicate that one quarter of all female children are sexually abused before age 14 and one third by age 18. Clearly, incest broadly defined, is a common problem that is seriously under-reported.

Ironically, the consequences of reporting incest are often as traumatizing to children as the incest itself. In California and in the United States generally, children who report incest are immediately removed from their home, often without their parents' knowledge, and placed in an unfamiliar foster home or shelter care. While ostensibly this is for their own protection, children rarely see it this way and they tend to see it as a form of punishment. In addition, they are immediately subjected to a series of humiliating fact-finding interviews by police officers, probation officers, and lawyers from the district attorney's office in an all-out effort to gain the necessary evidence to convict the perpetrator. Since most fathers deny responsibility, children are often required to testify against their father in a public court of law and are subjected to cross-examination by their father's defense lawyer in often highly explicit sexual detail. In the event that there is insufficient evidence to convict the father, many children are returned home, unprotected and vulnerable, to a hostile environment where they are likely to be remolested by the father and punished by mother and siblings for getting the family into such terrible trouble. Again, in other cases where there was insufficient evidence to convict the father, yet the juvenile probation department knows that incest occurred, the court takes the responsibility of making these children Wards of the Court and they remain in foster care until they are age 18. In either event the consequences of reporting often lead children to the wish that they had never revealed their closely kept secret.

It was in direct response to these exacerbating consequences that the Child Sex Abuse Treatment Program was originally formed. Fundamentally, the aim of the CSATP is two-fold: first, it operates in close contact with all arms of the criminal justice system in an effort to prevent the further victimization of children by the system and second, it aims to resocialize the perpetrators and their families such that the children can live in a safe and healthy atmosphere. The latter aim is effected by teaching family members how to develop skills for personal change both within the context of the family and the larger society. The method is summarized below.

The Program is organized into three complementary components: a professional staff of therapists and administrators; a corps of some thirty student interns who are working towards their California state licensing in marriage, family and child counselling; and a large self-help component comprised of offenders, victims and a growing number of women molested as children and now returning for therapy. This self-help group is known as Parents United and Daughters and Sons United. It is important to emphasize that all components work cooperatively. Parents United has grown to a sizeable organization within the United States, it was incorporated in 1975 and currently there are 165 chapters. In order for the model to be effective, however, the Parents United component must work in cooperation with the staff of professional therapists. It is the combination of professional therapists working with the self-help component that defines the Child Sex Abuse Treatment model. Currently the CSATP in San Jose receives about 800 referrals of intra-family sexual abuse each year of which more than 70 percent are cases of father- or stepfather-daughter incest, the rest being an assortment of grandfathers, uncles, brothers and quite a significant number of cases of father-son incest.

Currently, when the police receive a report of incest, the sponsorship arm of Parents United comes into play. A seasoned Parents United member, usually an offender who has completed nine months to a year in the program, will accompany the officer to interview the newly accused father. This father is encouraged to leave home immediately, thus allowing the victim to remain at home in the company of her mother. Fathers, naturally, are most reluctant to leave and the Parents United member explains that in the event he is found guilty the court will look favorably on his early cooperation. Since most fathers are indeed guilty they tend to cooperate. The consequence of this is that most children are able to stay home with their mothers and avoid the frightening strangeness of shelter care plus the terror so many of these children feel when isolated from their families and ignorant of what is happening at home. It also represents the first step in responsible parenting on the part of the father and this is clearly explained to him; currently about 90% of accused fathers admit guilt and voluntarily leave home. At this time the father is advised to have no further contact with his daughter and on his arraignment this becomes court ordered.

A Parents United sponsor, usually a seasoned mother, will also contact the victim and the victim's mother. She will refer the family to a trustworthy lawyer and she will explain to them what they can expect in the difficult weeks ahead. The family will be referred to the counselling program and an appointment will be made on a crisis basis. The family will be interviewed, individually, by a staff counsellor. Depending upon the counsellor's case load she/he will either continue to see the family or refer them to a student intern. The student intern will continue to work with the family for the next two years under the supervision of the staff counsellor.

The primary focus during the initial stages following disclosure is on the mother-daughter relationship. Contrary to much received wisdom on the subject, it has been our experience that mothers are rarely aware of the incestuous relationship while it is ongoing - knowledge comes as a profound and devastating shock. They are overwhelmed, particularly the mothers of older daughters, by conflicting feelings of jealousy and rivalry on the one hand and an agony of maternal concern and protectiveness on the other. For many mothers it takes about six weeks following disclosure to begin to function adequately. In this sense the process shares some significant similarities with the process of mourning. Part of the therapeutic aim is to help the mother see that her daughter was not responsible for the relationship with her father, rather, she is a victim of it. Furthermore, the mother is helped to see that her daughter desperately needs her support and acceptance, since many children tolerate incest out of the fear that their mother would hate them if they knew. Further, they may fear that knowledge of the relationship would cause the mother to have a nervous breakdown for which the daughter would be to blame.

During the initial stages of therapy, in addition to mother-daughter counselling, all family members are seen separately in individual therapy. As the family progresses the parents begin to be seen together in marriage counselling. When the therapist considers that the daughter is ready to face her father in a therapeutic situation permission is sought from the court for limited contact. The goals of father-daughter counselling are for the father to own the responsibility for the incestuous relationship and to alleviate, as far as possible, the burden of guilt incest victims invariably feel. In time all family members - father, mother, victims and unmolested siblings - will be seen in family therapy. In order for this to be possible the father is encouraged to inform his unmolested children about the nature of his violation. This, in part, is because unmolested siblings tend to blame the victim for causing the father's removal from the home and his subsequent incarceration. But it is also because part of the therapeutic aim is to break the enormous investment in secrecy that pervades families that violate the incest taboo. I have, for example, seen families in therapy where the father was having intercourse with all his daughters and none of the daughters was aware of the others' involvement. Each acquiesced to the relationship in the belief that if she did so then surely her father would leave her sisters alone.

During the first year in the program the father is usually sentenced for up to one year in the local county jail. He is released to the program for all counselling sessions and for group therapy with the self-help group Parents United. Furthermore, in line with the general resocialization aims of the program, he is released to his job during the day on work furlough, thus encouraging him to maintain his fiscal responsibilities toward his family.

At the same time that a new family is referred to therapy with an individual counsellor, they are also referred to group therapy. The group therapy program operates under the auspices of Parents United and Daughters and Sons United and is complementary to the individual therapy program. Many of the groups are run by the professional counsellors, some by the student interns, and many are co-led by seasoned Parents United members. A variety of groups are offered - each centering on different problem areas. Members are required to attend the groups in a predetermined order and it takes approximately one year to complete the group program. All groups run for eight-week sessions. New members begin with the orientation groups where, in a very real sense, they are enculturated into the philosophy of the program. That is, men learn that although they have violated this universal taboo, they are not social lepers and they can learn to be adequate fathers and husbands. They also learn, via peer confrontation techniques, that it is not acceptable to blame the daughter on grounds that she was seductive or the wife because she was frigid, nor can they retreat behind the cover of alcoholic incompetency or mental illness. The emphasis is on self-responsibility. Present in the orientation groups are women who were molested as children and who are returning now as adults for therapy. These women often confront new fathers with the kinds of questions they were never able to ask their own fathers, for example, "why did you do it?" This provides an opportunity for the fathers to begin to articulate their thoughts on the relationship they had with their daughters in a safe setting. Furthermore, these kinds of questions have much more power coming from victims than they do coming from interested therapists. Indeed, the function of the therapist in these groups is only to facilitate, the content is generated by the members.

Following orientation, offenders and their wives take a course in human sexuality. This is a regular adult extension course offered by a local university and led by a licensed sex therapist. The major emphasis in this course is on improving sexual communication and in demythologizing appropriate sexual behavior between adult couples. Other groups emphasize marriage counselling, parenting skills, and self-awareness. There is a special group for alcoholic offenders, but it should be emphasized that, contrary to the traditional view of the typical incest violator, alcholism is not a necessary characteristic any more than that he be a dim-witted farm laborer living in crowded quarters in the hills of Appalachia or southern Ireland.

The children are similarly organized into their own self-help group, Daughters and Sons United. One of the most often repeated statements by victims of incest is that they thought they were absolutely alone in what was happening to them. And indeed, many child victims of incest are social isolates, keeping to themselves in an all-out effort to maintain the terrible secret in their lives. Among the most therapeutic aspects of the children's groups is the opportunity for children to meet other victims and to find that they are ordinary children just like themselves. The relief these children experience is often dramatic.

A number of children's groups are offered and they are led by experienced counsellors. There are two play therapy groups for very small children, a pre-teen group for children 10 to 13, and a variety of groups for the older girls. In the older girls' groups, members who have been in the program for some time will assist the group leader as a facilitator. An increasing number of boys, victims of intra-familial homosexual molest, are being referred to the program. These boys begin the therapy program in a separate group but eventually join a mixed group of boys and girls. Additionally, an increasing number of youthful perpetrators are being referred. Much of the therapeutic thrust of the children's groups is oriented towards day-to-day events and problems; it is not solely geared toward the problem of incest since the children who attend the program are fully functional in that they attend school and are generally having to cope with day-to-day life. In my own experience of running children's groups for ten years I found that children are not particularly interested in talking about what happened to them but are very interested in talking about how what happened affects their current behavior. The children respond remarkably well to group therapy and I cannot stress enough the effectiveness of this form of therapy for child victims of incest. (The same holds true for adult victims who return to therapy - the relief of finding they are not alone and utterly stigmatized is compelling.) An independent evaluation study of the program showed that children who received treatment through CSATP did not persist in self-destructive behavior such as substance abuse, promiscuity or truancy.

In those families where there is maximum cooperation on the part of the parents - that is, full confession by the father, assumption of full responsibility for the incestuous relationship, sustained effort to engage in individual counselling, sex therapy, and responsible financial support for the family - the children, including the victim, do not stay in group therapy for extended periods. The effect of therapy filters down and the children prefer to spend their time involved in other activities rather than attend groups and family therapy sessions. Children who tend to stay with the program for extended periods are those who failed to build a worthwhile relationship with their mother or those whose parents divorced or those who are placed in foster care. In many ways, for these children, the program functions as a surrogate family.

On a final note I would like to add that in the year the program was initiated some 30 families were referred for treatment. By 1980 this rate had risen to 700 families and currently 800 families are referred, all coming from the same catchment area of about one million people. Clearly this does not represent a dramatic rise in the incidence of incest, although it certainly indicates that many more child victims of incest are now receiving treatment who would not, formerly, have received any treatment at all. But what accounts for this increase in referrals? Sgroi (1975), reporting on a sharp increase in reported cases of sexual abuse in Connecticut, ascribed it to more strictly enforced child abuse laws, increased public awareness of the problem, and the establishment of a hot line. Certainly, public awareness of child abuse has grown astronomically in the past few years within the United States. Time magazine, for example (Sept. 5, 1983), recently reported that in 1975 polls showed that only 10% of Americans considered child abuse to be a serious problem. A 1983 Harris survey placed the concern at 90%.

In San Jose, members of Parents United and Daughters and Sons United - father-offenders, mothers, victims - go out into the community and address agencies, clubs (Lions, Rotary, etc.), high schools and universities in an effort to inform the public that not only does child sexual abuse occur in the home but it happens all too frequently. And more importantly, that there is help available and a 24-hour hot line.

In sum, it seems that if the public is informed and services provided that are relevant to the problem, incest victims, and there are thousands out there, are more likely to come forward.

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# THE MAKING OF THE CLINICIAN

# THE MAKING OF THE CLINICIAN - AN INTRODUCTION

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"I have had a growing conviction that most traditional theoretical and technical papers about psychoanalysis and psychoanalytic psychotherapy, while contributing significantly to therapeutic understanding and efficacy, have failed to address a highly significant area: the personal experience, attitudes and involvement of the analyst, which contribute importantly to the interpersonal subtleties and uncharted techniques which may, in fact, constitute the effective cure of psychotherapy" (Frank, 1977).

The present symposium is an attempt to meet this familiar criticism, a criticism that applies a fortiori to clinical psychology. There have been other attempts; The Making of a Psychiatrist is the title of at least one book (Viscott, 1973) and the subtitle of another (Laing, 1985) but clearly in each case the finished article is a member of a kindred profession. Our own tends not to go in for such personal reflections, although we hope that the following chapters will help it to.

There is a sense, of course, in which there is no such thing as a finished article in any profession, but this is seldom acknowledged. Grantham (1984), for example, writing as a Basic Grade clinical psychologist, warns of the "dangers in assuming that anyone has 'arrived' in any one area of their work and that they do not need help from anyone else" (p. 65). In his view, however, clinical psychology does tend to adopt an arbitrary point at the end of the Basic Grade experience at which one sees oneself and is seen as a fully competent 'expert'; one has 'arrived', the bespoke clinician has been made.

Grantham argues "that further training should be viewed as an integral part of the clinical psychologist's work throughout his/her life cycle" (ibid. p. 65). We agree with his principle that there is no point at which learning stops and wish to broaden it to include learning about oneself. Issues of the emotional world of the helper are discussed in department common rooms and in the local hostelry, it is a focus for 'fringe' workshops and for conferences of Humanistic psychotherapists. It is no doubt hammered out within the home of many people in the helping professions, perhaps taking the form of arguments over the management of children or the support for ageing parents. The psychodynamic school has given the professional blessing for its disciples to write papers on the 'Burnout' phenomenon and the major Institutes insist on a personal analysis for its trainees.

Yet the establishment of clinical psychology still frowns upon its training courses finding the space for experiential groups, still teaches the Scientist-Practitioner model with its distanced objectivity as an ideal for its future professionals and still selects out candidates on the basis of an acknowledgement of their human frailty. It is as if we misuse the word 'clinical' in the way that football commentators do to describe a move evincing a cool-headed incisiveness of ruthless technical execution which was rather unfortunate for the opposition. This is not what the word means, but we wonder how often it carries just such connotations for us.

This section is written by a number of authors who collectively stand away from this tradition with its origins in the animal laboratory and who choose to address themselves to the importance of the person of the helper. In turn each will present a version of the clinician which is disengaged from the professional projection of the discipline to which they belong. Their papers however are far from homogenous, they range from the academic to the clinical from the personal to the spiritual. It is to <u>their</u> tradition, arguably, that the humanity of clinical psychology belongs, and in the reading of their papers the professional helper must turn to his or her own experience, own personal experience, to get the most valid of meanings. Each author in this section provides a setting, in the form of a theoretical structure or in the form of a clinical analogy, to which all clinicians can relate. To some, the following papers will simply provide a trigger to continue a process of introspection which is well familiar to them, to others it will open new doors. However, there are still others for whom the following papers will spark off an antagonism: the same antagonism that has previously split our profession and has, on both sides, caused an intolerance borne of the speaking of different languages. The hope must be that the incidence of this division grows weaker as we as a profession grow strong enough to accept that we are but as human and as frail as are our clients.

The purpose of the symposium at the Third Annual Merseyside Course in Clinical Psychology, on which this section of the book is based, was to examine what is often seen as a rather peripheral subject of inquiry; the possible personal meanings of claiming to act helpfully. The first speaker, David Brandon, took his title 'Selling Water by the River' from Zen, and it was from the Zen perspective of ordinariness that he unfolded his themes of the unimportance of ideologies and the subversiveness of love. The ordinariness and limitations of the helper were discussed by Miller Mair who suggested coming to know more of ourselves in relation to each other as a vital aspect of what he called 'Learning to Care'. These ideas are developed in this section in his poignant paper, 'Pretending to Care'. In 'Some Psychodynamic Aspects of Helping' Dave Pilgrim outlined the contributions of psychoanalysis to this understanding of ourselves as helpers whilst warning against psychological reductionism and the dangers of ignoring the social context of the helping professions. One such wider issue is that they get paid for 'providing' what is primarily a loving relationship, an observation that led David Smail, in the final paper 'Love for Sale', to draw an analogy between psychotherapy and prostitution, not in order to condemn either profession, but rather to clarify each as a moral undertaking. Unfortunately, this last paper was not available for publication here but we were delighted that Peter Lomas was able to accept our invitation to contribute to the written proceedings in its place. We have changed the order from that of the original presentations to accommodate it and to provide a different continuity of argument, beginning this time with the psychodynamic and developing in the direction of increasing laicization of the helping endeavor.

The issue of the life of the helper has been most fully acknowledged by the Dynamic schools of psychological theory because, since their modalities hinge upon the interaction between persons, they naturally make some attempt to understand the person of the therapist too, as one half of the equation as it were. It is to issues related to the psychodynamic aspects of helping that Pilgrim's paper is addressed - whilst noting that the attention given to them is nowhere near that paid to the patient's contributions to the interaction, even within these schools of thought. Freud, Foulkes and the Object Relations school are drawn upon to highlight key dynamics in the helping relationship and the psychopathology of helpers. His presentation of the central concept of countertransference is consistent with that of Sandler et al. (1973) who point out that the "'counter' in countertransference may ... indicate a reaction in the analyst which implies a parallel to the patient's transference (as in 'counterpoint') as well as being a reaction to them (as in 'counteract')". However, Pilgrim introduces an important caution about psychologistic reasoning when understanding careers in helping. His sociological caution draws attention to Sartre's emphasis on social opportunities that channel individual psychopathology. These opportunities are not random but are determined by demographic variables. Although a case is made within the psychoanalytic and Foulkesian schools for object-relations theory as a link between the personal and the social (see, for example, Hinshelwood, 1985), Pilgrim prefers to draw a line where solely psychological models fail to answer questions and other approaches may prove more fruitful. Clinical psychologists may find such a juxtaposition of psychology and sociology helpful in putting into context the process of their professional practice. Pilgrim has been associated with a contextual approach to knowledge production and continues this in his present contribution. As with other contributors to this section, Pilgrim brings into question whether a scientific understanding of professional practice can be divorced from the ethical and political context of professional life. He argues for a sort of binocular vision that incorporates both the synchronic (static in time) and diachronic (evolving in time) perspectives. This does not devalue the nuances of individual experience, but rather situates the latter in a set of social relationships.

The main part of Lomas' paper deals with the therapeutic response. He argues that the relationship with the patient is just as much a source of psychodynamic change as is the activity of interpretation and that these two aspects of therapy, called by Wolff (1971) the 'being with' and 'doing to' functions, have a certain qualitative similarity. In a sense he is saying that his ordinary responses within the relationship can be 'interpretations' and it is interesting that Rycroft (1986), coming from the opposite direction so to speak, notes that traditional interpretations contain a number of implicit responses at the ordinary level of human relating. Lomas' own view, which is supported by 'consumer' research such as that of Strupp et al. (1964), is that the human response upon which all enhancing therapeutic work is founded is one of acceptance. This basic response embodies the helper's belief that patient and therapist are more similar than otherwise; indeed the patient too, without any self disclosure from the therapist, may sense this according to Lomas. How else, after all, is accurate empathy possible? For Lomas, the work of therapy is undertaken by the persons involved, and although one may be called therapist and the other patient, he sees no justification whatever for any notions the former may have about technically imparting understanding to the latter in an impersonal transaction. Lomas concludes his paper with the recognition that psychotherapists, particularly in the state sector, are only occasionally available to those who would benefit from that very special form of helping relationship, and points out the sometime negative effects that designated 'experts' can have on natural helping processes unless they are aware of their own limitations. The 'limitations' of being a person 'in the same boat' as the client can be a powerful helping tool if it is recognized and taken account of in the nuances of the relationship.

Lomas argues that theories, models and ideas are of little use in the hands of those who are lacking in the 'gift' of helping. That training is important is not denied, but the natural therapist may be of help whatever their theoretical allegiances.

In an earlier work, Mair (1980) used George Kelly's suggestion that we view man as a 'form of motion' to develop his own thinking about coming to know personally - that is, as a matter of being engaged in a continuous movement through various forms of meeting with no conclusive permanent end in sight. It is from this perspective, in the present paper, that he describes his own journey from being a psychologist to becoming a psychotherapist, which for him has meant developing as a psychologist again in a more widely embracing way than before. His paper introduces us to ways of being and feeling that we often choose to leave unacknowledged, a choice encouraged by a scientific tradition of psychology which regards such introspective subjectivity with distaste. He proposes a new psychology of psychotherapy where that subjective realm, which has been cast out by scientific method is retained. Emphasis is on learning to inquire within and to establish and build our understanding upon a knowledge of ourselves rather than relying on ever and ever newer theoretical refinements from without ourselves. In this way self knowledge and personal development are integral parts of the continual process of becoming a psychotherapist wherein the extent of our fearlessness in getting to know ourselves sets the limits on our therapeutic abilities. In saying this, Mair talks of fear and aloneness, of desolation and despair, but he also talks of hope and courage.

In making the link between our professional training and the personal world of psychotherapy, Mair asks us to make a quantum leap to a new way of being that relies on personal rather than theoretical 'knowing', but none the less asks us to accept this as a respectable realm of a psychology of a different sort.

From ancient times, folklore has been familiar with the concept of knowing from within. In some cultures certain individuals were designated to have the power to search for knowledge for others from within themselves. Mair's call for psychotherapists is more modest. He asks only that we reach within ourselves to understand our own fears and hopes, uncertainties and optimism. When we have personally realized that, then we are on the path to helping others to do the same.

Speaking from his own experience he describes what it means to know personally in terms of confronting three issues. One is that the therapist is his or her own instrument of knowing. Although coming from a different background to the two preceding contributors his position here resembles theirs with regard to the therapist's personal experience - the instrument may be fallible but, as another psychoanalytic writer remarked, it is the best we have of its kind (Racker, 1968). Another feature of knowing personally is the necessity of viewing an individual within a context. As in Pilgrim's paper, this perspective is reminiscent of Foulkes' conception of the individual as part of a social network 'a little nodal point as it were' which can only artificially be considered in isolation (Foulkes, 1948); and to anticipate the final chapter, this view of the individual is also quite consistent with that of Buddhism.

The other issue to be confronted in coming to know personally is the need for imaginative play, and it is in this respect that Mair's writing on metaphor and the 'community of selves' have been highly influential (see Hobson, 1985). The process of psychotherapy is of an 'as if' world and the materials for this 'play', with which it is constructed, consist of our own ways of finding out. As with all play, rules are present and the most important of these regards limits and boundaries. Here Mair reminds us of something that is fundamental to psychotherapy, that learning about limits need not be constricting. It can be expanding. Indeed this chapter 'Pretending to Care', as do the others in this section, gives us a living example of this concept. In recognizing the difficulties and inadequacies of our role as helpers we can hopefully increase our ability to provide something worthwhile in the context of our relationships with clients. Mair's paper demonstrates something else of its own content, that is humanity and courage, a way of being which scientific psychology has no way of acknowledging. He speaks through the clinician's mask and pre-tends to care. There is a stretching out into a cloud of unknowing for the therapist as well as the patient, the therapeutic space being transitional for both for the making of the clinician has no end which is not an iron mask when viewed from the perspective of personal knowing.

David Brandon writes his paper 'Selling Water by the River' from the perspective of Zen Buddhism, and his message emphasizes the dehumanization which can take place through the helping process by the expunging of that very human quality, the experience of being a person, to which Mair, in his paper, ascribes the pre-eminent place in psychotherapy. In doing so Brandon begins by questioning the professional and theoretical stamp that marks the 'official' helper and that can be exploited by the Helping Professions in their monopolization of the right to provide such services. If the accretions of professionalism are stripped away then helping is revealed to be a very 'ordinary' process in his view (Brandon, 1981a and b). However, his main thesis concerns the 'hindering process' rather than the helping one; like that of Pilgrim it draws upon the psychoanalytic concepts of projection and projective identification, that the prejudice that is seen to act against those who are marginalized in our society is due to their capacity to make us recognize those aspects of our own selves that we keep hidden and shun. This marginalization of sections of society allows us to deal with the unacceptable parts of ourselves and our society through its externalization, by treating those carriers rather than ourselves. Theory, professionalism and the labels which attend them help us ever to increase the distance between 'us and them'. But it also allows us to express our loathing at, and control and punish, those aspects of our personalities which may cause us shame and guilt if we acknowledged them as belonging to us, as well as enabling us to disown any personal responsibility for the issues which emanate from them and the society we thereby create.

The new developments in theory and treatment can also be seen as frantic strivings to increase this distance between ourselves and that which we should by rights own and be responsible for. Brandon's final argument then is that the path to healing others is through experiencing and being oneself. Inevitably this implies reclaiming and addressing directly that which is painful to ourselves and eschewing those skills and techniques that we have acquired through our training which primarily act as protective shields. Like Lomas, Brandon has doubts about the place of expertise in therapy and with Mair he would put his emphasis on the centrality of personal experience instead, indeed this is fundamental to the Buddhist path he follows.

Japanese paintings of Hui-neng, the sixth patriarch of Zen, show him tearing up the Buddhist scriptures; there is to be 'no dependence' on words or letters for those who tread this particular path, according to an ancient Zen poem. Perhaps the key form in this line of verse is 'dependence' - Brandon is not saying that the clinician should avoid books, but rather that he or she will not discover the true process of helping in them. Yet the 'words and letters' of a clinical training are actually very valuable. As with the world of play discussed above, the tradition of a particular helping profession or school of therapy provides limits which are both constraints and opportunities. Without a discipline, a form within which to work and develop as a clinician, one is left with what Schafer (1983) has called the impossible job of making oneself up totally. On the other hand if one depends totally on the words and letters of the discipline, on its concepts, practices and so on, one does not have to make oneself up at all - the clinician is ready-made, by someone else!

Each contributor to this section is mindful of the ground against which helping figures, and each brings an aspect of that ground into focus. They are not debunking traditional forms of helping or entertaining the individualistic fantasy that we should just make ourselves up as clinicians as we go along without reference to the interpersonal matrix within which we are developing personally. Contrary to any such romantic notions of self-sufficiency, these writers emphasize context rather then diminish its importance lest we make the equally serious mistake of simply conforming. They show us that our helping does not take place in a political, personal or spiritual vacuum. Helping professions such as clinical psychology appear to have distanced themselves from these and other cognate concerns in order to differentiate themselves from other disciplines and so to be seen to be possessing a particular perspective on human affairs. However in doing so they have run the risk of becoming isolated from the human matrix of the very affairs in which they profess expertize.

What all these papers may lead us to consider is the emotional world of the clinician and those personal factors in our past and present lives that have led us into a career in helping, currently affect our work and also our ability to cope with it. We are not differentiated from our patients by their being the ones with the problems. Nor are we the ones, although the honest disclosures of some helping professionals show that 'wounded healers' (Rippere and Williams, 1985) can break down into depression. The metaphor used by Rippere and Williams in their study (ibid) is a Jungian concept which relates more to the helping process than to who has the problems. Indeed, Samuels (1985) has described how some post-Jungian writers have developed a bipersonal view of the archetypal image of the wounded healer in both the therapist and patient without recourse to locating 'health' in one and 'illness' in the other; helping draws on the suffering and strengths of both parties. Again it is not new for psychodynamicists to address these issues but the professional tide is a powerful one and it can be all too easy for our individuality and inner beliefs to be drowned. Most responsible clinicians argue for the space to attend to these matters and advocate the importance, if not of personal therapy, then of supervision, not just for those who are junior within the professions but for all of those who have face to face contact with clients. But supervision is not always available or seen to be a valid use of time for qualified clinicians especially perhaps those in the employ of the state. Even where it is, it can take many forms, and perhaps few of these in this technological age, provide the clinician with the opportunity to reach within and experience their own place in their work relationships.

Supervision tends to be seen as a means of imparting information. This is of course one of its functions, but when it is regarded as the only point of the exercise then there is dependence on letters and words again - a solely academic approach to human affairs. Throughout a Clinical Psychology training there is a great emphasis placed on academic standards which, whilst important, do not touch the area of personal knowing. Right at the start applicants with good degrees stand a better chance of becoming clinicians-in-the-making even though Semeonoff's (1980) analysis of degree class and postgraduate achievement has suggested, not surprisingly, that it is only in their written examination papers in Clinical Psychology that candidates with upper second class degrees do better than those with lower seconds in the overall assessment. Indeed Bender (1976) cites work which suggests that academic grades at undergraduate level actually correlate negatively with clinical ability. Nonetheless, selection on the grounds of academic excellence sets the key in which the Clinical Psychology course is conducted and students are trained, as Mair shows in this volume, in such a way that they are often unprepared for the range of personal suffering that they will encounter and experience in clinical practice. After a few years they are considered to have mastered their trade (Grantham op. cit.), requiring no further help they enter the market place.

For a number of years now the National Health Service has been looking at effective ways of collecting statistics with the eventual aim of improving economic efficiency. While on the surface this is obviously fair enough, efficiency in the caring professions cannot simply be measured in economic terms particularly by accountants and statisticians. How efficient is a clinician who, for reasons of personal survival, cannot meet their clients pain and distress? How efficient is it to have members of the community acting out their psychological distress because the state cannot acknowledge the need for resources to allow clinicians to provide for themselves sufficient to enable them to work effectively? And what sort of false economy is it to measure efficiency by numbers of attendances without appreciating that a proportion of patients will turn up time and time again - often to different helpers, because no one clinician has been able to devote enough of themselves in the service of helping their clients effect real change? It is easy to continue in this vein - discussing the National psychotropic drug bill, the costs of repeated psychiatric admission where the covert purpose is control rather than treatment, to discuss what we really mean by the term 'respite', and so on. But our purpose in this section is a more positive one, that is, to offer clinicians themselves a point from which to develop their own personal view of the forces that might be at work in their professional lives. It is a section that should give encouragement that within ourselves lies the path to more effective therapy, and that the journey along this path is one that, though it has many obstacles both overt and covert, it is beholden upon us to follow.

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# SOME PSYCHODYNAMIC ASPECTS OF HELPING:

# A CRITICAL OVERVIEW

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In this paper I will be considering some of the strengths and weaknesses of the psychodynamic perspective on the helping role. Over the past five or six years I have developed an interest in this issue arising from two sources. My own struggles in creatively using the client role in my personal therapy led me to question some of the motives for being a helper which lie outside of the need to earn a living on the one hand, and fulfil a relatively altruistic niche in society on the other. The second source of my interest came from experiences with Bill Barnes in running T-groups for clinical psychology students (Barnes and Pilgrim, 1983). At the outset, it might be useful to consider statements made during correspondence between Freud and Foulkes, the founder of group analysis. Foulkes had a prolonged personal concern about the issue of helping being a defence for the therapist against suffering. This prompted him to ask Freud's opinion on the matter and Freud indicated that:

> "It looks as if a number of analysts learn to make use of defensive mechanisms which enable them to evade the conclusion and requirements of analysis themselves, probably by applying them to others. They themselves remain as they are and escape the critical and corrective influence of analysis."

In turn, Foulkes concluded that:

> "The analyst, like his patient, may defend himself against recovery and cling tenaciously to illness and suffering. Like his patient? Perhaps also through his patient! This disturbing thought occurred to me a long time ago, does the analyst defend himself by his very profession as a psycho-analyst, by analyzing others?" (1961)

A Kleinian view of the dynamic being offered by both Freud and Foulkes is that through a process of projective identification, therapists may substitute work on their own suffering by working on the suffering of others.

Projective identification involves disposing of parts of one's self on to other people and thereby removing an inner danger. In the helping role, the danger seems to come from a damaged or vulnerable part of the self and this is dealt with by working on the damage or vulnerability of clients. It is to the credit of analytical writers that this phenomenon has been recognized. If it is taken seriously though, psychologists who are not part of an analytical culture may still learn from the dynamics being discussed. Szasz (1963), in discussing transference as a defence for the therapist, demonstrates how the analytical technique also is sustained to block out powerful erotic and aggressive feelings in the here and now of the interaction between the patient and therapist. Szasz argues that the concept of transference was developed by Freud as a necessary defence for regular therapeutic contact with clients. Transference interpretations allow the therapist not to take expressions of desire or hostility personally. The seminal example used by Szasz is that of Anna O. falling in love with Breuer and the latter beating a hasty retreat. Freud drew attention to the process of Anna's erotic feelings being displaced from earlier dramas into the therapeutic set-up. Freud then argued that if therapists can analytically raise themselves above the level of the actual personal feelings around in the relationship and instead analyze the process, then this will enlighten the client of their repetitive dramatic tendencies. Whilst Szasz does not deny the process of enlightenment advocated by Freud, he emphasizes that it has a further function, which is that it protects the therapist from raw personal feelings in the present.

Although the analytical tradition has taken the therapist's role seriously, by insisting upon the need for personal therapy for those conducting themselves in a helping capacity, it is interesting that the therapist's role is strangely neglected in psychodynamic literature. For instance, a rough content analysis of the International Journal of Psychoanalysis over the past twenty years indicates that only around two percent of the articles address themselves to the role of the therapist. The great majority of papers focus on the client's side of the relationship. This small proportional interest in the therapist's role is equally reflected in the British Journal of Medical Psychology over the twenty years, which is probably a good representative psychotherapeutic journal within the British context. This is not to say, however, that when psychotherapists have written about the therapeutic role, they have not struggled with some very important concepts and grasped many important nettles. A good example of this is Tower's (1955) paper simply entitled "Countertransference". Of particular importance in the literature that does discuss countertransference is the discrepancy highlighted between countertransference feelings which are induced by the clients, and therefore give important cues to the therapist about the repetition of the client's earlier life and, on the other hand, the countertransference feelings which the therapist repeatedly imports into the therapeutic set-up. In other words, it is important to distinguish between what is the therapist and what is induced in the therapist because of the peculiarities of the client.

As well as the issue of projective identification linking to care in the literature, another theme of control is discussed. The corrective and incarceration role is demanded by society from those working in psychiatric hospitals, special hospitals and prisons. A dynamic formulation of this role would indicate that rather than caring being a defence against suffering, control comes to the fore. The main dynamic in play here is identification with the aggressor. What is involved is primarily a parental assault or discipline upon the weak child. A second dynamic may also be that of envy and anger about the client. Like the carer, the controller unconsciously desires to be looked after, but is threatened by taking up a role of vulnerability and risking its consequences. The authoritarian aspects of the custodial role allows the professional to act out sadistic feelings internalized from a persecuting parent and feelings of anger provoked from envy. The first figure summarizes some recurring psychodynamic themes which link up past and present in the lives of professional helpers. What is indicated in the figure are some fantasized or actual infantile events which prime the child to take up a helping role in later life.

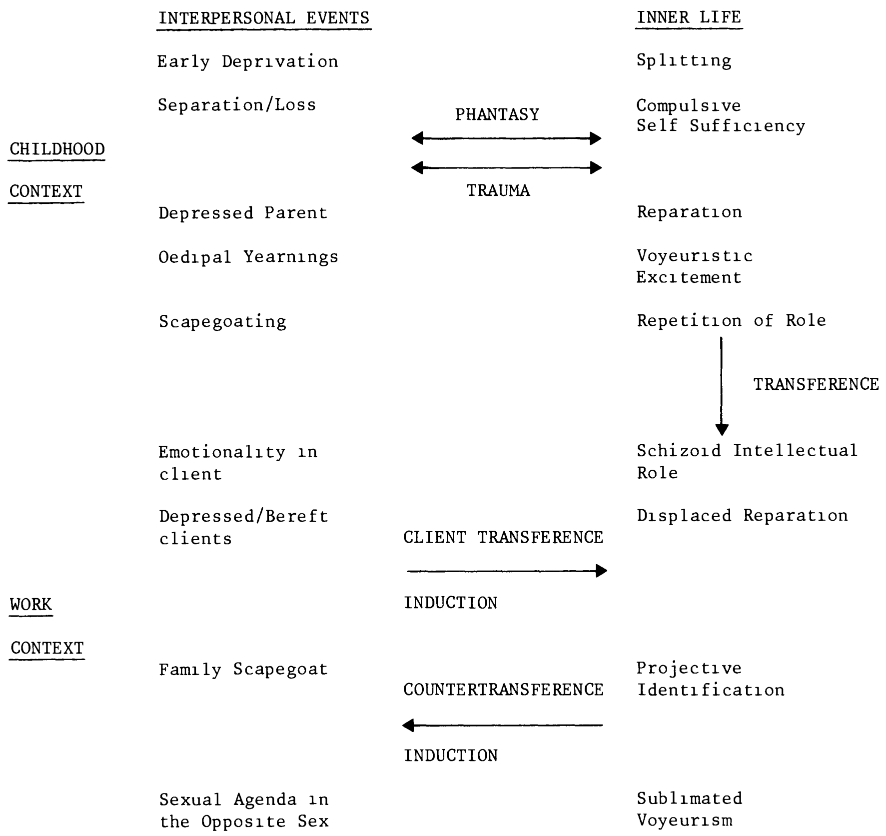

Fig. 1. Infantile links.

Moving on to Figure 2, an attempt is made to sketch pathways socially available for dealing with personal damage. Many examples are given in the literature of how people take up one of these pathways or alternatively oscillate between the pathways. Malan (1979) describes a mental welfare officer who eventually gave up dealing with distress externally, broke down and as a result came in touch with his internal vulnerability. Malan comments:

> "A particularly common example of the use of genuine feelings for defensive purposes occurs in what I call the 'helping profession syndrome', whereby the individual devotes his life to giving to others the care and concern he would like to have for himself."

Related to this "syndrome" is Bowlby's description of compulsive self-sufficiency in helpers, who have much difficulty in accepting help from others, even if it is available. It is certainly true in conducting groups of helping professionals that the theme of difficulty in taking up a weak position recurs with great regularity. Another version of oscillation within the three pathways is when habitual helping breaks down to persecution. Recurring and sad examples of this accrue every few years when psychiatric nurses are found guilty of abusing and assaulting the patients in their charge. It is important to note at this point, however, that an understanding of neglect and abuse in health care systems cannot be reduced to one factor, such as the one being considered at the moment - that of a psychological predisposition to sadistic acting out. A larger systemic analysis of closed institutions and the group demoralization that can occur

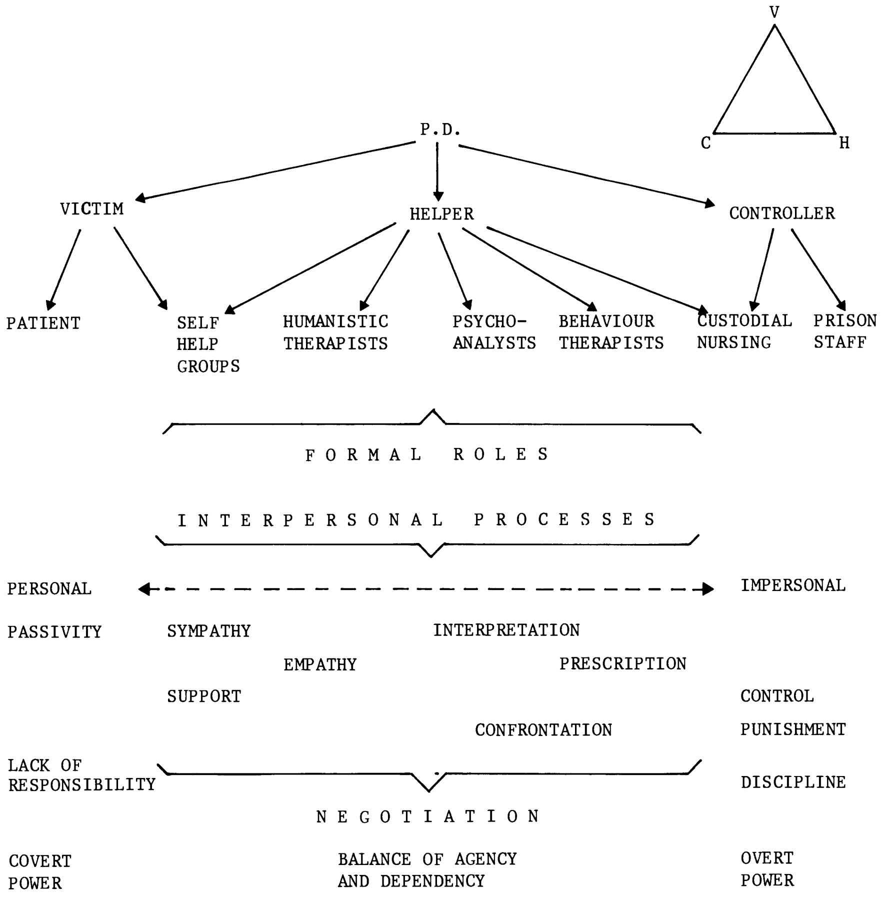

Fig. 2. Pathways open to personal damage.

at points over time needs to be opened out in order to elaborate the more personalistic hypotheses considered in the psychoanalytical literature. Returning to the issue of oscillations within the pathways, Michael Balint describes a patient who exemplifies a further permutation. This was a military policeman who was preoccupied with his strong macho image but eventually broke down. In this particular case, control had flipped into victim. With regard to helping itself, many examples can be given of patients becoming helpers: Samaritans, self-help group organizers and professional helpers all contain people who have switched role. Psychotherapists working on their own families of origin, frequently recognize themselves as scapegoats on the one hand or comforters of depressed parents on the other. As therapists then we may be creatively sublimating a part in earlier painful dramas. Our ability to identify with distress increases our capacity for intuition, empathy and a sense of shared human experience. If this has been survived, hope is communicated to patients. On the other hand, we run the danger of distorting communications, disposing of our own pain on to others and over-valuing particular counter-transference themes. The latter pitfall has led many brilliant psycho-dynamic theoreticians to generate whole edifices of dynamic psychology from their own inner dramas. This general statement can be justified if the psychological biographies of people as diverse as Freud, Jung, Adler and Guntrip are scrutinized in detail.

## A CAUTIONARY NOTE ON PSYCHOLOGICAL REDUCTIONISM

I would now like to draw attention to some disadvantages of the type of dynamic formulations that have been sketched above. What is at risk is some type of psychologism or psychological reductionism when we are trying to understand the minutiae of helping relationships. There is a danger that in our understanding we attribute too much causal power to the types of psychological theme that have been discussed above. What we need to strive towards is an understanding of a nexus over time of self in relation to social context. If this can be done we may trace the internal psychological issues with reference to a variety of social opportunities. Sartre describes this as understanding a person's "project" in relation to their "field of possibilities". Three important considerations have to be made with regard to the use and abuse of helping relationships:

1. The educational opportunities that lead to one type of career role rather than another being pursued are class derived. It is social class of origin rather than individual psychopathology that is more likely to determine whether a person becomes a nurse in Rampton or a psychoanalyst in Hampstead. There is now extensive sociological evidence (Halsey et al., 1979; Goldthorpe, 1979; Giddens, 1974) that classes tend to recruit from their own as far as employment or non-employment is concerned. Professions reproduce themselves through families from one generation to the next as one tendency. A stronger tendency is that the class-linked level of education determines where people find themselves within social and therefore helping structures. Navarro (1975) has shown that the typical hierarchical structure of health care set-ups reproduces the social class divisions of the wider society sustaining the health care system. This structural mirroring of the broader society according to Navarro is shown up in the class, gender and ethnic nature of the various professionals and workers within the health care system.

2. The social processes that funnel an interaction between a client and professional are outside of the control of these individuals. Where people find themselves within a social system is only partially determined by individual choice. What is dialectically linked to this choice process at the individual level is a process of opportunity or lack of it at the social level. For instance, at different historical points along life spans, vulnerable people, depending on their social opportunities, may be co-opted into delinquency, encouraged to pursue a career in medicine or be left with little in life but the last resort of a mental hospital (on this last point see Braginsky et al., 1973). These aspects of a social matrix over time include: material wealth; social opportunity; type of schooling; and expectations of one's primary group, i.e., family and peers. Once people find themselves working in, or being the consumers of, a health care system social processes remain immanent. For instance, returning to the division and sub-division of labor discussed by Navarro (1975), it is clear that some health care workers have more power and control over their lives and their actions than others. Within the mental health field for instance, the implications of medical hegemony are that non-medical therapists spend much time creating and defending autonomous space to practise therapy outside of the control of medical practitioners (Goldie, 1977; Baruch and Treacher, 1978; Pilgrim, 1983). The envy, frustration and aggressions provoked by the political rather than the psychodynamics of helping organizations need to be understood when we try to make sense of destructive or negligent events within the helping role. All too often it is easy to assume that the calm reflective creative space necessary to practise a caring relationship is available to people on a day to day basis in their workplace. We do not have to go far into the experiences of those of us who work in a traditional NHS psychiatric set-up to realize that this is clearly not the case.

3. Restricting scrutiny of professional ethics to individuals can produce a form of tunnel vision, so that we fail to assess the collective utility of professions to human welfare. For instance, the medical profession is carful to demand that its individual members are not negligent and it has a very strict code of conduct to judge and deal with those breaking the mores of the profession. On the other hand, a collective scrutiny of the medical profession indicates that it is anti-social and disabling in its activities. Driven by its need to maintain and extend its own entrenched power and fend off the competing claims for control from other professionals on the one hand and consumers on the other, medicine on a collective basis has been more preoccupied with self-reproduction rather than the general improvement of humanity's lot. Moral and political doubts about the motivations of the medical profession as a whole are amplified by an understanding of the corrupting value of the profit orientated hardware that sustains and patronizes health care systems. The pervasive influences of the pharmaceutical and medical technology companies inevitably influences the style and quality of health care supply. Thus, by restricting one's unit of analysis to the individual in a helping set-up one loses sight of the collective impact of helpers on their sustaining society.

In conclusion then, some methodologies are available to us to help us clarify the socio-psychologic of helping. In themselves economistic sociology on the one side and individualistic psychoanalysis on the other, give only a partial picture. We have to look to methodologies derived from the Frankfurt School to understand the sociological value of psychoanalysis (e.g., Habermas, 1974) and to Sartre's progressive regressive method (1960) to understand how to oscillate our attention between the biography of a person and their social context. Within social psychology in Britain the ethogenic initiative of Harré (Harré and Secord, 1973) provides us with a further methodological basis for understanding self in social context. In Figure 3 I have tried to indicate some of the elements involved in this complicated form of understanding.

It can be seen that the person in relation to society as an open system, has to be understood over time. In order to elaborate an understanding of the helping relationship, one needs to listen to the personal accounts that therapists and patients give of their lives, whilst at the same time examining the nature of society over time that has socialized them as people. Such a description has both synchronic and diachronic elements. This means one has to consider psychological and social events at a particular point in time and across time on a historical dimension. Sartre advocates that we move "back and forth" from biography to social system and from social system to biography. If we can make this movement successfully we start to construct some of the relationships between a person, their society and their work role and we generate a form of integrated knowledge which has both sociological and psychological elements. One of the main drawbacks about psychoanalysis and for that matter behavioral analysis, is that both of them represent a form of historical determinism. Whilst it is certainly clear that the past inevitably has an impact on the present, neither psychoanalysis nor behavioral analysis can in themselves become predictive sciences for one simple reason. Human beings live in an open social system and the type of predictive power demanded by scientific expectations cannot be extended to open systems. The best we can ever do is describe what Gregory Bateson has called "the pattern which connects" and the "pattern through time". This pattern has both predictable and unpredictable elements. Freud's description of repetition compulsion, and transference in particular, has been vital to our understanding of the predictable aspects of biographies. As people are in an open system, however, the predictable aspects of their lives tend to be clear with the wisdom of hindsight. Prospective statements about helping or any other behavior are extremely difficult to make.

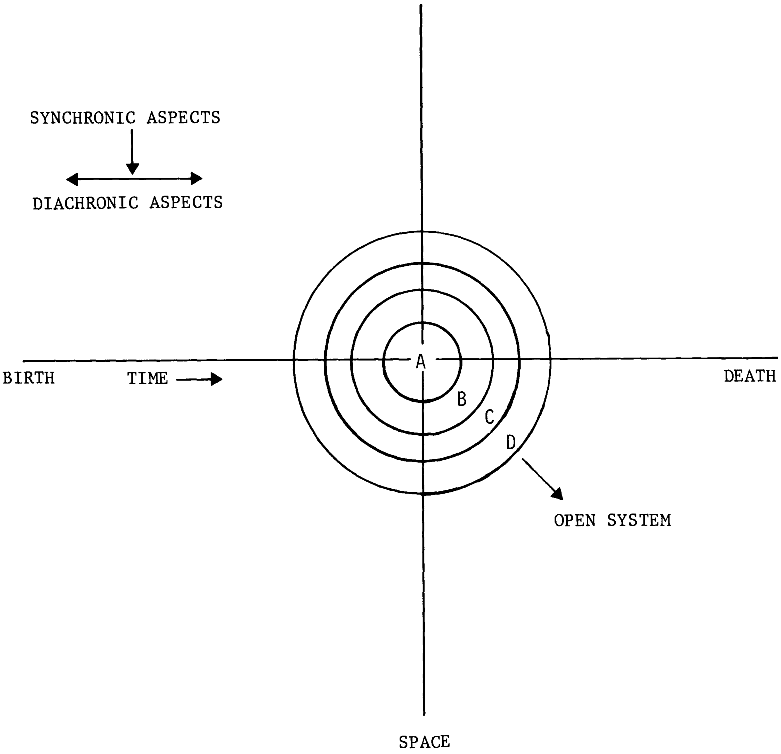

Fig. 3. Self in social context. A. Unconscious internal world. B. Conscious rule bound social world. C. Class, gender, ethnic, age links to others. D. Shared culture, economy etc.

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# WHAT IS A THERAPEUTIC RESPONSE?

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A young woman has been coming to see me for a few weeks. She is in her twenties, good-looking, rather wan and shy. On the occasion that I am writing about she looked at me with her usual directness as I opened the door, gave me a quiet smile and came in. Then she said: "May I use your loo?" "Yes. Or course," I replied. The hesitancy with which she asked the question prompted me to emphasize my answer: "Yes. Of course." I felt I needed to convey to her: "You do not need to ask with such hesitancy. You are welcome to use the loo. I do not regard your request as unusual or disturbing in any way." I could, when the session began, have made what is commonly called an interpretation. I could, for instance, have said: "I notice that during sessions, you are at pains not to be a nuisance to me. You never show any aggression, you speak little and quietly, you try to be 'good'. May it be that in going to the loo just before the session you try to get rid of the messy, dirty, unacceptable bits of yourself in case they emerge in some form during the session" This would have been, I think, quite a legitimate response. It makes sense, provided that one can accept the resemblance between the excretion of physical waste products and the expression of feelings, thoughts and attitudes which may be unacceptable to another person: and it may, in this case, have been relevant. However, I made no comment. This was not a conscious decision on my part and I can only guess at my reasons for the silence on the matter. They were, I think, as follows:

(1) Barbara (as I shall call her) comes a long way, by public transport, to see me, and may well need to go to the lavatory on arrival;
(2) Even if there had been a gain by making this interpretation it may have been off-set by diminishing the impact of my first response: "Of course." My answer was designed to enable someone, very unsure of herself, to feel that her behavior was acceptable. By contrast, the interpretation may have led her to feel critized. She may have then thought: "he doesn't think I should have used his loo"; or, at a deeper level, "He doesn't like my body; he doesn't like me";
(3) I thought that a considered observation about her behavior may lead her to feel that the relationship between us was based on my careful, continuous scrutiny of her;
(4) To have started the session with an interpretation would have set a certain tone to it which would have important meanings for her, not necessarily to her advantage.

In thinking about this brief interchange I am not suggesting that one course would have necessarily been better than the other, but that the two alternatives are in some way comparable therapeutic endeavors. What I wish to discuss is not the value, content or timing or psychoanalytical interpretations but their nature and the ways in which they differ from, or are similar to, the more ordinary response that we give to people both in psychotherapy and in daily living.

I would like to start by looking at my ordinary response to Barbara's request. Could this be thought of, in any way, as an interpretation in spite of its marked formal difference from the meaning given to the term by psychotherapists? I think, perhaps, it can. I am saying to Barbara: "I believe that your view of yourself, of our relationship, and of the way people can best behave towards each other is mistaken - or, at least, can be seen in a different light. I am a little surprised at your diffidence, for which, as I see it, there is no need." There may have been other implications (of the kind suggested above) for her in my response. Perhaps: "My body is more acceptable to him than I supposed. He doesn't regard me as an intrusion into his life even when I don't confine myself strictly to the agreement that I am allowed into his consulting room." That is to say, the comment would likely have symbolic as well as overt meanings: and the combination of the two may affect her relationship with me and her conception of herself. To broaden this idea to the utmost: I have presented her with a view of living, which she might then contrast with her own.

A view of living is, in a sense, an interpretation of living. Few thinkers now believe that the universe is out there waiting to be discovered, an objective entity stretched out for our unbiased senses to grasp. Even scientists have come to consider their observations to be interpretations (Bohn, 1983; Feyerabend, 1975). And the interpretative element plays a considerably greater part when we come to human relationships. In our interactions with people much - probably most - of what we do and say has the aim of influencing the other. And even when this is not the case we may unwittingly, simply by <u>being</u>, have an effect on others which alters their perspective of things (an effect which, in ordinary life, we often do not consider, but which when we are in positions of authority - as parents, teachers or psychotherapists - we may overlook to our cost). For example, if I were to dress in a bizarre fashion, I may simply convey: "These are the clothes that I like to wear." But I may also convey: "It is permissable to dress eccentrically," or: "This is how one <u>should</u> dress." And I may or may not intend my dress to represent either of these two latter meanings. But let us return to the session.

While Barbara was in the lavatory I walked into the consulting room, the door of which was propped open by a stone, and sat down in my accustomed chair (in this account I am leaving aside the messages given by the set up in which I work, including my dress, my chair, and Barbara's chair, although these are, of course, not without importance). When Barbara came in I said: "Please kick the stone away from the door; it will close itself then." By this act and by my words I convey something about the nature of our interaction which I take for granted as reasonable. I would say that I show that I believe it acceptable to both of us that our relationship, although task-orientated, can have a certain informality. We are not in Jane Austen country, where gentlemen open doors for ladies and ladies are not asked to kick stones. Yet I am polite: I say "Please," and, as far as I can tell, I speak in a friendly way; that is, I speak as to a friend. My attitude conveys, I think, that although Barbara thinks of herself as "sick" and turns to me as a professional, I respect her as I would a friend. But, of course, I will only convey this if I mean it. If my manner is strained and defensive I would probably give the opposite impression. One way of formulating my attitude could be: "In my view those, like you, who cannot cope with the world are not less valuable than those who can or who appear as if they can. Something has led you to think otherwise. I now want you to ask yourself whether you might have got it wrong."

What is the difference between these ordinary responses of mine and a psychoanalytical interpretation? It would appear to lie not in an exploration of the unconscious (for I assume that unconscious factors come into Barbara's attitude to me and will be influenced by how I behave towards her) but in their relationship to personal history. Whereas I do not, in the above, guide Barbara's thoughts towards her early childhood, many (although, of course, not all) psychoanalytic interpretations do so, and indeed, lay great stress on doing so. This does not mean that we may not, in daily living, make interpretations of people's behavior in the light of their past, particularly since the work of Freud became widely known). But, even when trying to help them, this is not our usual mode of approach whereas it dominates that of the psychoanalyst.

I have recounted this very brief interchange with meagre context and, while having the advantage of simplifying an event which is bound to be richly complex, my description is likely to be misleading. Although it is impossible to convey much of this complexity to the reader it may help a little if I say what I believe to be the most important happening between Barbara and I up to the time of this session.

We began badly. For various reasons I was very reluctant to accept her for psychotherapy. I doubted whether I could help her, I doubted whether I was the right person for her, and it was only under the pressure of her determination to come to me and my sympathy for her plight that I agreed to her request. I admitted my doubts during our initial meeting. She didn't appear unduly dismayed and we agreed that our contract should be provisional for the first few weeks. In a remarkably short time (for I only see her once a week) my misgivings have faded. I think that this is in part because her defences are not as formidable as I had expected and in part because I have so warmed to her that I am now less concerned about the possible anxiety and disappointment she may bring me. I am committed to her. This change in my feelings is bound to show in the way I am to her; and she is sure to sense this. While I do not think that the circumstances of our beginning invalidate the account of the episode described above they clearly have a bearing on it. Barbara would, I believe, be tentative in any case and with anyone. However, the point I wish to make is that my effect on Barbara is not only a function of my immediate words and actions but of the whole context of our relationship over a period of time.

There are few limits to the length of time of a piece of psychotherapy; it may be one session or five times a week for several years. There is, however, no essential difference in what is done. In both cases intellectual and emotional factors will play their part. But there are disparities in the degree to which various elements predominate. In long-term therapy a relationship gradually forms, the totality of which comes to mean more than the addition of the single interchanges, and the experience gained over a period of time will be emotionally profound. Rather, as in a marriage, the way the two people constantly feel about each other and behave towards each other will usually be decisive rather than any single event, however crucial this may sometimes be. In the case of my relationship with Barbara the impact of my continued acceptance of her will be more convincing than a single response of the kind I have described. Considered as an interpretation (in the extended use of the word) it will be more penetrating. In other words Barbara is more likely to be influenced to change her perception of herself and of the world by our relationship over a period of time than by anything I might say or do in one particular session. In saying this I do not wish to deny the value of psychoanalytical interpretations without which twentieth century psychotherapy would indeed be impoverished. Rather I wish to emphasize that the relationship itself, the ordinary way in which the therapist feels about and behaves towards his or her patient, is just as likely to make "Psychodynamic" changes in the latter as the formal, intellectual responses which are held by psychoanalysts to be the essence of their effectiveness, and is less different in quality from the traditional view of the nature of interpretation than is commonly supposed. It follows from this line of thought that the distinction between the building of trust (the "therapeutic alliance") and what can then take place within the context of this trust is not a valid one. I do not behave encouragingly towards Barbara so that work can be done between us; my encouragement _is_ the "work."

The sharp distinctions commonly made between analysis and therapeutic alliance, between technique and ordinary response, between interpretation and perception, between psychoanalysis and psychotherapy, are symptomatic of our contemporary way of regarding the universe. In everyday life it is, of course, necessary to make such distinctions we need to know the difference between a cow and a sheep and sophisticated elaborations of this kind of judgement have led to the growth of science. But the utility of these formulations has blinded us to the fact that we now see the world as fragmented instead of whole. Even in the East, where philosophy has emphasized wholeness the fragmented view of existence dominates practical living - increasingly so as Western technology gains influence. In psychotherapy fragmented thinking leads us to forget that _everything_ we do and say to the patient has an effect that is either therapeutic or antitherapeutic.* This omission will be a source of confusion to all who are involved in a therapeutic endeavor, whether as patient, practitioner or theoretician. (Because of my particular orientation and experience I write with psychoanalytical theory and technique in mind, but I see no reason why this point may not be valid, given different emphasis, if we were to talk about other schools of psychotherapy).

Let me return to my interview with Barbara. Once she sat in the chair one might consider that the session "proper" had commenced. What does this mean? Do I then adopt an entirely different attitude? Is there a change from the social to the professional? To some extent there is, but the change is perhaps not as fundamental as might be thought. It is comparable, I believe, to the kind of change of focus that can occur in ordinary life, as for example when a friend may come round to discuss a problem. After we've had a cup of coffee one may say: "Well, Jim, what's on your mind?" There is, however, a difference in the type of dilemma. Whereas the friend is probably bringing a predicament that is (or appears to be) in a relatively well defined area of their life, the patient - particularly in long-term psychotherapy - is bringing themselves. But, again, it is a matter of degree. In attending to the friend's problem (e.g. "Should I change my job?"), we will be of more help if we consider them as a whole, i.e. if we think of their individuality in order to get a better perspective on the particular dilemma. In therapy it is rather the other way round. The therapist looks at the problems which the patient brings in order to get a better perspective on their individuality. In each case there will be little gain if the wholeness of the other person is forgotten, and there will be risk if the helper does not take into account,

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*Binswanger criticized Freud's tendency to conceptualize symptoms in too mechanical a way and he was more concerned with the patient's perceptual world than the therapeutic vision of the interaction. (Binswanger, L. (1963), _Being in the World_, London, Souvenir).

with sensitivity, the totality of the relationship and the likely effect of their influence. Because, in therapy, the person is more clearly bringing themselves thereby placing themselves in an extremely vulnerable position, the therapist will likely behave with great carefulness, looking closely at the other's "self", and scrutinizing their own responses, not only in order to understand the other better but to try to ensure that they do not wield their power in a harmful way. Thus their stance is likely to be, in the main, a more measured one than the ordinary living. I do not intend to describe the session with Barbara - if only because I have not the space here and because I wish to preserve her anonymity but, in view of the above discussion, it may perhaps be useful to say a little about it in the hope of enabling the reader to get a sense, however slight, of the mode of the relationship.

It was a short while - as it usually is - before Barbara spoke. Then she said :"As I was coming here I thought "I don't know why I'm in this town. I don't feel in the present moment. There's something wrong with time; it has stood still. I'm looking to the end of the day - not that anything will happen then. And I'm looking to 12 o'clock, when it will be the end of the session."

I asked her if she had always felt like this.

"Yes. Ever since a child."

"Is it that you cannot imagine anything really changing? That there could be no gradual evolution, that there would have to be some kind of jump, as if by magic, and you know this cannot be?"

Barbara agreed with me and we went on to discuss her despairing belief that change was not possible, the events in her life that might have led to this belief, the sense of deadness associated with it, her need to share this feeling, and the difficulty she has in doing so in case she may disturb others. She also shyly admitted her wish to be of use to those who felt as she did. Barbara had not hitherto expressed her despair so openly and I felt closer to her as a consequence. I believe that she sensed my closeness. How should one formulate this interchange? There was elucidation and sharing. I did not talk about myself but I think that Barbara probably realized (whether consciously or not) that my own experience of the kind of despair that she was describing enabled me to share her feelings and talk about them in the way that I did.

All that I have gained from earlier workers in psychotherapy - from Freud, Winnicott, Searles, and many more - and all that I have learned from my own training and experience no doubt played a part in my understanding of Barbara's state of mind, but unless this knowledge was incorporated within an immediate, whole, empathic response based on my experience of myself, and indeed, unless this knowledge did not interfere with my capacity to react in a simple, ordinary way to her misery, I would have been of little use to her. To put it another way, perhaps one cannot fruitfully separate an interpretation made from a personal response involving sympathy, sharing and acceptance. If this is so, one might reasonably expect my behavior before and during the session to be of a piece. I notice that I have described my attitude as one of acceptance. I think that this is not by chance. Although the nature of psychotherapeutic help remains debatable (to say the least) there is an increasing belief that the warmth of the therapist plays a considerably more important part than was once thought. Many words can be used to describe the positive attitude of a therapist - warmth, love, empathy, encouragement, acceptance, and so on - and these words overlap. Perhaps it does not matter too much which words we use. I find the word acceptance comes readily to me because those who seek help inevitably feel themselves to be, in varying degree unacceptable. They have found themselves in a world which has not received them: and unless they find an experience where there appears to be a possibility that they will be accepted without unbearable distortion of the self, their psychic disabilities will persist. Most of the interchanges which occur in psychotherapy centre, I believe, on this point. However, whether or not we lay such emphasis on acceptance, we may wish to assert not merely that the personal element is important in psychotherapy but that it is the framework by means of which every therapeutic response we make has its meaning. There is no such thing as a technical move. Only a computer could manage such a thing.

From a pragmatic point of view the question to ask about psychoanalysis is not "Is it true?" but "Is it useful?" Furthermore not only "What parts of it are useful?" but "In what way can we make sense of the body of knowledge called psychoanalysis so that we can use it?" In wording the question in this way I am implying that, as therapists, we need to come to terms with the most relevant and useful body of knowledge available to us without necessarily accepting its own view of itself e.g. that it is a science and a technique. We need to see it in a new light while avoiding the temptation to reject the insights it has made available to us. And this applies to any therapeutic approach which is considered by its practitioners to be technical. The idea that our work is not technical brings the recognition that we can no longer maintain the illusion that we are impartial dispensers of interpretations, paradoxical injunctions or other forms of intervention; that we simply aim to help the patient to be what he wants to be or, for those whose aim is "adjustment", to be what society wants him to be. We are bound, because we are human, to have certain ideals and philosophies of living and, however much we may strain to be non-directive, to carry these prejudices to our patients. One can only hope for a dialogue that is as open as possible, in which we exploit our power as little as can be managed.

Of what stuff, and by what means, is a psychotherapist made? Some people, for whatever reasons, are more gifted at helping those in pain than others. Because we live in a free society we cannot (even if we had inspired judgement in these matters) draft the gifted ones into the profession and exclude the others. But I believe that selection is crucial and that those of us who are involved in teaching psychotherapy have a heavy responsibility in encouraging those who seem to possess this gift irrespective of their other abilities and credentials. I fear that at present selection committees are too impressed by professional status and academic distinction. Once a decision has been made and we wish to advise someone about the steps they should take to make themselves into a therapist what should we say? They will find themselves surrounded by a bewildering variety of institutes, societies and groups, many of which speak in languages as far removed from each other as Hindustani from Dutch. This is, unfortunately, a situation which is beyond our individual power to do much about and we will each recommend a course according to our predilections. However, what I believe to be of the greatest importance is that we encourage them to develop their own unique capacities to help rather than seek conversion to some school of thought - Freudian, Jungian, Behaviourist, etc. - however much they may gain from a critical engagement with these disciplines (Lomas, 1981). If it is correct to say that their contribution as a therapist will primarily be a function of their experience of and attitude to living then the fragmentation involved in basing their work on a special theory can only undermine their therapeutic potential. One may hope that in the future less didactic forms of teaching will emerge without any loss of the rigor and pursuit of excellence at present offered by our best training institutes.

Psychotherapy does not reach many of the people who need it. Most cannot pay for private treatment and in the public sector practitioners are scarce, have little time for each client and their endeavors are often beset by organizational requirements. Members of the public have themselves organized self help groups and have sometimes engaged the help of practitioners. But this help has often proved a mixed blessing and the experts tend to dominate and undermine the ideals on which the groups have been based (Chamberlain, 1978). So - what can be done? The best hope, I believe, lies in a recognition that the difference between the "experts" and the public is only one of degree. We are all in much the same sort of boat, and even those of us who have devoted our working lives to psychotherapy have only a little learning of a subject that is too vast, too elemental, too generalized, too elusive and too important to be left to any who might claim a monopoly of knowledge.

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# PRETENDING TO CARE

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I want here to tease out a few issues which seem to me to have some importance in the process of becoming a clinician. More particularly, I'm concerned with the move from a general training in psychology as a science, towards being a clinician involved in psychotherapy. Movement between these two worlds has sometimes been, for me, a confusing and threatening progression. I've been tussling, for years now, with the more theoretical (but none the less, practical) issues that are involved in the transition. We still seem, in practice, to be trying to carry across the methods of exploration and research that have been developed in general psychology, to apply them in the psychotherapeutic domain. I believe that this is, in the longer term, a hopeless task. It may be akin to trying to colonize and subjugate a spirited and distinctive race, with only superficial similarities to the aspiring master-race of scientific psychology. To the degree that the transfer of concepts and methods from one domain to the other is achieved, some understanding will be gained through imposing on the unknown realm the shapes of known conventions. Much of the native culture, however, will be driven out, underground or out of sight. In this situation, the experience of the psychologist moving from one domain to the other, is likely to become even more confusing. It will seem that we are gaining more knowledge, while actually obscuring the major issues and leaving the psychotherapeutic territory largely uncharted. Rather than acquiring living knowledge, habitable understanding, we may eventually find that only 'native' or 'naturalized' guides are then able to help us find our way around.

I believe it should be a major task for a psychology of psychotherapy to develop sensitively delineated maps and conceptual guides to these still relatively mysterious, psychological lands. Such a psychology should help us to a useful understanding of the landscapes and of the manners, customs, rituals and challenges of the people we may find there. In addition to attending to a few of the questions that I've been able to formulate, in retrospect, about this journey from being a psychologist to becoming a psychotherapist, I want to stress the importance of becoming a psychologist again, at a different level and in a wider way. The realm of psychotherapeutic experience and practice is one that requires us to make some conceptual, as well as practical, sense of it. We need to reach through our journeying towards a more adequate psychology of psychotherapy and of the issues of human experiencing that psychotherapy points towards.

## Caring and Knowing

Psychotherapy, in its various forms, is an expression of our current understanding of what is involved in caring; for caring somewhat more fully for 'persons' rather than 'patients', or some more limited social role. But psychotherapy is itself still limited and is in many respects a strangely ritualized cluster of ways of giving expression to social caring. In addition to being about helping and caring, the activities that we normally refer to under the broad label of 'psychotherapy', also have a focal concern with knowing and being known. It is an arena which highlights issues to do with 'knowing'; involving both ontology (ways of being) and epistemology (aspects of knowledge). It is a context, or a cluster of contexts, in and through which we engage in whatever is involved in coming to know ourselves and others. In psychotherapy, we struggle both with the issues of knowing in its many modes, and the many ways in which we seek to ignore, avoid and manage not to know. We are here thrust into the midst of knowing but also into the higher domain of seeking to come to know something of what it is to know and not to know, to be known and not to be known. This is a vital realm of human inquiry, concerning central aspects of our ways of living with ourselves and through each other. This reaches well beyond the social rituals we presently call 'psychotherapy.'

Our society is changing rapidly in so many ways. Our ways of engaging in the diversifying activities we consider to be 'psychotherapeutic' are changing too. Everything is in motion. Not only will we see major changes in what we understand as 'psychotherapy' (even its melting back into many other things), but we may see major changes in what we understand as 'psychology.' As we learn to draw more fully from our developing experiencing in the psychotherapeutic realm, and conceive more adequately what there we find and make, so we may find that we are creating a transformation in what we understand of what it is to know.

## Present Aims

In this presentation I want to speak mainly from my own experience. I hope that some of that will ring true in relation to some of yours. But even if you don't see things my way, I would like to encourage you to consider your own experience in this matter, and try to draw some statements from what you know that might give expression to the issues that have troubled or excited you.

I will attend briefly to three related topics. First, I'll sketch out a few points concerning 'knowing personally', with coming to know for yourself and relying on your own experiencing. Second, I'll note a few features of the psychotherapeutic situation, especially as regards the 'pretences' that often characterize much of what we do. Third, I'll try to draw attention to some of what may psychologically be involved in undertaking more of what is entailed in coming to know for yourself and relying on your own experiencing; in developing a psychology of psychotherapy or, more generally, a 'psychology of personal knowing.'

## Knowing for Yourself

For me, the move from being a beginning practitioner in the science of psychology towards being a fledgling psychotherapist, involved a range of particular adjustments, as well as quite general changes in attitude. You are likely to find yourself, increasingly, having to rely on yourself, rather than on the results of experiments or other formal pieces of knowledge. We are taught to rely on specific knowledge, of results or method, and then find that we are in the midst of 'non-specific factors' (though they may only be 'non specific' because we have not sought to know them in something of their terms, rather than finding that they don't seem clear when looked at through the goggles we have been taught, as scientists, to wear). Often, as beginning psychotherapists, we try to buttress ourselves against vulnerability and pain. We create safe forward encampments for ourselves by dressing carefully in the armour of some particular theory or by bringing with us the rolling stock and armaments of specialized techniques. By such means we can keep ourselves protected for a time, till we begin to get a feel for where we are, and can then begin to dare some sorties out beyond the pallisades of our previously prepared positions.

In this situation, there are at least three general questions you may, explicitly or implicitly, have to ask and answer: 'Who or what are you to trust?'; 'How can you enter more fully into your own, or someone else's experiencing?'; and 'How much of yourself, or of other people, are you willing to know?'

(i) Who or what are you to trust? As I've already said, you may start, as you are likely to have been taught as a psychologist, by trusting the 'protective clothing' or 'armaments' of factory made methods. But soon you will have to ask yourself if you are only going to do what your protective armour allows. Even while this armour may shield and encourage you, it will sometimes cramp your movements, and sometimes your client will be too quick and slippery, leaving you helpless, like a knight who has fallen off his horse.

Unless you begin to improvise on your own account, start from and repeatedly return to your own experience, you are going to be endlessly dependent, waiting for the next supply train from back at base (the psychological laboratories of the world). Unless you come to recognize that you are the only instrument of knowing you will always have with you, you will remain a bit-part actor in the psychotherapeutic drama. Of course the instrument of your own sensibilities is crude and fallible but, with discipline and loving care, it can be elaborated and refined.

All this, however, takes you in the opposite direction from most of your early psychological training which often seems intent on undermining who you are and what you may already have begun to sense and know. It also involves you in a gradual education of your capacity to feel, to touch and understand when nothing can be seen and no certified sign-posts tell you officially what supposedly is so. And it means that you must begin to care as much for clues and hints and signs as for those more formal friends, 'evidence' and 'proof.' You have to learn to live on the move rather than rely on fixed positions and externally fortified encampments.

(ii) How can you enter more fully into your own or someone else's experiencing? How can we 'transcend the obvious'? How can we reach beyond the common sense view of things, the way things obviously are? We learn our prescribed, and often willingly accepted, parts. We gradually undertake to present ourselves as this or that kind of person; undertake to appear, to ourselves as well as those around us, as relatively consistent in many aspects of our lives. When the consistency becomes too much, the rigidities too real, psychotherapeutic help may be a means of struggling with such roles that have become too thoroughly engrained. And within the context of psychotherapy, we have to experiment again. We may have to undertake many other parts of who we are, that we do not yet clearly know we are, or might yet be. This undertaking of other parts is similarly required of you as therapist. Since you may, through your own flexibility, encourage change in those who seek your aid.

Put briefly, as therapist or client, you will need recourse to imaginative play, make-believe, possibilities, fictions of what may yet be realized. And this brings you immediately into the realm of the possible and the unproven. It takes you away from the established and the safely respectable. We find ourselves in a theatre of uncertainty, surprise, new possibilities in being. We are taken to a place where everything we securely know is put in question. Everything becomes relative, insubstantial, other than we may have been assured it was. Through metaphor, new possibilities of meaning, of living, can be entered and explored (Mair, 1977a), new costumes, new plays, new parts, new access to the scripts we did not know we were being spoken by. The person, locked in inarticulate loneliness, may become a thriving, bustling, 'community of selves' (Mair, 1977b) when they begin to explore themselves as if they were more than an isolated island, a unitary soul.

We are here at the meeting place of many diciplines, many ways by which we may enter into knowing what we did not know or scarcely knew we knew. Painting, poetry, sculpture, theatre, computing, astronomy, physics, music....every vehicle of human expression is potentially useful for some particular searching to enter and know as a living thing. The previously secure world may tremble beneath your feet. Your familiar masks may become more flimsy than you thought they were. You, yourself, may be in the vestibule of change.

(iii) How much of yourself, or of other people, are you willing to know? It is easier to deal with bits of people than with all of them. It is easier to deal with people in terms of particular problems than to probe more widely. It is easier to deal with people in terms of prepared procedures rather than allow more fluidity and flow. All these easier ways may be useful, may often be enough. But sometimes they will not do. Sometimes they will not touch and hold and heal that which is closer to the heart of the matter. It will become necessary to listen to the person in the context of their whole life, rather than bits and pieces only. This may well require you, with almost all of who you are, to meet almost all of them.

Again, you may then be drawn beyond where you have been prepared to go, prepared to know. This is new territory, wilder and less charted than the formal farm-steadings of psychology-as-a-domestic-science had prepared you for. What may be required of you is something stranger than the conventions of ordinary social meeting that you familiarly know.

We are all nurtured and strangled, sustained and starved, liberated and trapped within the moving web of our own experiencing, of our place and time. We are endlessly in relationships. Everything is between here and there, this and those, self and other selves. Multiple meetings of many kinds constitute who we are. We are in it together. We cannot step out and start again. And almost everything between us, which constitutes the relationships we are constituted by, is invisible and unmarked. We have to learn how to develop and use radar-scanners of our own, tuned especially to the moving patterns of intention, the force fields of action and reaction, the pressures and vacuums of approach and veering away, many kinds and places of meeting, many ways and means of parting. Here again, we are not in a place we have been professionally trained to know.

No wonder many find this realm too threatening, too strange, too undefined, too intangible, too difficult to grasp by the heavy-footed ways we have, as psychologists, been taught to use.

## The Psychotherapeutic Situation

In moving from psychology towards psychotherapy, you need to know something more of who you are yourself. You do not, overnight, or even after a weekend workshop, become a 'fully functioning person.' Most of us do not get far in the course of years, or over our whole lives. With our inadequacies, we have to do the best we can. I want to say a little about that and about myself, here.

I do not get on easily or comfortably with people, do not find it easy to fully care for people, as some around me seem to do. I do not find much of what many people seem mostly concerned with of much interest to me, in relation to what I seem to need and be. I do not find it easy to let myself be known, nor reach across, in ordinary life, to care enought to know those I daily meet in intimate, professional, ways. And yet I do seem to need, or want, to know intimately and be known. It is not just lack of interest or concern... quite the opposite, perhaps.

So I find the conventions of the psychotherapeutic role a powerful help to me. I am protected in a diving bell, provided with the loose, protective clothing of a role. Together, my client and I, we inhabit the oxygen tent of a protected world in which things are different from the outside world (different and yet so much the same). Life and death are issues here, battled for in specially supportive air. Here I can pretend to care. I can pre-tend, can reach beyond and in front of myself as far as caring is concerned. My intention (what I hold to in my life) is to care, but here I can pre-tend, stretch forward to something of how it may yet be for me, and them.

Who, here is more in need is not always an easy thing to say. Here I am, gentle, firm, loving, understanding, knowledgeable, a helper...the good guy, the saint in thin disguise, the ideal man, ideal son, lover, husband, friend...if only...if only it were true! We are in the land of make-believe, of figments of the mind, of fictions, other ways to be. The rules of ordinary gravity do not quite hold. We are allowed to play. This is an invention of our own. This is how we can be other than we ordinarily are. Here we reach beyond, to how it might yet be.

It is, this invention of ours, this place of adult play, bought at a price. It requires its own laws. There are limits and rules (different limits and rules, but rules there are!). As therapist, you bring all of you, but you will not be known (how fine for those who fear to be known, and are struggling to find a way, but not quite yet!). You meet only a little and from time to time (how fine for those who cannot sustain the enveloping messiness of ordinary meeting... not yet at least!). You come out of the sun at whatever angle may usefully startle and sustain (how fine for those who cannot easily be real within the ordinary rules!). You accompany another in their search, only hint at and gently touch your own (how fine for those who fear to venture far from home!). You rest within the prosthetic womb of being less, and also more, than who you know you are (how fine if you are a psychological cripple whose deficiencies just fit the place of make-believe!).

How fine, till you must face your world alone!

We reach beyond ourselves to reach into who we and they yet may be. But we may succumb to the prevalent industrial disease of supposing we are already someone other than we are; believe we are good and kind and caring, trusting, noble, fine! We may be in danger of believing this when we have not yet reached beyond being someone who merely needs to believe, and needs to be sustained by those who need to believe, that we are the paragon we long to be.

We are in a place of opportunity and personal danger (just as GPs are with the drugs that they prescribe). And <u>limits</u> may be of the essence of this other world. Rollo May (1975) suggests that creativity itself requires limits, 'for the creative act arises out of the struggle of human beings with and against that which limits them - a psychology of creation must also be about limits.' Confronting limits, he says, may actually turn out to be expansive, 'limiting and expanding thus go together.' Form provides the essential boundaries and structure for the creative act. 'Persons in therapy - or anybody for that matter - are not simply engaged in knowing their world; what they are engaged in' suggests May, 'is a passionate reforming of their world by virtue of their inter-relationship within it.'

Thus it may be that out of our own limits and the limits we both impose and endure in the psychotherapeutic world of serious pretending, something of broader human use may yet be made.

## Caring to Know

What I have said suggests that there is much that may be new as you move from the realm of psychology in its conventional, academic, forms towards psychotherapy as a world of purposive make-believe. For some, it will be enough to move from there to here and do no more. They will want to settle, put down roots in the new soil, learn to live in a different way, never return.

That is not enough for me, and I want to suggest that it should not be enough for you. A psychology of personal knowing will require much more than we have yet achieved; and the wider, more personally involving modes of knowing that are part of the psychotherapeutic world, hint at how far we still have to go. We have no adequate psychology of psychotherapy, and I believe that we will need some quite different conception of science if we are to encompass the personal knowing and seeking to know of those who are engaged therein.

We do not have any adequate mapping of the territories of human knowing and what variously is involved; the different modes and manners of knowing and seeking not to know. Every way of knowing is, at the same time, a way of ignoring, of turning a particular blind eye, of seeking not to know. We are for ever in the uncertain process of deceiving ourselves by seeking mainly what we seek to know. Personal knowing must include both subjective and objective knowing; to seek to know objectively is itself a personal act.

As we move into the psychotherapeutic situation, we realize more fully that we know so much more, through our intuitive sensing, than we can spell out or clearly say. We need to understand so much more of what and how we know. We live still in the belief that we should move from the firm ground of fact, but in the psychotherapeutic situation, people sometimes learn 'to fly.' They find that fictions are as useful, if not more useful than fact, in helping us create and recreate something of our worlds.

We have generally been taught that knowing is somehow separate from who we are. Yet in the psychotherapeutic world we see so clearly that knowing has to be lived and owned and undertaken as our own if it is to help us change. If we, or our clients, do not come to know in this living way, we simply act a part, remain apart, knowing only in the head, do not really know.

All this highlights that in psychotherapy we are engaged in the huge issue of responsible knowing, of really undertaking what we know as an imaginative and moral choice. In seeking to understand more fully what is involved in such surprising, courageous action in the conversation of our lives, we will need to develop a different kind of discipline. Our technical knowing has already far outrun our powers to undertake the moral weight and pain of what we have created for our world. So far, we mainly know about, do not know fully for ourselves.

Through psychotherapy, and other ways of seriously pretending towards what we still only dimly sense, we may be able to compose a moral science of action, in and between and amongst ourselves. Unless we come more fully to know ourselves and each other; care enough to know more of what it is to know and to be known; to know and not to know; then we may not create the means by which to care beyond the limits of our present often careless and quite uncaring ways.

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# SELLING WATER BY THE RIVER

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It is worthwhile looking in detail at the process of 'helping people'. Especially the professionalized process from the Agony Aunts in women's magazines to the whole industry of counselling and psychotherapy. I have chosen the title from Zen Buddhism and want to relate those processes to religious practice. How do we purvey to people that which is everywhere freely available. Selling water by the river. Everywhere there is naturally help and love, warmth and affection (as well as the opposites) and yet some make a living out of selling it. Paid Helpers.

In one sense we live in a lost world. As Irmgard Schloegl (1977), a modern Zen teacher, writes:

> "We in the West, having squandered our spiritual inheritance, are compelled to look for a replacement. For whether we know it or not, we need to fill our inner hollowness itself with some archaic eruption from within, and fasten on to some trendy ... ism. Fulfilment, however, is something quite different from zealous enthusiasm, or from merely having one's way. In fulfilment, both the heart and mind are content, the break between heart and mind, between reason and emotions, is healed."

We produce successive cool generations, trapped in the head, detached from the body like Page Three of the Sun. We can become absorbed in the prettiness, sexiness, cleverness but scarcely ever in the wisdom. We can see ourselves as increasingly trapped by inexorable forces over which we have no control at all. The world is lost for us. How can we regain it?

Somehow we have to return inside ourselves. To stop living on the skin of ourselves. The journey inwards is truly a religious journey. It is to discover our personal strength and capacity for genuine love as well as for genuine suffering. That journey also opens up an awareness of our natural unity with all things. We lose our separateness and grow to become part of the world.

Our ideologies, tricks and techniques are essentially useless. The mess of beliefs conveyed through the media as in newspapers, TV and radio, can become prisons, internal acquisitions which clutter up our minds, giving us less and less room in which to move. The dilemma is nicely conveyed in 'The Guardian' cartoon about the Polytechnic. One of the central figures is the constipated George Webber, unable to achieve any kind of spontaneity because everything in life has become the manifestation of some philosophical principle. A one time college teaching colleague once put the dilemma even less tactfully when commenting on social work students: "They are the sort of people who couldn't even commit adultery except on principle."

Our practice changes situations, not necessarily beliefs. In a journey through the Peoples Republic of China in 1976, I heard everywhere the slogan 'Women hold up half the sky' (Mao Tze Tung) and constant talk about the new status of women, from men. The women I spoke to had noticed no real changes. They were still at the bottom of the pile socially and economically. Social psychology questions the relationships between beliefs and relevant action and behavior. Most of us find any close connection quite difficult. The revolution comes when sufficient people live as if it had already happened. Even Buddhism has no integral importance. Zen recognizes that in the statement: "If you should see the Buddha on the road - kill Him!" The real trick is to see the world ever more clearly. A confusing ambition! Our ideologies can prevent us from confronting the world with fewer and fewer delusions. The clutter of beliefs can prevent us from finding a truly helpful gateway to genuine love and caring.

Over the last twenty-five years, I have worked with so-called marginal people. With people who were homeless, alcoholic, drug addicted and, more recently, with those who were mentally handicapped and mentally ill. Most of these people carried the huge fantasies of the so-called ordinary citizens. They were seen as spoiled, imperfect, objects of dread, objects of menace, ugly and frightening. Most are shut away in mental hospitals miles away from our towns where most of us live.

Last year I was working hard to get Peter Wilson out of secure hospital. He had been behind bars for thirty-five years. A large, shy man who had broken into a beach hut in the West Country all those years ago and been put away. Eventually we gained his freedom. He came to stay with us. Before leaving the hospital a staff member spoke to me privately. "David, do you know what you're doing? This man is an animal. A beast." Well, he was not. His table manners and standards of hygiene were fine.

Such people take on part of our own ugliness, our own marginality. They carry a huge burden composed largely of *our* shadows, personal fears and lack of personal acceptance. That makes it difficult to see devalued people. They become hidden inside a vicious circle. Our relationships with them lack reciprocity. They are not equal because they are not fully human. Associated with the perceptions of ugliness is a thinly veiled hostility sometimes concealed by a mawkish sentimentality. The jollying along, "Come along now Fred", of the traditional old peoples' home especially. We are sentimental and head patting about the 'low grades' and the 'subnormals'. Local communities oppose group homes for former hospital patients because they will "lower our rateable values and rape our daughters" or more dishonestly: "this is not a good enough neighborhood for mentally handicapped people to live in". We deprive devalued people of power and integration. We deprive them of the dignity of giving. We prevent them from coming home.

Segregation arises from fundamental fears. We have failed to come to terms with our mad and handicapped side. Our forms of helping can become merely technological, stale and constipated because we defend ourselves so well from our natural state of personal chaos. We have to begin to integrate both the orderly and chaotic aspects of our nature. Only from that unity can we aid the healing process. We heal from our wounds as well as from other parts. Carl Jung (1978) puts these dilemmas very precisely: "In spite of our proud domination of nature, we are still her victims, for we have not even learned to control our own nature. Slowly but, it appears inevitably, we are courting disaster". How important it is to turn and face that Steppenwolf side of us which we most fear, otherwise we spend our whole lives pursued by the hounds of Hell.

Helping flows from the guts and bran of our daily living. It has nothing to do with a shallow niceness. Krishnamurti (1978) writes clearly: "I know many people, so-called monks, good social workers and so on, who have trained themselves not to be angry. But the real flame has gone, they never had it, they are kind, generous people, they will help you, give you their money, their coat, their shelter, but the real thing is nowhere there. I want to find out how to let this thing flower in us; once it flowers you can't destroy it".

In our professionalized helping, we can easily cut off that energy of which Krishnamurti writes. Our personal vitality can become castrated by niceness; love replaced by shallow courtesy. Niceness can also conceal a lust for power; helping people can be the ultimate power game - a greed of giving, a lust to be needed. It may mean more simply that we cannot take from others, that both our work and personal relationships are fundamentally unreciprocal. That may mean what the barriers between social workers and clients, doctor and patient are all about. A stockade to protect our vulnerability as professionals. A craving to give, help junkies - with a high incidence of suicide and attempted suicide. The price of playing hero or heroine is like the fate of Icarus to have the sun melt your wax wings. There are no real wings, all are waxen.

Who are we? Who are others in relationship to us? To what extent can we freely enter into relationships with those who come for help? What prevents us? Do we treat our own hurts and wounds at the expense of others? From where do we get our own nutrition? Genuine help arises out of its own nature. As the Tao Te Ching has it:

> "Highest good is like water. Because water excels in benefiting the myriad creatures without contending with them and settles where none would like to be, it comes close to the Way."

Real help is much more ordinary than our magical fantasies which pull us to explore a million new tricks and technologies rather than to explore our innate compassion and ability to listen. We would rather travel outwards than inwards. We will offer anything - gestalt therapy; neuro-linguistic programing; co-counselling; rebirthing; psycho-analysis; transactional analysis - any package silver foil wrapped (and nothing wrong with any of the packages) except the only real diamond we have, ourselves. If we do not give of ourselves, however effective the technique, we rob our patients. We steal from ourselves.

Rinzai (Schloegl, 1975), the great Zen teacher, put it all more concretely:

> "Followers of the Way, the Buddha-Dharma needs no skilled application. Just be your ordinary selves with nothing further to seek, relieving nature, wearing robes and eating. When tired I sleep. Fools laugh at me, the wise understand."

We have to return to the body, the neglected area of wisdom in twentieth century western society. Not through the pornography of aerobics or the puritanism of jogging but through re-discovering its subtle harmony, the quiet rhythms, the importance of breathing and the awareness of it. The Buddha, that great teacher, was concerned with the physical dimensions.

"In this fathomlong body is the world, the beginning of the world and the end of the world." Fundamental religious truths cannot be stated through concepts alone. They elude the cleverness and neatness of the mind. Zen Buddhism puts it: "Rather than understand, simply experience". There are three stages of understanding, each deeper than the one before:

> "Hearing with the ear, pondering in the heart, and practice with the body." (Yeshe, 1978)

Learning again to listen to the still small voices which come from deep within the body; learning to respect its wisdom, our wisdom.

In societies like ours, based squarely on exploitation, on using and manipulating people, genuine love has an inherently subversive quality. It is revolutionary. Our personal pilgrimage is inextricably bound up with the future of the whole community. Another Mao Tze Tung quotation goes: "Not only in China but inside every Chinaman, a revolution".

Here we are concerned with the power of love rather than the love of power. The Buddhist experience of Nirvana is about mental health, a practical and personal experience of integration, of coming together. The restoration of healthy conditions of life in the here and now rather than the there and then. When we package that delicate and valuable process into the freezer of the mental health supermarket, it can be called therapy. It has as much relationship to real life, real problems and joy and flowering as the cellophane wrapped pork chops in the supermarket freezer has to living animals. Cliff Cunningham reminds us that myxomatosis and expertosis have the same symptoms. On catching either disease, both rabbits and experts get swollen heads and become blind.

The true process of help is not found in books about therapy and psychology. These books emphasize the extreme cleverness of the therapist and the essential stupidity of the people they are trying to help. Lama Thubten Yeshe (1978) expresses the true process best:

> "If I want to help you, the best thing I can do is to try and aid you in developing your own wisdom. True help would be to introduce you to your own reality, to let you become more aware and knowledgeable of yourself."

Thomas Kuhn has pointed out that scientific theories usually do not stand or fall according to their 'truth content'. At present we believe in the makeability of the world. Our therapies are part of the whole process of manufacturing people instead of trying to see their original face, to see them as they are really. Geoff Shepherd (1980) writes very wisely: "The social skills model seems to fit our current prejudices about the nature of social interaction. It is rational, mechanistic and, above all, technological. Until we accept a new paradigm, and the idea that some social problems are not amenable to the 'technological fix', I expect that social skills training will continue to hold sway."

Man as artefact. To turn away from manufacturing people, to look at our pain as well as that of others. To become apprentices again, knowing less than we did before. To give up being heroes and return to mortality. To risk ourselves. That would be a real pilgrimage.

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# MEDICAL PROBLEMS OF WOMEN

# MEDICAL PROBLEMS OF WOMEN

## AN INTRODUCTION

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There is currently growing interest amongst both health care professionals and the general public in the contribution of psychology to the understanding and management of women's medical and surgical problems. In many ways, this interest is a reflection of the development of behavioral medicine and the increasing contribution that psychologists are making to all areas of medical research and practice. Some of the 'medical problems of women' that have received the attention of psychologists have exact parallels amongst medical problems of men and give rise to no specific difficulties as a result of the sex of the patient. General issues concerning, for example: compliance with treatment regimes, preparation for surgery, problems resulting from smoking, alcoholism and other addictions, as well as the problems of certain chronic diseases such as arthritis and diabetes, involve similar problems for both men and women. However, some of the difficulties for which women consult the medical profession are clearly not shared with male patients and pose problems quite specific to their sex. These include primarily those problems that arise from women's reproductive functions and which obviously include processes such as conception, contraception, childbirth, termination of pregnancy, menopausal changes, menstruation, carcinoma and surgical intervention of women's reproductive organs. There are also problems which, although not exclusively experienced by women, are nevertheless experienced much more frequently by women, such as cancer of the breast.

This Section is concerned with health problems that are experienced exclusively or much more frequently by women than men. That is not to say that men are not involved in the problems to be discussed. Certainly male partners may be very closely involved in the processes of pregnancy or childbirth. However, the problems to be considered are presented to the medical profession as a physical problem or illness, experienced by the woman. In introducing this Section, it seems important to question how appropriate it is to continue to consider some of the so-called 'medical' problems of women within the context of a medical model.

It could be argued that some 'medical' problems, i.e., problems presenting with physical symptoms which have received treatment from medical practitioners, are not really medical problems at all but rather normal physiological changes occurring as part of a woman's reproductive life cycle. For example, the menopause, and its associated physical and psychological changes could be construed as a normal part of female ageing, occurring as a result of natural physiological changes. In many cultural groups it is clearly viewed as such. In Western society in recent years, however, the so-called 'symptoms' of the menopause have come to be seen within illness terms and to require medical assessment and even treatment. Cooke's paper on 'Psychological and Physical Interactions in the Climacteric' concludes that the physical changes of the menopause have received considerably more attention by medical personnel and the general public than other processes, such as psychosocial changes, occurring at this time of life. It is possible that distress, experienced at this time and attributed to the concomitant physical changes, is in fact a response to psychosocial events. Cooke suggests that the psychological changes at this time have been largely ignored by those 'treating' menopausal problems and the assessment and management of women presenting with both physical and psychological difficulties at this time of their life is seen within physical medical terms. Indeed, this view has led some authors to view the menopause as a 'deficiency disease' (Giele, 1982). Cooke argues that this is an inadequate model to account for the observations of psychological and physical changes in the climacteric.

It is interesting that psychologists who have had, as a profession, considerable experience of criticizing the 'medical model' in the field of psychological problems should not have discussed these issues in relation to physical problems in any great length. Most critical writing of this nature has been left to feminist writers (e.g., Roberts, 1981) and psychologists turning their attentions to physical problems of women have, on the whole, not challenged the medical framework.

Arguments such as those used by Szasz (1972) in his criticism of the medical model of psychological problems could, however, equally well be applied to the medical approach to changes occurring at certain developmental stages, such as the menopause. Szasz argues that construing psychological distress within illness terms, rather than 'problems in living' obscures the real problem facing the individual at that time. His argument applied to the menopause would lead one to suggest that construing problems at that time of life as symptoms of hormonal changes may obscure the identification and amelioration of distressing psychosocial problems. The fact that 'treatment' for the problem takes the form of drugs (usually hormone replacement), may further act to deflect the patient's attention from psychological issues and confirm her beliefs that the cause of her difficulties is hormonal. It has been shown that drug treatments used in the management of psychological problems such as depression and anxiety can shift a patient's belief in the underlying cause of their difficulties towards a more 'medical' or 'illness' explanation than they held before the drug treatment (Whitman and Duffy, 1961). It seems quite likely that similar processes may occur as a result of drug treatment for other problems, particularly those like the menopause where the presenting problem is a complex interaction of physical and psychological changes. In view of the fact that beliefs about the underlying cause of a problem can influence not just clinical practice but also the nature of the research and the hypotheses to be tested, it seems important that psychologists keep an open mind about the applicability of the medical 'model' to the problems that they start to investigate, as they move towards conducting research and practising clinically in areas of general health problems.

The menopause is not the only topic discussed in this Section where the applicability of the medical model could be questioned. Problems associated with the menstrual cycle are generally attributed to the associated hormonal changes. Slade (in this volume) reviews psychological theories of premenstrual distress which provide credible alternatives to physiological explanations of the occurrence of symptoms in the premenstrual phase. Psychological theories of premenstrual problems are supported by the few studies which use prospective recordings of mood throughout the menstrual cycle and which fail to replicate the marked cyclicity of mood changes that are reported by studies using retrospective assessments of mood during the menstrual cycle. This research suggests that much of the reporting of physical and psychological symptoms in the premenstrual phase may not be a direct result of hormonal changes but result from complex psychological processes involving the expectation of symptoms and the labelling of physical changes as symptoms at that particular time of the month. It follows that women for whom no marked cyclicity of symptom reporting is demonstrated, are less likely to respond to pharmacological interventions. In her paper, Slade suggests how psychological interventions may be implemented for women who present with problems associated with the menstrual cycle. Unfortunately, psychological explanations and interventions have yet to have any marked impact on current views of the cause of premenstrual distress and problems associated with the menstrual cycle are still largely managed with physical interventions by the medical profession. Although it has been suggested in this introduction that it may be counter-productive to view some of women's 'medical' problems within an illness framework, it would be inappropriate to criticize medical contributions to women's health problems too heavily. Indeed, the advances that have been made in both obstetrics and gynaecology have produced increases in women's life expectancy, as well as improving the quality of their lives.

Termination of pregnancy represents an example of a medical procedure that has a vast impact on the quality of many women's lives. The fact that it is now relatively safe and easily available has, in conjunction with the major advances in methods of contraception, given women the right to control their lives in a way which previous generations of women were quite unable to do. The psychological correlates of the termination of pregnancy are, however, very poorly understood. Although it is widely appreciated that the decision to terminate a pregnancy is difficult to make and may result in distress for some considerable time afterwards, the nature of any psychological support required by patients undergoing termination is poorly understood. Clarke in her paper 'Is pregnancy counselling necessary?' reports that although the DHSS guidelines say that every woman seeking an abortion should have the opportunity to obtain counselling, in practice this is not always available to women who do not request it. It is only the private clinics that routinely offer counselling to all patients. It would also appear that, in many cases, the medical staff view counselling as an aid to the decision making process. Once a woman has made up her mind to have a termination, she is no longer seen as needing counselling opportunities. In view of the complicated psychological processes involved in the termination of pregnancy even if the decision has been clearly made by the patient, problems of grief and confusion are unlikely to be avoided. Problems may occur at a later date or may re-emerge during a later pregnancy. Counselling cannot therefore be evaluated in terms of its short term consequences such as ease of arriving at a decision. However technically safe and advanced the termination procedures are, the psychological hazards of terminating a pregnancy are poorly understood and clearly warrant further research.

The fourth paper in this Section is concerned with another area where medical and technical advances have been greatly beneficial to women's health management. Breast cancer, as Ashcroft et al., indicate, is a common and fatal illness. It is also an illness where the effects of the medical intervention can be devastating. Radical mastectomy is a disfiguring operation and the effects of such massive surgery on a woman's psychological status and post surgical recovery are largely undescribed. Ashcroft outlines an important study whose results will certainly aid surgeons in the choice of the surgical intervention that has the least disturbing psychological, as well as physical consequences.

The following Section covers four different areas, in which psychologists are applying their clinical and research skills to aid the understanding of women's health problems. It will be clear from the papers that psychologists are in a position to be able to offer both methodological as well as conceptual contributions to developments in these areas. It is to be hoped that close collaboration between medical and psychological research will lead to a more integrated approach to understanding women's health issues.

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# PSYCHOLOGICAL AND PHYSICAL INTERACTIONS DURING THE CLIMACTERIC

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## INTRODUCTION

Psychological distress experienced by women during mid-life has long been attributed to the menopause. As early as 1848 Morrison attributed various manifestations of psychological disturbance to the experience of the menopause. These manifestations included insanity, depression, intoxication, suicide attempts and the acquisition of a sense of religion. Morrison (1848) argued that these manifestations occurred not only because of the physical concomitants of the cessation of menses but also because of the psychosocial implications of the changes. Similar views are apparent in the current literature.

Before outlining the aims of this Chapter, it is necessary to distinguish between two related yet distinct phenomena that are often confused. These phenomena are the menopause and the climacteric. Neugarten and Kraines (1965) indicated that although the two terms have frequently been treated as synonymous, they refer to distinct physiological processes. The menopause is a discrete physiological event marked by the cessation of menses; this occurs on average at the age of fifty-one years (Neugarten and Kraines, 1965; Studd et al., 1977). The climacteric is a long term physiological process, caused by the involution of the ovaries, which results in a variety of physiological changes including the menopause. Studd et al. (1977) indicated that the climacteric may last twenty years, beginning ten years before the menopause and terminating some ten years after the menopause. While both phenomena will be considered, this Chapter will emphasize the general process of the climacteric rather than the more discrete event of the menopause. In general, the interaction of physical and psychosocial factors and their relation to psychological disturbance during the climacteric will be considered. Four specific issues will be focused upon. First, both the physical and the psychological symptoms associated with the climacteric will be described. Second, the associations among menopausal status, psychosocial features and psychological disturbance will be considered. Third, the hypothesis that the specific physical changes associated with the menopause produce psychological disturbance will be evaluated. Fourth, empirical evidence, derived from a recent community study, will be examined to highlight the influence of psychosocial variables on psychological well-being during the climacteric.

## PHYSICAL AND PSYCHOLOGICAL CHANGES DURING THE CLIMACTERIC

### Physical Changes

The physical changes associated with the menopause are most readily detectable in the urogenital tract (Studd et al., 1977). The vaginal wall may become thin, atrophic and dry (Beard, 1975; Rybo and Westerberg, 1971). Both the cervix and the uterus may shrink in size and general pelvic involution may result in urge incontinence (Lauritzen and Muller, 1977). Ostereoporosis, or the loss of calcium from the bone, follows from the decline in oestrogen levels. This increases the risk of spine and hip fractures (Shoemaker et al., 1977; Lindsay et al., 1978; Prill, 1978).

### Symptoms and Signs

Nathanson and Lorenz (1982) indicated that the number of symptoms associated with the climacteric is 'legion'. Unfortunately, not only have a legion of symptoms been attributed to the menopause, but also, there has been very little agreement about which symptoms can be regarded as being particularly characteristic of the climacteric (Bart and Grossman, 1976; Parlee, 1978; Flint, 1975; Ososfsky and Seidenberg, 1970; Tucker, 1977). Studd et al. (1977), in a review based on clinical studies, argued that there are four distinct groups of symptoms associated with the climacteric, namely, vasomotor symptoms, sexual symptoms, musculoskeletal symptoms and psychological symptoms.

Typical vasomotor symptoms are hot flushes, sweating, chills and moist and numb extremities. Sexual symptoms such as dyspaurenia may result as a consequence of atropic vaginitis or because of a lack of vaginal lubrication (Studd et al., 1977). Loss of libido is common, occurring in approximately a quarter of women (Moore et al., 1975). Typical musculoskeletal symptoms might include aches and pains in the neck, shoulders, elbows or hands due to reduced muscular strength. Symptoms within the psychological domain are extremely varied and include irritability, tension, depression and diminished drive and energy (Brown and Brown, 1976; Studd et al., 1977). Brown and Brown (1976) indicated that these psychological symptoms are not peculiar to the climacteric but could occur at other times of life.

Less detailed, but perhaps more representative, information about symptoms comes from epidemiological studies. Neugarten and Kraines (1965) and Prill (1976) argued that the characteristic symptoms of the climacteric were somatic in form; for example, hot flushes, weight gain, aches in the back of the neck, numbness and tingling. They failed, however, to provide evidence that the rate of psychosomatic or psychological symptoms increased in general population menopausal subjects. Jaszmann et al. (1969) argued that only the vasomotor symptoms demonstrated a close temporal relationship with the menopause, the association between the menopause and symptoms such as depression, sleeplessness and palpitations being less clear. Ballinger (1975), using the GHQ to detect psychiatric cases, demonstrated an increase in the rate of non-psychotic psychiatric cases during the climacteric but prior to the menopause. Greene and Cooke (1980) found a similar increase in psychological symptoms in the early half of the climacteric prior to the menopause. Weissman (1979) found that the highest rate of depressive symptomatology occurred in women prior to the climacteric and declined thereafter.

In summary, while the results from community studies are not consistent, they are suggestive of a rise in non-specific psychological disturbance during the early climacteric. The association of these symptoms with the menopause is far from clear.

## PSYCHOSOCIAL CHANGES DURING THE CLIMACTERIC

The climacteric is a period of life marked by profound physical changes. Equally, it is a period of profound psychosocial change (Dominian, 1977). Notman (1979) argued cogently that the psychological distress experienced during this period may be more closely linked to psychosocial changes than biological changes, than was previously thought.

Various psychosocial changes have been implicated in the aetiology of psychological distress. The 'empty nest' has been regarded as important. Neugarten (1979) indicated that the 'empty nest' refers to the period after the last child has left home but prior to widowhood. The term has also been used to denote the transition into this state. Neugarten (1968; 1974) failed to find evidence to support the view that the 'empty nest' period is typically a time of crisis. Indeed, Neugarten (1979) indicated that the crisis does not arise after children have left home but rather when children fail to leave home at an appropriate age. Lowenthal and Chiriboga (1972) argued that the departure of the last child generally was anticipated as being a relief rather than a crisis. The view that the 'empty nest', or the transition into the 'empty nest', produces psychological distress, while popular is not supported by substantial empirical evidence. Krystal and Chiriboga (1979), on reviewing the evidence, argued that " ... the so-called 'crisis' of the empty nest may be more myth than reality" (p. 215). Other psychosocial changes have been implicated. Common psychosocial changes at this period might include the loss of parents or the loss of a husband. The loss of parents may not only be due to death but also, in a symbolic form, due to the transition of parents into highly dependent roles. Lieberman (1978) empirically demonstrated that a major stress during the climacteric may be the transition of parents from a supporting role to a supported role. Neugarten (1979) suggested that another important transition may be from mother to grandmother. This transition may be two-edged; the grandchild representing a new source of gratification, yet also, a potent sign of ageing.

To conclude this Section on the characteristic features of the climacteric, it might be argued that two broad etiological hypotheses pertaining to psychological disturbance exist. The first, and perhaps the predominant hypothesis, the biological hypothesis, is that psychological disturbance is a consequence of the profound and far reaching physical changes of this period. The second broad hypothesis, the psychosocial hypothesis, is that psychological disturbance is a consequence of the psychosocial changes inherent in this period. The relative validity of these two broad hypotheses not only has theoretical implications, but also may have implications for the treatment of psychological disturbance experienced at this time. Giele (1982a) argued that the narrow 'deficiency disease' view of the menopause has resulted in the widespread use of oestrogen replacement therapy. The long term use of exogenous oestrogen is not uncommon. Stadel and Weiss (1975) indicated that within their sample the median duration of use was 10 years. Nathanson and Lorenz (1982) contended that the long term use of exogenous oestrogen could lead to significant risks of endometrial cancer. If the biological hypothesis is valid these risks may be necessary. Support for the psychosocial hypothesis, however, would tend to imply the need for psychological treatment (see Cooke, 1984).

A study was designed to make preliminary tests of the two opposing hypotheses. The methodological difficulties in the design of the study will now be described in order to illustrate some of the problems found in carrying out research in this area.

## METHODOLOGICAL REQUIREMENTS OF THE STUDY

In designing a study to compare the biological and the psychosocial explanations, not only is it necessary to find a reliable and valid measure of psychological disturbance, but also it is necessary to systematically define and measure the biological and psychosocial constructs of interest. The problems inherent in this task will now be examined.

### Measuring Psychological Symptoms

It was argued above that the symptoms associated with the climacteric are not only legion in number, but also heterogeneous in form. Symptoms that have been attributed to the climacteric range from hot flushes, sweating and dysparenia through muscular pain to depression, tension and irritability. Greene (1976) argued that most studies considered only a small and an ad hoc sub-set of the total set of potential climacteric symptoms. For example, the Blatt Menopausal Index (Blatt et al., 1953), perhaps the most commonly used instrument, suffers from the disadvantage that symptoms from a variety of symptom domains (i.e., vasomotor, somatic and psychological) are added together in an essentially arbitrary fashion.

It has been argued in detail elsewhere (Cooke, 1982a; 1984) that a prerequisite condition for research into the association between gynaecological phenomena and psychological disturbance is the availability of discrete homogeneous measures of psychological disturbance. Factor analytic procedures can be used to distill and aggregate psychological symptoms into distinct homogeneous syndromes of psychological disturbance (Eysenck, 1953; Garside and Roth, 1978). Greene (1976) carried out a factorial study of a small group of women at the climacteric. He subjected information about forty-five symptoms to Principal Factor Analysis. Three significant factors or syndromes of disturbance emerged. First, a 'psychological' factor specified by depressed mood, panic attacks, crying spells and worrying. Second, a 'somatic' factor, specified by faintness, dizzyness, headaches and tingling or numbness of the body. Third, a 'vasomotor' factor specified by hot flushes, sweating and cold hands and feet. The reliability of the factor scales based on the first two factors were found to be acceptable. Using factor analytic procedures, therefore, the legion and diverse symptoms of the climacteric can be distilled into discrete syndromes and measured accurately. In addition, the results of Green's study emphasize the absence of a unitary 'menopausal' syndrome.

### Defining Menopausal Status

Differences in the definitions of menopausal status may be another factor contributing to the lack of consensus in the literature. Menopausal status has often been defined by the presence or absence of vasomotor symptoms. This procedure is open to contamination. Age is ignored and thereby a young woman who has experienced an artificial menopause and older women who are distinctly post-menopausal are defined as menopausal. Of the methods available for defining menopausal status, that adopted by McKinlay and Jefferys (1974) is probably the most satisfactory. Only 'at risk' women (i.e., between 40 to 55 years) are considered and clear distinction is made between menopausal women and pre- and post-menopausal women. The criteria used are:

1. Pre-menopausal: menstruated within the last three months with no change in regularity or volume in the previous year;
2. Transitional: menstruated within the last three months but with some changes in regularity or volume in the previous year;
3. Menopause: last menstruated between three and twelve months ago;
4. Post-menopausal: last menstruated more than twelve months ago.

Using these criteria, menopausal status is defined in terms of the cessation of menses rather than in terms of the symptoms that are assumed to follow from it. The conceptually important distinction between menopausal and post-menopausal women is also established.

## Defining the Climacteric

Defining the climacteric is rather difficult because of the insidious nature of the pathological changes associated with it. One useful, but not entirely satisfactory, approach is to define the climacteric in terms of age. Studd et al. (1977) contended that the climacteric covers a period from the late thirties to the early fifties, beginning some ten years before the menopause and terminating some ten years afterwards. In the study to be considered below the climacteric was arbitrarily defined as occurring between the ages of thirty-five years and fifty-four years.

## Measuring Psychosocial Variables

Moving from the biological domain to the psychosocial domain, it is not only necessary to operationalize the concept of psychosocial transition, but also aspects of the psychosocial context within which these transitions occur. Many of the psychosocial transitions assumed to be important during the climacteric can be described as stressful life events. These include the departure of children from home, illnesses and deaths of parents, aunts and uncles and perhaps the loss of husband through death or separation.

Over the last decade procedures for systematically measuring stressful life events have been developed. The conceptual difficulties inherent in attributing causal significance to the association between stressful life events and symptoms have been tackled (e.g., Brown, 1974; Tennant et al., 1981a; Cooke, 1982a; 1984; 1986). These conceptual difficulties cannot be described here. However, it is perhaps important to note that reliable and valid information about the experience of stressful life events can only be obtained through the use of in-depth interviewing. It is particularly important that the interviewer attempts to distinguish those events that are a consequence of psychological symptoms from those that are the putative cause of symptoms. For example, an individual might develop symptoms such as irritability, poor concentration and withdrawness and as a consequence lose her job because of poor work performance. In such a case the stressful life event of 'job loss' would be 'dependent' on symptoms rather than a potential cause of symptoms. In the study to be described, a non-directive, semi-structured interviewing procedure was used to determine which 'independent' events had been experienced by the subject in the previous twelve months (see Cooke, 1980, for a full account of the life event interview). This procedure has proved to be reliable (Cooke, 1985). A list of sixty-three carefully defined events was used as the basis of the interview. Individual levels of life stress were estimated by adding the consensually derived normative weights of the degree of upset produced by particular events (Paykel et al., 1976). The same procedure can be applied to estimate the level of stress associated with particular sub-groups of events. The procedures for measuring life events assess discrete changes in the psychosocial domain. More permanent aspects of the psychosocial domain will now be considered.

## Measuring Social Support

In the social psychiatry literature it has been argued that social relationships may have either an effect directly on health or an indirect effect through the amelioration of the impact of stressful life events (Cobb, 1976; Henderson et al., 1980; Miller and Ingham, 1976; Brown and

Harris, 1978). The latter view was clearly enunciated by Cobb (1976), "... it appears that social support can protect people in crisis from a wide variety of pathological states: from low birth weight to death, from arthritis through tuberculosis to depression, alcoholism and the social breakdown syndrome" (p. 300). Cobb argued that social support has general importance for health. However, previous attempts to demonstrate its importance with regard to psychological disturbance during the climacteric have been limited.

Measuring social support is fraught with difficulties (Henderson et al., 1980) as it is often difficult to distinguish between short-lived symptom determined changes and long-standing deficits in support. Weissman (1975) and Weissman et al. (1981) reviewed some twenty-six scales that are available to measure an individual's social relationships and social adjustment. The Social Adjustment Scale, developed by Paykel et al. (1971), was used in this study. This scale is based on a semi-structured interview with detailed and specific anchor points. Information about relationships with friends, family, spouse and children was obtained. Both performance behavior and 'softer' interpersonal behavior were measured. Performance behavior included the number and extent of contacts with friends, while interpersonal behavior included the ability to confide and also the levels of dependency, submissiveness and domineering behavior towards members of the social group. These measures achieved adequate inter-rater reliability (Cooke, 1983).

Having briefly considered some of the methodological difficulties in this area and the procedures used in this study the results will now be considered.

## PREDICTORS OF PSYCHOLOGICAL DISTURBANCE DURING THE CLIMACTERIC: A SCOTTISH GENERAL POPULATION STUDY

A random sample of the general population living in Glasgow was drawn. Respondents were interviewed about their experience of stressful life events, the extent and quality of their social relationships, demographic and personality variables as well as a variety of psychological symptoms (Cooke, 1980a; 1980b; 1981; 1982a; 1985; Greene and Cooke, 1980; Cooke and Greene, 1982; Cooke and Allan, 1983; 1984). The procedures outlined above were used. Four hundred and eight respondents, of whom seventy-eight were women during the climacteric, were interviewed. It was possible, therefore, to assess the importance of both discrete life events, such as loss of spouse, parents and the departure of children from home as well as the psychosocial context in which these events took place.

Five specific issues were of interest:

1. Is there a relationship between psychological, somatic and vasomotor symptoms and menopausal status?
2. Are psychological and somatic symptoms elevated during the climacteric?
3. Do stressful life events produce psychological and somatic disturbance during the climacteric?
4. Does the quality of the social context affect the symptoms at the climacteric either directly or indirectly?
5. The effect that psychosocial factors have on stressful life events.

### 1. Symptoms and Menopausal Status

When menopausal and non-menopausal women are compared with regard to their level of both the psychological syndrome and the somatic syndrome,

Table 1. Comparison of Menopausal and Non-Menopausal Women on the Psychological, Somatic and Vasomotor Syndromes

| | Menopausal | | Non-menopausal | | | |
|---|---|---|---|---|---|---|
| Syndrome Prob. | Mean | S.D. | Mean | S.D. | t | |
| Psychological | 12.17 | 12.03 | 11.40 | 14.82 | 0.33 | 0.74 |
| Somatic | 5.28 | 6.17 | 4.68 | 8.09 | 0.22 | 0.82 |
| Vasomotor | 2.67 | 3.55 | 3.83 | 4.84 | 1.12 | 0.27 |

there is a non-significant trend for menopausal women to report higher levels.

A non-significant trend is also apparent with regard to the vasomotor syndrome; with, perhaps paradoxically, the non-menopausal women reporting more symptoms. Additional analysis indicates that the post-menopausal group is significantly higher than the other groups. This rather curious finding might be explained by the findings of Thompson et al. (1973) that oestrogen deficiency is at its greatest between one and three years after the cessation of menses. This evidence would suggest that the biological event of the menopause does not generally give rise to a substantial increase in psychological or somatic symptoms in this general population sample.

The hypothesis that the menopause per se produces psychological and somatic distress can be examined further by looking at levels of symptomatology across the climacteric period.

## 2. Symptoms during the Climacteric

The second issue of concern is whether there is an association between the climacteric and symptoms. To facilitate clear evaluation of this aspect it is essential that climacteric women are compared with non-climacteric women. Previous studies have failed to do this. Symptom levels across the four decades between 25 years and 65 years are tabulated in Table 2 to allow comparison.

Table 2. Climacteric Status and Level of Psychological and Somatic Syndromes

| | Climacteric status | | | |
|---|---|---|---|---|
| Syndrome | Pre- | Early | Late | Post- |
| Psychological Mean | 7.15 | 11.47 | 9.03 | 7.43 |
| S.D. | 4.67 | 10.51 | 7.08 | 9.49 |
| Somatic Mean | 2.33 | 4.56 | 3.57 | 2.05 |
| S.D. | 2.37 | 5.43 | 4.67 | 2.90 |

Examination of the mean values reveals that the severity of both the psychological and the somatic 'menopausal' syndromes rise around the late thirties, reach a peak in the early forties, decline slightly in the late forties and early fifties continuing to fall into the early sixties. The mean values of the pre-climacteric and the early climacteric groups are significantly different on both the psychological and somatic syndromes

($p < 0.05$). When early climacteric women are compared with post-climacteric women, the only significant difference is with regard to the somatic syndrome ($p < 0.02$). These results confirm that symptoms are elevated during the climacteric, in general, and during the early part in particular. The results have further significance, however, in regard to attributing causal significance to the menopause. These results indicate that the elevation in symptoms occurs sometime before the majority of women cease to menstruate.

To summarize the analysis so far, it would appear that psychological and somatic symptoms are elevated during the climacteric. However, this elevation cannot be attributed to the biological or psychosocial effects in the menopause per se. Several psychosocial explanations will now be considered.

## 3. Stressful Life Events and Syndromes during the Climacteric

Many of the psychosocial changes that are thought to characterize the climacteric (Dominian, 1977) can be operationalized in terms of stressful life events. The respondent's experience of stressful life events over the previous twelve months was evaluated and operationalized in terms of an index of total life stress (TLS) (see above).

The pattern of the TLS index throughout the climacteric period mimics the pattern of both the psychological and the somatic syndromes. That is, there is a non-significant tendency for the TLS index to increase during the early part of the climacteric period and decline in the post climacteric period. Further analysis was then carried out to determine: first, whether there is an association between the TLS index and each of the syndromes; and second, whether the TLS index was a relatively more effective predictor of the syndromes than menopausal status or age. Hierarchical Regression Analysis (Cohen and Cohen, 1975) was used with first order and all interaction effects being considered (Greene and Cooke, 1980).

The patterns of results for each syndrome are essentially similar. Twenty-six percent of the variance in the psychological syndrome and thirty percent of the variance in the somatic syndrome can be explained by age, TLS, menopausal status and their mutual interactions. In each case, the level of the TLS index accounts for a significant and substantial amount of the variance. The level of life stress experienced by women during this period is, therefore, an important predictor of these 'menopausal' syndromes. Neither age or menopausal status made a significant direct contribution to the prediction of the two syndromes. Age and the TLS index, however, interacted. In the early climacteric the association between TLS and the two syndromes is stronger than in the late climacteric. This interaction may be explained by two alternative but not mutually exclusive hypotheses. First, while there is no significant increase in the absolute level of life stress experienced during the climacteric, there may be qualitative differences; qualitative differences of particular significance to women at this age. Second, women at this period, while not experiencing more life stress, may be particularly susceptible or vulnerable to that which they do experience. These two hypotheses will now be examined.

## 4. Important Qualities of Events during the Climacteric

Within the literature on the climacteric are various speculations about the types of life events thought to be of particular significance. The departure of children from home and the death of parents and significant others have been regarded as being important. Life events that entail the departure of significant others from the social field of the respondent have been termed 'exit' events (Paykel et al., 1974; 1978).

Comparison of the level of 'exit' life stress across climacteric status reveals a significant difference between pre- and early climacteric respondents ($p < 0.005$). Life stress associated with other events (i.e., 'non-exit' events) did not differ significantly. Therefore, although women in the early climacteric period do not experience significantly greater levels of life stress, the quality or meaning of the life events that they do experience is different. Further correlational analysis (Cooke and Greene, 1982) revealed that 'exit' events are important predictors, however, only in respect to the somatic syndrome. They had no impact on the psychological syndrome. The 'exit' events were examined to determine whether speculations about the importance of the 'empty nest' or losses of significant others could be confirmed. A dramatic contrast emerged. Deaths were responsible for approximately sixty percent of all the 'exit' events in the climacteric period as compared with only five percent in the pre-climacteric period. Only one death of spouse was recorded in the climacteric group the other deaths being of members of the preceding generation. Two thirds of the deaths were described as being the death of a close friend or a <u>significant relative</u>. The effect of these 'death exits on the somatic syndrome, but not on the psychological syndrome, is perhaps curious. It could be speculated that the death of a significant other may increase the individual's sensitivity to somatic symptoms. During the climacteric, perhaps women are particularly sensitive because of the wide range of profound age related physical changes that they are experiencing.

In summary, the first hypothesis concerning the elevation of symptoms during the early part of the climacteric is partially confirmed. The qualitatively different events experienced by women at this period appear to have a particular effect on somatic distress.

## 5. Psychosocial Factors and the Response to Stressful Life Events

The total life stress index predicted the severity of the psychological syndrome during the climacteric. The rise in the psychological syndrome during the early part of the climacteric was not accompanied by an equivalent rise in life stress. Given the presence of an association between the two variables and the absence of a significant increase in TLS, it is parsimonious to assume that during the climacteric period women are particularly susceptible to the stress that they do experience.

Many authors (Lowenthal and Haven, 1968; Cobb, 1976; Brown and Harris, 1978; Miller and Ingham, 1976; Henderson et al., 1980) have argued that the social context can influence susceptibility to events. While the importance of the social context has been emphasized there has been little consensus about the manner in which it influences the impact of events. Three major hypotheses are apparent in the literature (Cooke, 1985). Under the vulnerability hypothesis, poor social support is thought to increase the level of symptoms in the presence of life stress but have no effect in its absence. Under the independent causes hypothesis, poor social support is thought to increase the level of symptoms irrespective of the level of life stress. Under the synergism hypothesis, poor social support and life stress have independent effects on symptoms, but, in addition, their concatenation produces a disproportionate increase in symptoms. The relative merits of these hypotheses and their implications for the understanding of the effect of stressful life events have been discussed fully elsewhere (Cooke, 1983). It should perhaps be noted in passing, however, that the vulnerability hypothesis has most intuitive appeal to the clinician because it implies that intervention to improve a person's social support network might help to 'immunise' them from ubiquitous and inevitable life events.

Brown and Harris (1978), describing a study of women between the ages of eighteen and sixty-five, argued that four factors make women vulnerable to life events. These four factors were: the lack of a close confiding relationship; loss of mother before the age of eleven; lack of employment outside the home; and the presence of three or more young children at home. These results serve as an appropriate starting point for the search for factors that make climacteric women susceptible to life events. Each of these individual factors and a summated vulnerability index will be considered in the following preliminary analysis. In addition, the level of involvement and the quality of communication with children, as measured by the procedures of Paykel et al. (1971) will also be considered.

The three hypotheses can be distinguished by using Hierarchical Regression Analysis (see Cooke, 1983 for technical details). When Hierarchical Regression Analysis was carried out with the TLS index as the index of life stress and each of the above additional variables, the following results emerged (Table 3). The simple relationship between the TLS index and the psychological syndrome explains 24 percent of the variance. The addition of specific variables to this simple relationship increases the variance explained by up to 22 percent. Therefore, nearly half of the variability in the psychological symptoms of these climacteric women can be explained by stressful life events and individual psychosocial factors.

Table 3. The Influence of Total Life Stress and Psychosocial Variables on the Psychological Syndrome

| Psychosocial variable | Hypothesis corroborated | Variance explained |
|---|---|---|
| Loss of Mother before 11 | Vulnerability | 35% |
| Employment Status | Vulnerability | 29% |
| Number of Children Under 15 Years at Home | No Effect | 24% |
| Degree of Confiding with Spouse | No Effect | 28% |
| Summated Vulnerability Index | Independent Causes | 30% |
| Number of Confidants Available | Synergy | 46% |
| Degree of Involvement with Children | Independent Causes | 31% |
| Quality of Communication with Children | No Effect | 29% |

Perhaps of greater interest than the magnitude of effect is the manner in which the additional variables affected the symptoms. Both the loss of mother before the age of eleven and employment status act as vulnerability factors. That is, they have an influence on the level of the psychological syndrome but only following the experience of stressful life events. The degree of involvement with children, that is, the extent to which the respondent is involved with their children's progress at school, their interests, friends, dates and their special problems, is directly associated with the psychological syndrome. Determining the direction of causal effect is always difficult with this type of variable. On the one hand, the association may merely reflect the concern of the over-anxious parent. On the other hand, it may reflect the view, expressed by Bart and Grossman (1978), that women who are heavily committed to child bearing are particularly susceptible to depression at this time.

Perhaps the most interesting finding refers to the number of confidants available. Forty-six percent of the variance in the psychological syndrome is explained by the TLS index and the number of confidants available. These two variables had a synergistic influence. That is, both life events and the number of confidants available independently affect the psychological symptoms experienced, but, in addition, if a respondent lacks confidants and is under stress then her level of psychological distress is disproportionately enhanced. One possible interpretation of this powerful effect is that confidants help to diffuse the impact of life events. Silver and Wortman (1981), in their important review on the reactions to life events, emphasized the importance of a setting that allows the ventilation of emotion. Confidants may provide this. There is a danger, however, in assuming this direction of causality without further evidence. Perhaps women who are susceptible to psychological symptoms are also unable to form close confiding relationships (Murphy, 1982).

Moving from the psychological syndrome to the somatic syndrome, the TLS index alone predicted 27 percent of the variance in the somatic syndrome. Particular additional variables increased the variance explained by up to 16 percent. Early loss of mother acts as a vulnerability factor and employment status has a synergistic effect. Once again the most important additional variable is the number of confidants available.

Table 4. The Influence of Total Life Stress and Psychosocial Variables on the Somatic Syndrome

| Psychosocial variable | Hypothesis corroborated | Variance explained |
|---|---|---|
| Loss of Mother Before 11 | Vulnerability | 41% |
| Employment Status | Synergy | 33% |
| Number of Children Under 15 years at home | No effect | 30% |
| Degree of confiding with spouse | No effect | 29% |
| Summated vulnerability index | Independent effect | 33% |
| Number of Confidants Available | Synergy | 43% |
| Degree of involvement with Children | No effect | 30% |
| Quality of Communication with Children | No effect | 29% |

Two general conclusions may be drawn from these findings about the influence that the psychosocial context has on climacteric women's responses to stressful life events. First, aspects of the psychosocial context, such as the number of confidants available and the vulnerability index have effects, in their own right, on the psychological and somatic symptoms experienced by women during the climacteric. These effects occur irrespective of whether the climacteric women are under stress or not. Second, there are specific aspects of the psychosocial context, such as early loss of mother and employment status, that influence the extent to which climacteric women respond to the impact of stressful life events. While climacteric women may not suffer from more stress than other women, aspects of the psychosocial context make them vulnerable to the events that they do experience.

## CONCLUSION

Both speculation and empirical evidence suggest that the climacteric period can be a period of both profound physical change and profound psychosocial change. The role of stressful life events in producing psychological and somatic distress during this period, together with the modifying influence of other psychosocial factors, stands to emphasize the need for a shift from the narrow 'deficiency disease' concept (Giele, 1982a). The 'menopause' has long been used as a catch-all explanation for psychological distress experienced by women over a significant proportion of the life span. While it cannot be denied that profound physical changes do occur, it is not sufficient to assume that they are an exclusive cause of psychological distress at this time. A broader perspective is required. This would imply that the therapeutic burden should be shifted. A partial shift from general practitioners and gynaecologists towards other professional groups such as social workers, psychiatrists and clinical psychologists might be required. This would entail a shift in therapeutic strategy from Hormone Replacement Therapy and/or tranquillisers towards 'psychological' treatments in the broadest sense.

From the point of view of the clinical psychologist, some of the psychosocially determined distress could be tackled using the extensive range of behavioral and cognitive techniques that have become common place over the last two decades (e.g., Beck et al., 1980). The evidence presented above about the importance of confidants suggests that techniques aimed at improving the quality of social support networks might be of particular relevance (Trower et al., 1977). 'Self-help' procedures with their low cost and high relative accessibility might be of value (Dow, 1982). However, given the empirical evidence presented above regarding the importance of stressful life events, perhaps the main thrust of any therapeutic endeavor should be directed towards ameliorating the effects of these events. This might entail the provision of a setting that allows the ventilation of feelings (Silver and Wortman, 1980), cognitive techniques that help the subject alter her perception of particular events (Blackburn et al., 1981) and structured guidance towards the generation of 'neutralizing' life events (Tennant et al., 1981b) which delimit the impact of a stressful life event. (See Cooke, 1984, for a full discussion of therapeutic strategies.)

The above suggestions involve intervention at the individual level. Giele (1982b) argued not only for the implementation of social policies aimed at producing equal education and employment opportunities, but also for community support and child care facilities for women with multiple roles. Kamerman (1979) argued for social policy aimed at encouraging the sharing of bread-winning and home-making responsibilities. Macrosocial changes of this nature, although difficult to implement, might reduce the level of psychological disturbance in some women. There is no empirical evidence that such changes would influence the total rate of disorder amongst climacteric women. Emancipation may represent an avenue for improved psychological health. However, an increase in one form of psychological disturbance, alcoholism, has been regarded as being the 'ransom of emancipation' (Shaw, 1980).

It must be concluded that while the climacteric period of life is characterized by profound physical changes, many of the psychological symptoms experienced at this time can be directly attributed to psychosocial factors. Our understanding of this period of life can only be enhanced by more detailed study of the interactions among physical and psychosocial factors.

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# MENSTRUAL CYCLE DISORDERS: PSYCHOLOGICAL THEORIES AND THE POTENTIAL ROLE OF THE CLINICAL PSYCHOLOGIST

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## INTRODUCTION

The effect of the menstrual cycle on mood and behavior has been the subject of extensive study. The nature and etiology of physiological and psychological cycle related changes have been widely debated. The assumption that biological explanations are adequate and that the medical model is appropriate for these cyclic disorders has been questioned. Psychologists have been involved in much of the research which has stimulated more flexible thinking and generated a move away from a strictly medical model. With these changes clinical psychologists have gradually become more involved in working with women complaining of cyclic symptoms.

It is timely to consider the psychological theories of causation which have been proposed, particularly those concerning emotional fluctuations. Implications of these theories for psychological therapy will be discussed. In addition the need for adequate assessment before intervention is considered, together with useful psychometric instruments for this. Possible therapeutic methods, particularly for women with cyclic emotional changes, are described and research using some of these methods is reported.

Clinical psychologists are likely to become involved with women reporting emotional or pain symptoms which they relate to their menstrual cycles through a variety of channels. Women referred because of general anxiety, depression or symptoms such as tension related headaches may report strong exacerbations in frequency or severity of symptoms premenstrually and/or menstrually. In general practice or through direct referrals from gynaecologists, patients reporting premenstrual tension or even dysmenorrhea may be encountered. Psychologists working with children and families may see mothers reporting fears of harming children through outbursts of anger or irritability which the women concerned relate to their menstrual cycles. Behavioral programs developed to modify parent/child interactions may founder and a mother may relate difficulties to changes in her level of calmness and control at different cycle phases. Clearly, clinical psychologists today may become involved in assessment and therapy with women complaining of cyclic changes related to their menstrual cycles in a considerable variety of ways.

It is important to define the type of symptoms which women commonly report. The term "premenstrual syndrome" is notably unhelpful as more than one hundred and twenty physical and psychological symptoms have at some time been encompassed by this phase. Inadequate and varied definitions of the symptoms constituting a "premenstrual syndrome" have significantly impeded progress in research. Perhaps the most widely reported emotional problems are irritability, anger, anxiety, or depression. Tiredness is also a common symptom and may be considered as coming within a psychological context. Pain symptoms such as abdominal cramps (particularly during menstruation), headache and backache may also be reported. In the absence of specific pathology and with the developments in psychological methods of pain control these would be considered to come within the realms of possible psychological intervention. Symptoms of water retention which include abdominal swelling and tender breasts are generally treated by the use of diuretics. It is likely that women complaining of predominantly psychological rather than physical symptoms would reach a psychology clinic.

## PHYSIOLOGICAL THEORIES OF ETIOLOGY

Numerous physiological theories have been proposed to account for cyclic changes. These have included claims for a deficiency of progesterone, excess oestrogen, disorders of the sodium balance, hypoglycaemia, vitamin deficiency, menstrual toxins, excess prolactin and many others. These are very adequately reviewed by Reid and Yen (1981) and will not be further considered here as this paper specifically seeks to focus on psychological aspects. It is notable that despite considerable technological advances, particularly in the field of hormonal measurement, theories remain to be substantiated. Claims for effectiveness of various compounds in ameliorating cyclic symptoms abound but these are rarely replicated in double blind trials when the most notable effect is generally the level of placebo response. In many cases interpretation of efficacy has been difficult because of inadequate assessment of an individual's symptoms before inclusion in a trial.

## PSYCHOLOGICAL THEORIES OF ETIOLOGY

In common with physiological hypotheses a variety of psychological factors have been proposed to account for the development of cyclic symptoms and these will be considered in more detail.

### Attitudes to Femininity

The process of menstruation is a physical sign of being female. It is unsurprising that earliest theories specifically considered this aspect and that it was hypothesized that rejection of femininity and consequent feelings of resentment might be significant factors in disorders of menstruation.

Early studies were mainly anecdotal and contained opinion rather than specific data. A range of symptoms including amenorrhoea, dysmenorrhoea and premenstrual tension were said to be associated with rejection of feminine roles (Menninger, 1939; Wittkower and Wilson, 1940; Fortin et al., 1958). In a similar vein, Shainess (1961, 1962) suggested that adequate preparation for menarche and maternal reaction to this event were critical factors in a girl's acceptance of, and attitude to, her own femininity. She suggested that menstrual symptomatology arose in subjects whose menarches were unsatisfactory experiences which led them to reject their own femininity.

Several later studies based on questionnaire findings have reported data further substantiating this hypothesis. Paulson (1961) found that complaining of high levels of premenstrual tension was associated with difficulties in fulfilling traditional female psychosexual and psychosocial roles. Berry and McGuire (1972) considered attitudes to female biological functioning and reported that low acceptance of this was associated particularly with pain both premenstrually and menstrually. Whilst the association with negative emotions during these phases was in the same direction they did not attain significance.

An alternative view has been supported by other workers. Douvan and Adelson (1966) reported a positive relationship between traditional female goals and interests and discomfort during menstruation. Gough (1975) noted significant correlations between scores on the femininity scale of the California Psychological Inventory and levels of premenstrual, menstrual and intermenstrual symptomatology. However, this scale is unusual as it does not include items concerning female social roles but questions which reliably discriminate between males and females. Some such as, "I prefer a bath to a shower," affirmative scored as female, seem somewhat idiosyncratic. In addition, the fact that the association was found with symptoms during all phases may indicate that a general, rather than cyclic, tendency to complain was in fact being monitored.

Paige (1973) in a study of different religious groupings found a significant relationship between traditional family and motherhood orientation and problems during menstruation amongst a sample of practising Catholic women. However, this factor was less influential amongst Jewish women and of no importance in a Protestant Group. The influence of different religious and cultural values will be further considered in a later section.

A series of more recent studies has failed to significantly clarify the issues. Slade and Jenner (1980) found that extreme attitudes to female social roles, either very traditional or very egalitarian, were associated with menstrual but not premenstrual complaining of physical and psychological symptoms. Woods and Launius (1979) noted a low but statistically significant correlation between masculine scores on the Bem Sex Role Inventory and premenstrual discomfort. Chernovetz et al. (1979), using the same scale, reported very different results. High femininity scores were significantly positively associated with a general measure of discomfort around the time of menstruation.

Finally, Watts et al. (1980) reported that a group of premenstrual tension sufferers did not differ from controls on attitudes to "feminine stereotypes", "childbearing or rearing" or "menarche and menses". However, there were highly significant differences on attitudes towards "the body and genitals" and "sex and masturbation" with the premenstrual tension group rating these more negatively.

In these studies acceptance of social and biological roles are often confused and one does not necessarily predict the other. Cause and effect are unclear as women with high levels of discomfort associated with their menstrual cycles are likely to view their biological functioning with less equanimity. It is difficult to draw any coherent thread from these studies. On balance the findings indicate that negative attitudes to female psychosexual functioning tend to be associated with complaints of premenstrual and menstrual distress. Studies considering psychosocial attitudes and monitoring levels of feminine-type interests are more evenly divided some indicating more 'feminine' women complain of cyclic suffering and others reporting the opposite.

It must be noted that the studies considered in this section report on women complaining of suffering cyclic symptoms. Results to be considered in a later section have demonstrated the unreliability of long-term retrospective reporting, particularly of emotional symptoms. Complaining of, does not necessarily imply suffering from cyclical changes.

## Sociocultural Theories

There are suggestions that a cultural stereotype concerning the negative effects of the menstrual cycle exists. Parlee (1974) reported that males asked to indicate what women experience during the menstrual cycle reported virtually identical patterns of symptoms and symptom changes to women. Clark and Ruble (1978) found that even premenarcheal girls and boys of the same age, as well as girls who have experienced menarche, believed many symptoms to be associated with the menstrual cycle. There are, therefore, grounds for believing that learning may influence the development of menstrual cycle symptoms.

Attempts have been made to assess the influence of cultural and religious values on attitudes toward the menstrual cycle. In general, menstruating women have been considered endowed by the supernatural, holding powers for good or evil. Claims for the effects of menstruating women and menstrual blood have ranged from the destruction of crops, the miscarrying of pregnant animals to the rusting of iron (Rackham's translation of Pliny, 1938). There are some reports of positive aspects. For example, Pliny wrote: "If a woman strips herself naked while she is menstruating and walks around a field of wheat the caterpillars, worms, and other vermin will fall off from the ears of corn." However, this remains a destructive phenomenon and positive claims tend to be greatly outweighed by negative aspects.

In many cultures women have been restricted in their activities during their menstrual flows. This might take the form of being excluded from preparation and cooking of food, participation in religious activities or the prohibition of sexual intercourse. Extreme examples have involved the relegation of women to special menstrual huts and therefore segregation from the rest of the community during menses (Stephens, 1961). Among Australian aboriginals, boys were at one time taught that if they ever set eyes on menstrual blood "their hair would turn grey and their vigor abate prematurely". Women were, therefore, expected to live apart during their menses. There are numerous other examples of prohibitive customs mainly with the aim of the protection of males from the evil influence of menstruating women.

Many religions promote the view that a woman is "unclean" during her menstrual phase. For example, the Hindu law giver Manu stated, "the wisdom, the energy, the strength, the sight and the vitality of a man who approaches a woman in her courses will utterly perish; whereas if he avoids her his wisdom, energy, strength, sight and vitality will all increase." Writings in a similar vein can be found in the authorative texts of many religions. The Persian law giver Zoraster proclaimed menstruation to be the work of the Devil. Mohammed stated in the Koran: "So keep apart from women in their menstruation and go not near till they are cleansed." Orthodox Jewish women were told to abstain from sexual intercourse during menstruation (Leach and Fried, 1950) and for seven days afterward they were compelled to enter the ritual "Mikvar" to be cleansed. The Christian religion is no exception. From Leviticus Chapter XV the following is taken: "If a woman has issue and her issue in her flesh be blood she shall be put apart seven days and whosoever toucheth her shall be unclean until the even." The history of cultural and religious attitudes to menstruation are in general agreement that a woman is to be shamed and rejected during this time. In Western societies the seclusion of menstruating women does not apply. Similarly the restrictions on activities such as cooking and food preparation are not relevant. However, the menstrual sexual taboo is still very much alive. Although there is not physical or medical reason why sexual intercourse should not take place at that time Paige (1973) reported over half her sample of women refrained from intercourse during menstruation.

There is, therefore, ample evidence of a general negative ethos surrounding menstruation. This is further substantiated by a study of euphemisms in use in place of the actual term of menstruation. Ernster (1975) reported one hundred and twenty eight words and phrases which were used, most of which had very negative connotations and included "the curse", "being unwell" and "to come sick". The prevalence of euphemistic terms can only maintain negative cultural attitudes and enhance the expectation of distress the terms imply. The viewpoint that women regard menstruation in a very negative light is queried by Brooks et al. (1977) who reported that their sample of college students accepted menstruation in a very "matter of a fact" manner whilst still reporting physical and psychological cyclic symptoms.

The hypothesis that some cyclic symptoms may be acquired through social learning and society's expectations has its supporters. One problem is that the negative evaluations appear specifically restricted to the phase of menstruation and the explanation for premenstrual symptoms would require the postulation of premonitary distress to signals of the impending arrival of an unpleasant event. Sociocultural values have developed grounds for the expectation of distress associated with the menstrual cycle. It is possible that other factors may then begin to operate.

There is evidence that attribution of an episode of irritability to the approach or onset of menstruation is viewed with greater tolerance and as less blame-worthy than other alternative reasons (Ruble et al., 1982). Males, rather more than females, viewed menstrual related distress as external to the individual and hence more outside their control or responsibility. Whilst in one respect it would seem a positive factor that women should receive such supportiveness there is also the possibility that premenstrual and menstrual distress behavior may receive differential reinforcement. This may contribute to the development of a syndrome as there are considerable opportunities for the development of secondary gain. The view of premenstrual dysphoria as hormonally induced implies a total relinquishment of responsibility for behavior and hence a freedom to express anger, resentment or other emotions without recrimination. It should be noted that the research quoted referred to American college males and that such findings concerning their attitudes may not apply to other groups of men.

## Personality Variables

Many researchers have considered the role of personality factors and their association with menstrual cycle disorders. It is recognized that the nature of personality and the usefulness of the concept of 'traits' is polemical within clinical psychology. Nevertheless, in a consideration of psychological studies of the menstrual cycle and their therapeutic implications this body of work could not be omitted. Once again it is important to recognize that results mainly refer to women complaining of menstrual cycle related symptoms and that such a group may not constitute an accurate assessment of those actually experiencing these changes. Studies have mainly focused on measures of adjustment such as neuroticism, anxiety and psychiatric status. Various measures of general adjustment have been used. Neuroticism, from the Eysenck inventories which have been most commonly utilized, is defined as "the general emotional lability of the personality, the emotional over-responsiveness and the liability to breakdown under stress" (Eysenck, 1959). Other authors have used a plethora of criteria, including psychiatric classification as suffering from a neurotic disorder, retrospective assessments of case notes for psychoneuroses and even retrospective measures of adjustment in childhood.

Sainsbury (1960) observed significantly raised neuroticism scores on the Maudsley Personality Inventory (MPI) among patients attending hospital for dysmenorrhoea. However, the results referred to a highly selected sample as the typical sufferer does not attend a hospital clinic for this problem. Hirt et al. (1967) reported a significant correlation between dysmenorrhoea and anxiety as measured by the Cattell 16 Personality Factor Questionnaire (16PF). In this study, a measure of neuroticism failed to show a significant association with symptomatology. Coppen and Kessel (1963), in a large scale survey, reported an association between neuroticism and premenstrual symptoms but not dysmenorrhoea. This was confirmed by McCormick (1975) who also found that anxiety from the Taylor Manifest Anxiety Scale (TMAS) showed a significant relationship with complaints of premenstrual, but not menstrual, symptoms. Halbreich and Kas (1977) reported an association between premenstrual tension and trait anxiety from the TMAS.

Some authors have considered the relationship between menstrual cycle distress and psychiatric disturbance. Rees (1953) reported that there was a significantly higher incidence of premenstrual tension in psychiatric and psychosomatic patients than in normal women. However, within a normal group there was no association between levels of premenstrual tension and incidence of personality instability or neuroses. Glare (1977) studied a group of women attending their general practitioners (but not specifically for menstrual cycle difficulties). The General Health Questionnaire (GHQ) which is utilized for screening general populations for psychological disturbance was used. There were approximately equal numbers of women complaining of premenstrual symptoms who were psychologically healthy as were psychologically disturbed. However, few women who complained of psychological difficulties reported themselves free of premenstrual symptoms. The indications appear to be that women suffering from psychological disturbances (of a neurotic rather than psychotic nature) have a high tendency to complain of cyclic symptoms. However, there may be another group whose general adjustment is quite adequate.

Other studies of wider ranging personality factors have failed to show any consistent profile specifically related to cyclic suffering other than to reiterate, on various different measures, the importance of proneness to worry and general emotional lability. Slade (1978) includes a detailed consideration of studies considering general personality questionnaires and utilizing such scales as the Minnesota Multiphasic Personality Inventory and the Cattel 16 Personality Factor Questionnaire.

## General Life Stresses

Another possibility is that complaining of cyclic changes might represent a reaction to life stresses. Wood et al. (1979) reported that premenstrual sufferers tended to be separated, divorced or dissatisfied with their work. In addition, women with emotional or sexual problems were more likely to suffer. A study of the influence of life events (Siegel et al., 1979) also supports the view that complaints of cyclic symptoms are more likely to occur during a phase of life characterized by other difficulties.

## IMPLICATIONS FOR THERAPY

Whilst the research tends to have been inconclusive it does suggest possible areas for consideration when a patient's prevailing complaint involves cyclic symptoms. Attitudes towards being female, in biological and social spheres should be explored. The importance of social learning may also require consideration. It is of interest whether a woman's mother or older sisters or other significant females in her life appear to have experienced similar distress, and whether a basic assumption about the general negativity of menstruation was a feature of adolescent development.

Present social environment may also be an important factor. Attitude of the husband or other significant adults requires evaluation. The possibility of secondary gain in the form of sympathy or attention must be considered as negative reinforcement may be operating in terms of relinquishment of household responsibility or possibly through avoidance of sexual relations. Careful assessment of possible maintaining factors and general attitude and reactions to minor illness is necessary. It is sometimes the case that complaints of menstrual cycle distress can be indicators of marital or sexual difficulties and the symptoms may even be utilized wittingly or unwittingly as weapons in an ongoing battle. There are also indications that women complaining of cyclic symptoms are likely to be undergoing stressful phases of their lives. It is, therefore, of value to consider general areas of difficulty and it is possible that resolution of other stresses may lead to a reduction in symptomatology.

### Assessment

Before any sort of therapy is undertaken adequate assessment of symptomatology is vital. It has been shown that retrospective reporting of symptoms about different phases is grossly unreliable (McCance et al., 1937; Aplenalp et al., 1979). High percentages of women report suffering from both psychological and physiological symptoms, particularly premenstrually, when data is collected retrospectively and at a single assessment for all phases. However, daily data collected concurrently with the cycle phases shows a different pattern. Whilst changes in levels of physical symptoms such as pain or water retention are still apparent there is often a failure to demonstrate significant emotional changes. As psychologists are particularly likely to be referred patients with complaints of emotional change careful initial assessment is paramount. Several reviews (Slade, 1983a; Slade, 1981; Gannon, 1981) consider these issues in further detail. Thus, many patients referred complaining of emotional symptoms related to the menstrual cycle will, on full assessment, not demonstrate such changes. Many difficulties may masquerade under the guise of a premenstrual syndrome. This particular label, to most people, immediately implies hormonal disturbance and hence a condition beyond the individual's control. It is psychologically less threatening to utilize such an explanation for distress than to accept alternatives which do not negate the individual's own role and responsibility.

Explanations for the apparent discrepancy between belief about suffering and actual experiences are required. The factors of expectation, social reinforcement of distress behavior and attributional patterns together appear to provide one logical rationale. Expectation of distress associated with menstruation is certainly common. Rubel (1979), for example, reported that women who were led to believe that their menses were due in one or two days reported a higher degree of distress, particularly physical symptoms, than did those who believed they were intermenstrual. The two groups were, in fact, experiencing identical phases. Therefore, there is evidence for expectation of distress and as already stated, the possibility of social reinforcement of distress behavior. Then patterns of attribution may further serve to foster a belief in cyclic suffering. Koeske and Koeske (1975) reported that negative states were more likely than positive states to be attributed to biological causes. Whilst negative emotions occurring premenstrually may be mentally attributed to the menstrual cycle, positive emotions occurring during this phase would be more likely to be attributed to environmental circumstances and hence not construed as evidence for the absence of a premenstrual syndrome. Therefore, if women in general suffer considerable variations in emotions regardless of phase, differential labelling of causation at different cycle phases may influence beliefs in suffering from cyclic symptoms. Adequate assessment is therefore vital and must be undertaken before any other intervention.

## Assessment Methodology

It is suggested that daily data, particularly pertaining to the symptoms complained of, is recorded over a minimum duration of eight weeks. Mood scales such as the Profile of Mood States (POMS) (McNaire et al., 1971) and the Mood Adjectives Checklist (MACL) (Nowlis, 1966) may be appropriate. A more concise, though probably less sensitive measure, is provided by the "negative affect factor" consisting of eight items from the Moos Menstrual Distress Questionnaire (Moos, 1977). Other factors from this scale could be utilized for assessment of physical symptoms if required.

It is important that clear explanation for this period of assessment is given. It is usually sufficient to explain that in order to be of most help to a patient it is necessary that a clear picture of the changes being experienced and their timing in relation to her cycle is obtained. It is vital that daily reports should be recorded on separate sheets without reference to the previous day's data, in order to maximise the independence of self observations. Patients should be instructed not to refer back to previous sheets until the full completion of monitoring. In addition, the practice by which symptoms and bleeding days are recorded on a single card is to be discouraged. In this circumstance again assessment is being made each day with direct reference to cycle day. Days of bleeding should be recorded separately and the individual specifically cautioned to consider carefully how she has felt that day rather than where she has reached in her cycle. In a recent study Slade (1983b) found that, of six women referred to a premenstrual clinic because of cyclic emotional changes, only two showed these changes when daily data using the Profile of Mood States was recorded. The other four women showed considerable emotional fluctuations throughout their cycles but levels in the premenstruum did not differ significantly from other phases.

If it appears that emotional fluctuations do not occur cyclically then it is appropriate to reconsider the nature of the patient's problems and progress according to an ordinary therapeutic intervention depending on the nature and levels of distress detailed in the recordings. In many circumstances the women concerned, on being presented with their own data and the obvious lack of cyclic change, will begin to verbalise other topics of distress.

If emotional changes do appear to occur cyclically then therapy would, ideally, focus on modifying or secondly on coping more adequately with these states. A vital initial step, without which progress would not be made, would involve reorientation away from the viewpoint that such emotional changes are unalterable except by hormonal intervention. Psychological intervention would then, ideally, involve the exploration of issues already detailed as a result of the review of the psychological research. More specific methodology which might be of value would include the development of anxiety management or relaxation techniques for anxiety and the use of cognitive strategies in combating depression. Techniques such as stress inoculation, anger control and problem solving may be useful for modifying levels of irritability and temper outbursts. Differential reinforcement for coping behavior by significant others, together with reduction or reinforcement for illness behavior, would be a necessary prerequisite for successful change. Also, structured, self or spouse controlled reinforcement programs for successful coping could often be of value.

In addition to these measures, capitalizing on the limited temporal nature of symptoms could be achieved by preplanning, where possible, non-stressful days during the critical period. These would ideally require the inclusion of specific pleasurable activities. In addition, it is recommended that critical days should be neither over - nor under-active. The former can lead to increased irritability or tension and the latter to lengthy periods of negative thinking and hence feelings of depression and lethargy.

Acceptance of the problems and the development of a warm supportive atmosphere during assessment interviews also seem to be of great value in overcoming these difficulties and probably account for the high placebo response to drug therapy. Group work is an approach with obvious benefits of social support. However, a cautionary note is appropriate. Many such groups have been established and complaining of symptoms has been the only prerequisite for acceptance. This can be exceedingly damaging since, as already stated, this represents inadequate evidence that the symptoms are in reality cyclic. Acceptance into a menstrual cycle distress group or treatment at such a clinic serves to confirm and reinforce this label. When this is inappropriate it will tend to obscure the real problem and generate resistance to more appropriate intervention at a later date. Adequate assessment before any form of therapy is essential.

## Efficacy of Psychological Therapies

It is unfortunate that there are few studies of efficacy of psychological therapies with menstrual cycle disorders. There have been conflicting suggestions about the usefulness of psychotherapy (Rees, 1953b; Fortin et al., 1958) with premenstrual emotional symptoms. However, these early reports show a lack of initial assessment data or information about methodology and evaluation.

The groups of workers who have published research concerning efficacy of psychological intervention more recently have utilized the concepts of spasmodic and congestive dysmenorrhoea which are themselves polemic. The latter refers particularly to menstrual symptoms and the former to those in the premenstruum. The two categories are hypothesized to be mutually exclusive. However, there is also disagreement about the validity of this dichotomy. This work has specifically been directed towards pain control. Chesney and Tasto (1975), Cox and Meyer (1978) and Tasto and Hesney (1974) have used a simple adaptation of desensitization in which subjects were first taught progressive relaxation and then given practice in maintaining their state of relaxation while imagining scenes concerning menstruation. Theoretically, through a reduction in anxiety, pain and discomfort should be reduced. There were indications that such methods were beneficial particularly with menstrual pain. There was disagreement about efficacy with premenstrual symptoms.

More recently Quillen and Denny (1982) reported the use of an adaptation of anxiety management training, again in an attempt to control menstrual cycle related pain. After training in relaxation this technique involved deliberately simulating the feelings of discomfort and relaxing these away with the help of visual imagery. These workers reported positive effects for subjects in the spheres of both premenstrual and menstrual pain and also that these effects seemed to influence levels of autonomic symptoms and behavioral change.

## CONCLUSIONS

It is clear that the area of menstrual cycle difficulties, particularly emotional changes, is one in which the clinical psychologist has potential for useful therapeutic involvement. There is, however, an overwhelming need for well controlled studies of the effects of structured psychological therapies with menstrual cycle problems. It is vital that rigorous criteria for cyclic suffering based on sequential daily data are fulfilled before subjects are accepted into an experimental sample. Failure to adhere to this will sadly only serve to increase the confusion which abounds in this area.

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# IS PREGNANCY COUNSELLING NECESSARY?

## THE VIEWS OF CAMDEN WOMEN

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## INTRODUCTION

For some time many writers and practitioners have been expressing the view that counselling prospective abortion patients is less essential than it was during the early years of the 1967 Abortion Act, given that a more mature attitude to birth control now prevails (Simma, 1977; Allen, 1981). They feel that abortion clients are simply unlucky or careless and may need no more than a little support through a stressful experience. Even a DHSS circular, published in 1977, states: "Counselling should not be unnecessarily prolonged where the doctors involved and the woman herself are in no doubt that an abortion should be performed" (DHSS, 1977).

More recently, others have pointed to the danger that counselling can be seen as an obligatory ritual, where women have to justify their decisions to professionals (Figa-Talamanca, 1981; Allen, 1981). However, one glance at the literature on pregnancy counselling shows there are widely differing definitions and interpretations of the exact nature and aims of abortion counselling. The fact that these have never been clearly defined to everybody's satisfaction and that there are no legal requirements or clear DHSS guidelines for the counselling of abortion clients - its purpose, what it should consist of, who should give it or what it might hope to achieve - has led to very wide variation in the quality and quantity of pre-abortion counselling. It can vary from brief questioning by doctors to intensive (and perhaps repeated) discussion with professional or lay counsellors, but very rarely clinical psychologists. In general these differences are particularly marked between the National Health Service and the private abortion services, a discrepancy which may be related to the strict DHSS inspections of the private sector.

### DHSS Guidelines

The Lane Report in 1974 first expressed the view that every woman seeking an abortion should have the opportunity to obtain counselling before the abortion decision was taken. This was seen as: "providing the opportunitites for discussion, information, explanation and advice".

Following acceptance by the government of the Lane Committee's recommendations on counselling, the DHSS issued a circular to appropriate bodies (DHSS, 1977). This stated that: "all women who feel in need of independent advice during pregnancy should have the opportunity to receive counselling" which should "aim to ensure that the pregnant woman has a full opportunity to make a reasoned assessment of her own wishes and circumstances, to obtain any advice she may need in reaching her own decision and to secure that aftercare facilities, including social work help which she may need, can be made available". Perhaps one of the most important statements in the whole document is: "that counselling should be both non-judgemental and non-directional. It is in no sense a way of putting pressure on the woman either for or against abortion".

Objectives of Counselling

1. Many doctors still regard the main objective of counselling as being "to ascertain whether or not the situation conforms to the requirements for legal abortion" (Hawkins and Elder, 1979). However, several others have been considered important and I shall mention these briefly in order to illustrate the scope. (They have been documented elsewhere, Doggett, 1981.) These should be considered bearing in mind that a "counselling session" for prospective abortion patients is usually very brief, maybe 10 to 20 minutes.

2. During counselling a woman should be given the opportunity to clarify her feelings about her pregnancy and its possible termination and to accept her own responsibility for her eventual decision. This has been shown to be related to a successful psychological outcome to termination of pregnancy (Ashton, 1980; Figa-Talmanca, 1981).

3. Counselling should aim to provide psychological support and reassurance which have been shown to attenuate emotional trauma, i.e., anxiety, stress, regret and even pain (Bracken, 1977; Hawkins and Elder, 1979; Broome, 1979; Ashton, 1980).

4. Whatever decision is made, counselling should provide continuing practical help and information. This might involve explanations of abortion techniques, the risk of operation, hospital or clinical procedures and the importance of medical follow-up (Simms, 1977).

5. The DHSS has advised that counselling should always include discussion of contraceptive techniques and available services (DHSS, 1977). While there is some evidence that counselling can encourage effective future use of contraception (Kay and Thompson, 1977; Hunton and Spicer, 1979), this is not always the case (Ashton, 1980; Jones). Also the timing of such instruction, i.e., before or after the operation, is debatable (Figa-Talamanca, 1981).

6. Counselling should aim to detect any risk factors for adverse psychological reaction to abortion, e.g., pressure from significant others to terminate, previous psychopathology, the very young, ambivalence about the decision and terminations for medical rather than social reasons (Broome, 1979; Ashton, 1980). At the same time, the woman's privacy should be respected (Figa-Talamanca, 1981).

7. Deciding on an abortion may be an occasion for a woman to reconsider her relationships and future goals. Thus, counselling may include providing an opportunity for positive growth experience (Simma, 1977; Figa-Talmanca, 1981).

In order to fulfil these objectives many private and public health services have preferred to utilize the skills of individual counsellors and doctors rather than lay down strict rules concerning counselling sessions. This creates even wider variation in the nature, content and type of counselling, further confounding the vague definitions and interpretations. Perhaps nowhere are expectations of counselling more at variance than between the abortion clients on the one hand and professional workers (whether medical or non-medical) on the other. These discrepancies can manifest themselves in the emphasis given to counselling. As this is a professional audience, I think it will prove illuminating to examine the experiences and opinions of the recipients of various health care services concerning their decision to have an abortion and of the counselling they received. The results I shall describe are from a study undertaken in London at the end of 1981.

## THE CAMDEN ABORTION STUDY

### Background

The study was designed to investigate and identify the factors that led Camden women to seek abortions in the commercial or charitable clinics or in the NHS. The aim was to interview all women resident in Camden who had had terminations between September 1st and November 30th 1981. The only studies to have previously attempted to interview women having private abortions have concentrated mainly on the charitable agencies (the Pregnancy Advisory Service and the British Pregnancy Advisory Service) rather than the commerical private clinics. Numerous difficulties are involved in identifying and interviewing women who have had abortions. These arise from the controversial and sensitive nature of the subject under investigation and are complicated further when considering the private services. However, in spite of these difficulties, we did manage to identify 289 women and interview 180, as Table 1 shows.

Table 1. Response Rate and Numbers of Camden Women Presenting for Abortions Between 1.9.81 and 30.11.81

| Women Approached | | | Women Not Approached | | | |
|---|---|---|---|---|---|---|
| Inter-viewed | Refusals | Missed* | Disquali-fied** | Not Approached *** | Census Total | OPCS Figures Ø |
| 180 | 8 | 43 | 2 | 56 | 289 | 319 |

*Agencies failed to report women to us at the time of operation.
**2 in Camden only for the operation i.e. not resident.
***Patients of 2 non-cooperating consultants.
ØUnpublished data for the period 1.9.81 - 30.11.81.

Half (51%) of these women had abortions in NHS hospitals and half (49%) in private clinics (29% commercial and 20% charitable). It is possible that we missed a handful of women who were referred privately to private facilities shown by the OPCS figures in Table 2. The women were interviewed using a structured questionnaire, usually before they left the hospital or clinic (82%). This lasted for about an hour and, where possible, was conducted in private.

Table 2. Response Rate and Place of Abortion

| Place of Abortion | Women Interviewed | | Women Not Interviewed | | Census Total | | OPCS Figures* | |
|---|---|---|---|---|---|---|---|---|
| | | % | | % | | % | | % |
| NHS Hospital | 91 | 51 | 64 | 59 | 155 | 54 | 154 | 48 |
| Commercial Clinic | 53 | 29 | 14 | 13 | 67 | 23 | 165 | 52 |
| Charitable CLinic | 36 | 20 | 31 | 28 | 67 | 23 | | |
| Total | 180 | 100 | 109 | 100 | 289 | 100 | 319 | 100 |

*OPCS unpublished data for the period 1.9.81 - 30.11.81.

Before examining the women's opinions about counselling it is important to describe with whom the women discussed their feelings about the pregnancy and when they made the decision to have an abortion.

## Discussions about the Pregnancy

Most of the women (88%) had talked to someone about the possibility of being pregnant at an early stage before the pregnancy was confirmed. From Table 3 it can be seen that few women went immediately to talk to a doctor or other professional person before they had discussed the (possible) pregnancy with someone else. The table shows that partners and friends are the people the women most often turned to for early discussion.

Table 3. First Person With Whom (Possible) Pregnancy Discussed

| First person woman talked to | % |
|---|---|
| Husband | 11 |
| Boyfriend/putative father | 40 |
| Girlfriend(s) | 20 |
| Doctor | 13 |
| Mother | 3 |
| Other female relative | 3 |
| Counsellor | 2 |
| Other person (e.g. pregnancy testing staff, work colleagues) | 8 |
| Number (=100%) | 180 |

In fact, most of the women did discuss the pregnancy and the possibility of an abortion at some stage with their partner, friends and relatives, which suggests that these people played an important part in the women's decision-making processes. It may be that the women merely found it helpful to express their feelings and any doubts to their partners or friends in order to make up their own minds rather than asking for any constructive advice. Isobel Allen (1981) has expressed the opinion that both of these roles can be important.

Partners and friends together were also considered to be the most helpful out of all the people that the women talked to when discussing the pregnancy, as Table 4 shows. What is also interesting is that nearly half (44%) of the women attending charitable clinics said that a counsellor was the most helpful person they had talked to at any stage. Women attending charitable clinics routinely saw a counsellor as did most (66%) of those attending commercial clinics but women attending NHS hospitals rarely (16%) saw someone acting in that capacity, such as a medical social worker. In fact, one third of the NHS and commercial patients and just under one half of the charitable clinic patients who saw a counsellor named the counsellor as the most helpful person they had talked to. GPs were rarely mentioned as the most helpful person and one in eight women said that they had found no-one helpful.

Table 4. Most Helpful Person by Place of Abortion

| | Women having abortions in:- | | | |
|---|---|---|---|---|
| Most helpful person talked to | NHS hospitals % | Commercial clinics % | Charitable clinics % | All women % |
| No-one | 16 | 11 | 3 | 12 |
| Counsellor | 6 | 23 | 44 | 19 |
| Husband/boyfriend | 16 | 17 | 22 | 18 |
| Girlfriend | 16 | 15 | 6 | 14 |
| NHS hospital doctor | 18 | 0 | 0 | 9 |
| Non-NHS doctor | 0 | 7 | 5 | 3 |
| GP | 7 | 7 | 3 | 6 |
| Mother | 7 | 2 | 3 | 4 |
| Other/cannot distinguish | 14 | 17 | 14 | 15 |
| Number (=100%) | 88 | 53 | 36 | 177* |

*3 missing observations.

## The Abortion Decision

Thus, while a woman's partner, her friends and relatives were important in discussing the pregnancy and abortion decision, at the end of the day most women (75%) felt that the abortion decision was their own. Although, as demonstrated in Table 5, there is some room for believing, like Allen (1981, p. 53), that the attitude of the husband or boyfriend is, for some women, an important factor in the decision about whether or not to have an abortion.

Table 5. The Abortion Decision

| Who made abortion decision:- | All women % |
|---|---|
| Own decision | 75 |
| Joint decision | 11 |
| Husband/boyfriend greatest influence | 11 |
| Someone else greatest influence | 3 |
| Number (=100%) | 180 |

Three out of four women had made up their mind about wanting an abortion before they saw a doctor, which for many of them was before the pregnancy had been confirmed. This means that by the time women consulted their GP, a pregnancy advisory bureau or some other doctor, and after they had had their pregnancy confirmed, most women already knew what they wanted to do, having thought about it and discussed it with their partner and/or with friends or relatives. Thus due consideration must be given to Allen's views that any counselling which does not take this into account will be regarded as intrusive and creating unnecessary obstacles. As she put it: "There can be no doubt that interviews and consultations with doctors were frequently seen as hurdles to be overcome in the race to get an abortion. There was evidence that many women had a functional view of their interviews with doctors ..." (Allen, 1981, p. 50).

However, half (52%) of the women did say that they had considered continuing with the pregnancy at some stage but for most this was only right at the beginning of the pregnancy when they were still discussing the options open to them, as shown in Table 6. Of the women who said they had considered continuing with the pregnancy, only 17% said they had not discussed this with anyone. Most of the women had discussed this with their partner or with friends and relatives or both. Very few of the women had discussed this with a doctor or counsellor and these included the women who did not continue the pregnancy for health reasons.

Table 6. Whether Women Considered Continuing with Pregnancy

| Stage at which women considered continuing | Women % | |
|---|---|---|
| Never | 48 | |
| At beginning | 24 | 52 |
| From time to time | 6 | |
| Up until hospital admission | 2 | |
| Right up to last minute | 10 | |
| Other | 10 | |
| Number (=100%) | 178* | |

*2 missing observations.

It is difficult to say why women did not discuss their doubts with a professional person. It may well have been because they felt that expressing doubt might prejudice their chances of getting an abortion. However, there is evidence that the majority of women had made up their mind before they consulted a professional person. Women becoming unwantedly pregnant and those who end up seeking abortions are not a homogeneous group, and to try to simplify their motives and reasons for action would be an injustice as well as totally misleading. The same reasoning applies to how easy or difficult women find the decision to seek a termination. Different women facing similar material and emotional circumstances may approach the decision with different attitudes, moral beliefs and desires. To underline the difference, just under half of the women (43%) said that they had found the decision 'very easy to make', whereas a quarter (24%) said that they had found the decision 'not very easy' and a third (33%) said that they had found it 'difficult'.

## Counselling

So did the women feel they had had enough opportunity to obtain advice or counselling before they had their operation?

The majority of women (89%) said that they felt they had received adequate counselling, but a few (4%) were uncertain about this and thirteen women (7%) felt they had not been given the opportunity to discuss their decision or received enough counselling or advice. All, except one, were women who had NHS or commercial clinic operations (8 NHS and 4 commercial clinic patients).

This may well be because, as I mentioned earlier, the women attending charitable bureaux routinely saw a lay counsellor and named them as the most helpful person to whom they had spoken. Hence, some women who only saw a doctor felt they had not been given the opportunity to discuss their decision. As one woman, who saw only NHS doctors, put it: "There wasn't any - no professional counselling. The doctor takes down your details, asks you questions but doesn't discuss your decision with you. He should have seen I was upset".

Others specifically mentioned that they would have liked more factual information and advice as well as counselling: "He only explained briefly about the operation. I wasn't shown a diagram or pictures which I think would have made it easier to understand. Also I would have liked to talk to a social worker about things. For example if I had decided to continue, could I have got a free flat, etc.".

One woman perhaps summed up the feelings of many of the women and identified the most important role for counselling. She said she was not sure if she would have liked more discussion or advice because: "I can't help being influenced by what my boyfriend wants because he's so involved anyway. It's difficult because you get to the stage where you're going round in circles. I've been lucky because I was connected to the ... (agency) and the nurses here have been great. It's care more than anything you need - makes you feel better about doing it and gives you support in your decision. I think maybe it would have helped to talk to someone who could be objective".

It must be remembered though that only some women approaching a professional (whether a doctor or counsellor) will need further counselling about their decision. The fact that the majority of the women felt they had received adequate counselling does not tell us very much. It is not clear whether this was because they had received professional counselling or not since we could not monitor the actions of doctors nor measure the quality or quantity of any counselling given to women. However, there are indications that the women who routinely saw a lay counsellor found this helpful and it is also likely that some women did receive counselling from doctors and/or others and as such were satisfied with this.

Only two women complained about the counselling they had received:

"I had enough because I had made the decision but if it was my daughter - aged 16 - I don't think the counselling was enough. It's too easy for them to get an abortion without any backing and counselling. They need to consider the implication of all these things".

"The spirit in which I was offered a social worker was as if I was a 17 year old child. I really felt that the social worker might have the same attitude so I didn't see her".

There is, then, evidence that half of the women had never had any doubts about wanting an abortion and over three-quarters had made up their minds before they had any contact with professionals. Most of these women had made up their own minds, usually after talking to their partners or friends, and counselling was seen as unnecessary, for example:

"I didn't ask for much because my mind was made up but I know they would have given it if I'd wanted it";

"I think I did my own counselling";

"Too many people discussing it would have confused the issue".

## Discussion

The main problem, then, becomes how to distinguish the minority of women who do need to talk through their decision, doubts or worries with a doctor or counsellor. It might be argued that only 17% of the women in this study needed professional counselling about their decision. These were the 10% of women who had considered continuing with the pregnancy right up until the last minute, a further 2% who considered continuing with the pregnancy until they were admitted to hospital, those who wanted to continue but decided not to do so for health reasons (2%) and 3% who considered continuing 'at some other stage' (see Table 6).

While there is complete agreement throughout the literature that any woman who expressly requests it should be given the opportunity for unhurried discussion of any problems related to her pregnancy or any other areas of concern, divided opinions arise in respect of those women who do not put forward their need for counselling. The concept of counselling as a 'screening' process by means of which patients who need further help can be identified still finds favor in the counselling literature but as Doggett (1981) concluded: "In the absence of such research, perhaps the only conclusion which can be reached is that patients who do need further help will identify themselves in the course of discussions with trained and sensitive staff".

There is also the problem, already mentioned, that women might be reluctant to admit any ambivalence to a professional in case it prejudices their chance of being referred for an abortion. Cheetham (1977) recognized these problems and made some important suggestions in relation to counselling. She pointed out that a busy outpatient clinic or GP surgery is not the most congenial place to discuss an abortion decision. One of the suggestions made by Cheetham was that doctors should agree to arrange a hospital appointment for the woman before they attempt to review the woman's feelings with her. This would help allay the woman's fears of not being referred and help to remove the judgemental relationship between the doctor and her.

This also points to the relevance of lay counsellors, medical social workers, health visitors and clinical psychologists in the counselling of women about the abortion decision. Previous studies indicate that the concept of removing counselling from the process of applying for an abortion is valuable (Doggett, 1981). This may often be impossible within the National Health Service, but when women have been given the opportunity for discussion with non-medical personnel they have generally welcomed it and the Camden study findings would endorse this (Allen, 1981; Clarke et al., 1983; Hare and Heywood, 1981; Marshall, 1981).

One difficulty to be emphasized here is the distinction between counselling and advice. It is clear that some women did not perceive differences between the two, and many more women said they would have welcomed more advice and factual information than wanted further counselling. There is definitely evidence that some women felt that they were not told enough about the abortion itself and other factual matters. Table 7 shows the kinds of additional information the women requested - including details about the operation itself; the implications for future health; advice about contraception and more information about hospital or clinic procedures.

Table 7. Additional Information Required by Women

| More information about:- | Women requesting this % |
|---|---|
| Operation or anaesthetic | 17 |
| Physical feelings or pain | 13 |
| Future health | 21 |
| Other<br>e.g. clinic procedure, contraception, emotional feelings | 25 |
| Number (=100%) | 176* |

The problem in separating counselling and information is that while doctors and professionals may be the best people to give factual information this does not necessarily mean that they are the best people to discuss the woman's decision with her. It is likely that some women were 'counselled' by a doctor but did not recognize it as such because of their view of the formal nature of their encounter with a doctor. Thus the skill of the counsellor, whoever this may be, must be the ability to strike a balance between the practical and informational elements of counselling on the one hand and the emotional and supportive elements on the other, or to detect which need predominates at any one time and not to undertake in-depth counselling if not required. As Doggett (1981) put it: "Only then can counselling avoid the charge that it exists more for the benefit of the professional than the patient".

It is important to remember that from the woman's point of view 'counselling' takes place formally and informally at all stages of the process of making a decision and obtaining an abortion. As such, all personnel with whom the woman comes into contact must be aware of their role and the importance of giving accurate up-to-date information and the need to avoid confusing and conflicting advice.

## CONCLUDING REMARKS

To return to the question posed in the title of this paper, while the findings described above emphasize the fact that most women have made up their minds about requesting an abortion and usually have been 'counselled' and given emotional support by partners and friends before they approach a doctor or other professional and as such do not need further counselling about their decision, there may still be a need for providing more factual information in counselling sessions. Also there is the problem of identifying the minority of women who do need intensive counselling about their abortion decision and perhaps referring to other professionals for help, e.g., clinical psychologists or medical social workers.

There is a regrettable dearth of British studies on the long-term psychological sequelae of induced abortion and pregnancy counselling which has precluded putting counselling on a rational basis. Hence doctors and women cannot be fully aware of the extent of any psychological risks (Hawkins and Elder, 1979). Although papers from North America abound and others offering general advice do appear, the number of studies is limited and controlled studies are rare (Marshall, 1981). This is understandable given that a satisfactory method of evaluating counselling services is not easy to find. Numerous methodological difficulties are involved including the fact that results may show only over a long period and may be difficult, if not impossible, to quantify; taking account of the quality of counselling is very difficult; different measures of outcome, e.g., repeat abortion requests, contraceptive use, adverse psychological reactions, make comparisons between studies difficult; insubstantial or faulty study design may tend to mean that lack of effectiveness predominates; and the fact that failure to recognize that women who seek abortion are not a homogeneous group can lead to erroneous generalizations about counselling and other aspects of abortion services.

However, with regard to the short term, the recommendations regarding the counselling and information needs of women that were made as a result of the Camden study might prove useful guidelines for services in other areas (Clarke et al., 1983):

1. There should be a rationalization of counselling for women requesting abortion.

2. Counselling should be removed as far as possible from the process of applying for an abortion. It is suggested that GPs should be aware that a minority of women may need emotional support and time to discuss their feelings.

3. What is important is that any one offering counselling should be trained and that training in counselling should be an integral part of the medical curriculum.

4. All personnel with whom the woman comes into contact must be aware of the importance of giving full, accurate information and the need to avoid confusing or conflicting advice.

5. Doctors should give women clear and full information about the risks of abortion, the operation, the process of referral and future health and personal requirements.

6. It is important to raise levels of awareness about birth control by publicity. Also it is important that there is a general awareness of the pregnancy risks which occur at times of relationship change.

7. Information about preventive services and family planning clinics should be well publicised in residential hostels, doctors' surgeries and other places where groups at risk of unwanted pregnancy live and work.

8. A systematic approach towards contraceptive advice should be adopted, with a sifting of abortion patients to see what advice is needed and at what stage.

9. Detailed discussion of contraception and the woman's need for it must precede prescription in order to be effective. There is now some evidence that contraceptive advice may be more effective when offered after the abortion procedure and it is recommended that this should be

investigated. Also it may be relevant only to give the women detailed advice on where they can obtain help, including postcoital contraception, if they do not need to use contraception immediately. This could be a contact address, telephone number or an appointment to assess birth control needs two or three weeks after the operation.

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# PSYCHOLOGICAL ASPECTS OF BREAST CANCER TREATMENT

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## BREAST CANCER: THE NATURE OF THE PROBLEM

Breast cancer has been described as a "major health problem" (Kalache and Vessey, 1982); it is the cause of death for 12,000 women each year in England and Wales. In Britain it is estimated that one woman in 17 will contract the disease; in the United States the figure is even higher, one in 14. Breast cancer is the major cause of death in women aged between 35 and 54 years. It is not surprising therefore that this century has seen numerous studies conducted in an attempt to find both cause and cure for the disease. Despite this endeavor the last 30 years have seen not a decrease but an increase in deaths from breast cancer in most countries (Office of Population Censuses and Surveys, 1977).

The very nature of the disease has been a much debated problem (Baum, 1982), and along with different hypotheses concerning its nature have gone different methods of treatment. For many years it was the vogue to regard breast cancer as starting as a discrete malignancy which spread in continuity from its origin. It was assumed that cancerous cells within the breast would spread along lymphatic channels until they reached the first group of regional lymph nodes where they would be temporarily arrested. Then, in most cases, they would pass on to more distant lymph nodes and then ultimately to the skeleton and vital organs. Given this hypothesis it makes good sense to treat the disease by a classical radical mastectomy. This operation, credited to Halsted (1878), involves total removal of the breast and clearance of the axillary nodes. The Halsted mastectomy has been, and still is, extremely popular and has resulted in increased survival rate (at least when compared to no treatment at all).

However, as Baum (1982) indicates, this basic hypothesis ignores a great deal of evidence that cancer does not necessarily have to pass in an orderly progression along lymphatic channels but can gain direct access to the blood via venous invasion. Also, there is no reason to suppose that the lymph nodes are effective filters, but rather the disease may involve cells metastasizing early in regional nodes without these nodes having any blocking ability (MacDonald, 1951; Baum and Coyle, 1977; Fisher and Gebhardt, 1978). Given this, it is perhaps surprising that removal of the breast and axillary lymph nodes has any effect at all on survival rates. If breast cancer is regarded as a systemic rather than localized disease it follows that the cancer may disseminate from the moment of its initial appearance to anywhere in the body. Removal of the breast can never therefore 'cure' the problem. However, it may perhaps be argued that removal of the major area of the cancer to some extent frees the immune system to control any remaining malignancy elsewhere. The question then arises, how much of the breast is it necessary to remove? Will removal of the lump itself be sufficient and at least as beneficial as a full mastectomy?

The problem of choosing the most suitable operation is not solely dependent on one's conception of the mode of dissemination of the disease, for breast cancer does not have homogeneous characteristics (Veronesi and Costa, 1982). The patient may present with a carcinoma which is contained within a duct or lobe of the breast tissue, apparently a non-infiltrating, non-invasive disease with no detectable lymph node involvement; alternatively, the cancer may be a locally advanced invasive type, with axillary node involvement and may even spread to the breast skin and nipple. Whereas mastectomy might be the treatment of choice with the invasive cancer, it might perhaps represent over-treatment for the former example (Fisher, 1982). Of course, there may be a range of stages of the disease between these two examples and the treatment of choice for these are, perhaps, even more open to contention. So it would appear that the study of the disease is fraught with difficulties. First, it is heterogeneous in nature; the cancer cells themselves may vary, with different types carrying a different prognosis. Also, the malignancy may arise at different sites within the breast and be detectably disseminated throughout the breast area and the rest of the body to varying degrees. There are problems in accuracy both in diagnosing the type of cell present (Gravelle, 1982) and also in accurate staging of the progress of the disease.

Partly because of these difficulties treatment for breast cancer has not met with a large degree of success. Perhaps it is not surprising that patients who present with <u>advanced</u> disease have a poor chance of survival. Moreover, Brinkley and Haybittle (1975), in assessing patients that had presented with <u>early</u> breast cancer and had been given a mastectomy, found that up to 25 years after the operation, over 70 percent of the women had died of their disease. Given such statistics as these it is hardly surprising that there are many trials currently being conducted to find the most beneficial treatment for breast cancer. As yet, it is not possible to specify the <u>optimum</u> extent of surgery and/or radiotherapy for a given stage of the cancer. And, of course, there are yet alternative treatments (e.g., chemotherapy; endocrine therapy) which are being investigated and which are often used with more advanced cancer (Farber, 1971; Holland, 1973).

This present state of affairs is, understandably, not conducive to the psychological well-being of a woman who contracts breast cancer. Not only does she have to cope with the trauma of treatment, her fears about radiotherapy or possible mutilating effects of surgery, she does not even have the benefit of being assured of a cure for her disease or even the reassurance that "the best that can be done" is being done. It is not surprising therefore that psychologists and others concerned primarily with psychological health have had an increasing role to play in helping the breast cancer victim.

## THE IMPACT OF BREAST CANCER ON THE PSYCHOLOGICAL WELL-BEING OF THE PERSON

Until the last 15 years there were very few investigations of the impact of breast cancer on the patient's psychological health. However, it would appear that some common difficulties and patterns of emotional and social response are emerging. Predictably, depression is the most prevalent response (Goldsmith and Alday, 1971) and this is often accompanied by anxiety (Schoenberg and Carr, 1970; Lee and Maguire, 1975) or sometimes by anger (Robbins, 1973). Such emotional distress is extremely persistent and is often in evidence one or two years after diagnosis of the cancer (Morris, Greer and White, 1977).

Where a mastectomy has been performed there have often been other changes. As well as practical difficulties such as adapting clothes to fit, being able to do domestic tasks (Bard and Dyk, 1956) and feeling well enough to return to work (Morris et al., 1977), there are a wealth of other, more psychosocial, problems. For example, there may be difficulties with adapting to a different body image (Buls, Jones, Bennett and Chan, 1976); a fear of loss of femininity or physical attractiveness (Ray, 1977); marital or sexual difficulties (Anstice, 1970; Jamison, Wellisch and Pasnau, 1978; Maguire, 1978); lowered self-esteem (Polivy, 1977); and inability to cope socially or to indulge in general life activities (Burdick, 1975). It might be expected that some of these problems are experienced to a greater extent by patients undergoing radical rather than conservative breast surgery. However, it might be supposed that even removal of the lump may result in some similar problems to full mastectomy. For example, it is possible that a woman might perceive herself as less feminine simply as a result of knowing one major sexual characteristic is diseased. Psychological trauma across various forms of treatment is, as yet, not fully understood.

Of course, despite mode of treatment, all patients are presented with the fact of serious disease and may therefore all potentially experience fear of cancer and death. It is possible that different treatments may affect such fears differentially, independently of their immediate effectiveness in ridding the patient of the cancerous breast lump. Again, the role of various treatments in alleviating such fears is not fully known. In reviews of the literature (Meyerowitz, 1980; Morris, 1979) the studies cited are most often concerned with one mode of treatment, usually mastectomy, and a control patient group is either absent or, more often, consists of either patients with benign breast lumps (Morris et al., 1977) or patients with different diseases such as cholecystectomy patients (Ray, 1978), or alternatively people with no particular pathology such as population and neighborhood matched controls (Craig, Comstock and Geiser, 1974). Therefore, although there are trials conducted comparing the success (in terms of rate of local recurrence of the cancer and overall survival rate) of various forms of treatment (Halnan, 1979; Hayward, 1977), concomitant psychological studies are rare. Although they do exist (Sanger and Reznikoff, 1981) they are often conducted on relatively small numbers of patients, and either psychological tests are limited or follow-up data are not collected for a prolonged period.

As well as studies concerned with psychological change brought about by breast cancer, there have been, in recent years, investigations into related areas concerned with the psychosocial life of the person. For example, there has been concern to find reasons why women delay seeking help when they find a breast lump (Cameron and Hinton, 1968; Greer, 1974; Worden and Weisman, 1975); another area of research involves elucidating the various coping styles which women use when they experience cancer (Ray, Lindop and Gibson, 1982).

Despite the recent growth of research into the psychological impact of breast cancer, it was felt that there was a need for structured comparison of psychological changes which occur as a function of two popular modes of treatment, mastectomy and lumpectomy. This, therefore, is the project currently being conducted here in Liverpool.

## THE LIVERPOOL PROJECT

This project, sponsored by the Cancer Research Campaign, was designed to test two major hypotheses. These were:

1. The psychological disability experienced by patients treated for breast cancer is due to the destruction of self image as a result of mastectomy rather than fear of the disease process;
2. A mode of treatment which preserves the breast will result in a lower psychological morbidity.

It was therefore planned to use tests and interviews to:

A. Compare the psychopathology of a group of patients with breast cancer undergoing mastectomy with that of a similar group undergoing conservative surgery with radiotherapy;
B. Elucidate what element of the known response to mastectomy is due to loss of self image engendered by mutilating surgery and what is due to fear of the diagnosis of cancer;
C. Develop predictive criteria from pre-treatment characteristics which would allow selection of the treatment mode least likely to cause major psychological disability in a given patient and to identify those patients most at risk of major problems. Special attention could then be given to these patients.

Unless one mode of treatment shows a clear clinical advantage in terms of disease free interval and survival, the selection of treatment could be based on which method produces the most favorable psychological response. This would differ among patients depending, probably, on their attitude to the disease and their attitude to their breasts.

The project started in October 1982. All patients presenting with breast problems to our weekly clinic at the Royal Liverpool Hospital and Broadgreen Hospital are asked to participate in the study. They are seen, therefore, before diagnosis is made. Those with early breast cancer may be given either radical mastectomy or conservative surgery (lumpectomy plus radiotherapy to the axillary nodes of the affected breast).

The literature indicates areas of major interest for psychological investigation. Tests used therefore include measures of body satisfaction (both a general test and a more particular test designed by us to find particular attitudes towards the breast); anxiety and depression measures (the State-Trait Anxiety Inventory, Spielberger, Gorsuch and Lushene, 1970; the Leeds Scales, Snaith, Bridge and Hamilton, 1977); tests of Social Avoidance and Distress and Fear of Negative Evaluation (Watson and Friend, 1969); evaluation of marital satisfaction (Locke and Wallace, 1959); measures of self-esteem with the PERI Scales (Dohrenwend, Shrout, Egri and Mendelsohn, 1980). Finally, it has been suggested (Brown and Harris, 1978) that the occurrence of major life events prior to disease may be related to psychological adaption to the illness, so the frequency of life events is also investigated (Holmes and Rahe, 1967). This battery of tests is given to the participants in the project when they first arrive at the clinic and are repeated at three-month and one year follow-up investigations after the operation.

Patients are also interviewed the day before their operation and post-operatively, when they are sufficiently recovered and wanting to talk (usually two to three days after the operation). On these two occasions they are also given tests of anxiety and depression, but the main aim is to let the patient talk. Usually women seem extremely happy to have someone to whom they can voice their fears and hopes; it is an opportunity to have an in-depth conversation about the impact of the disease on the patient and her life. Experience has shown that each patient normally has one particular area that she wishes to explore first, and she is given the freedom to do this. As well as expressing her thoughts and feelings the patient often requests information; for example, about the technicalities of the operation and wherever possible, full answers are given. Generally three main areas are discussed. These are:

1. The fact of the presence of the disease itself, that the patient has cancer;
2. Effects of the operation on physical appearance (this, predictably, tends to be more of an issue with mastectomy patients; the scarring produced by lumpectomy and changes brought about by radiotherapy are usually less of a concern with patients seen so far);
3. Fears about treatment, the operation itself and being in hospital (and, where radiotherapy is to follow, worries about this).

There are, of course, other (often related) areas of concern, such as loss of femininity; lowered self-esteem; reaction of friends; effects on ability to socialize, or to do housework, or to return to work; effects on quality of sex life and more general marital or family interactions; worries about recurrence of a lump or spread of the cancer. Generally it has been found that these areas can be subsumed under the three main areas outlined. So, for instance, loss of femininity or quality of sex life might be dealt with whilst talking over worries about change in physical appearance as a result of the operation. Occasionally certain concerns, such as reaction of friends, or lowered self-esteem, might be subsumed under more than one area; for example, under the umbrella of worry about cancer and worry about appearance. The patient, herself, largely determines the exact course of the interview. Direction may be given where appropriate, but as some women will not, indeed refuse, to discuss certain topics it is thought tactless, inappropriate, and in all probability futile, to try to force them. However, it has been found so far that simply providing a 'listening ear' is quite enough of a stimulus to prompt talking about a whole gamut of problems.

Most information gathered from interview is acquired prior to the operation. At the end of this first full interview the patient can usually state which of the three main areas of worry (fear of cancer; fear of adverse change in physical appearance; fear of the treatment) is of most concern. In fact, the patient can usually rank-order the three main areas in terms of which is causing them the most concern. Some women find it useful to 'objectify' their thoughts this way, and can give a number (between 1 and 10, where 1 is 'no concern at all', and 10 is 'as concerned as possible') to each area.

After the operation the patients, understandably, want to talk mostly about their experience of the day of the operation and their feelings on recovering from it. These topics are therefore explored.

The patient is sent the full battery of questionnaires three months after the operation. She is also invited to come to see the psychologist if she wishes, either to discuss her general progress or to seek help for specific problems (for example, she may well have feelings of depression; she may be experiencing marital difficulties, etc.). An additional questionnaire is sent at this time dealing with how the patient is coping, in a specific way. For example, it might be relevant to know whether she has returned to work; whether domestic tasks seem harder than before; has her sexual relationship altered; does she worry about her physical appearance; does the thought of a recurrence ever trouble her; if radiotherapy was given, how did she find the treatment? Similar types of questions are asked, along with the standard battery of tests, at the one year follow-up.

A considerable quantity of information is therefore being gathered about the psychological and social state of the patient. Hopefully a pattern should emerge which will show how patients, with various psychological predispositions and psychosocial characteristics, adapt and cope with treatment for early stage breast cancer.

Originally it was proposed that those patients who presented with early breast cancer would enter the trial and be randomly assigned to two experimental groups, the radical mastectomy group or the lumpectomy plus radiotherapy group. It was hoped that, ultimately, there would be 100 patients in each group. In the past it has been found that letting the patient choose her own treatment has led to some confusion on the part of the woman involved. It was thought, therefore, that patients would be happy to enter the present trial and let the choice be made for them. However, we felt ethically obliged to give the patient three possibilities, namely: (1) to have a radical mastectomy; (2) to have a lumpectomy plus radiotherapy; or (3) to enter the trial and be randomly assigned to one of these two treatments.

The patient is thus faced with a dilemma. Some women appear to have no difficulty at all in choosing. So far (and given our limited sample), those who have chosen lumpectomy and radiotherapy have expressed a strong and perhaps predictable feeling of satisfaction with their breasts and therefore have an interest in maintaining their physical wholeness. These patients also seem to show little apprehension about radiotherapy, nor are they much bothered by having to attend for this treatment after their initial stay in hospital.

Women who have without hesitation chosen a mastectomy have expressed strong fear in interview, of the disease and of dying. Although *they also* may desire to keep their breast and are strongly satisfied with their appearance, they perceive the mastectomy as the more established and hence possibly, safer, operation. Most of these women seem to understand cancer as a localized rather than a systemic disease. By choosing a mastectomy they may not, in fact, increase their chances of survival (although these results remain to be seen) but they do, ipso facto, reduce the risk of recurrence of cancer in the same breast, to zero. There is always a possibility of course that cancer may recur in the other breast, or indeed elsewhere within the body, but they feel that in choosing a mastectomy they have done all they can (mostly by sacrificing a breast) to reduce this risk.

Occasionally patients opt to enter the trial. This does not seem motivated by a wish to help medical science but rather, as far as can be judged in interview, by an unwillingness to believe that medicine does not have the definitive answer, and that whatever they are told by a doctor must be a better choice than they, as members of the general public, could make. Obviously a portion of the pre-operative interview is dedicated to finding how each woman made her choice. Often, in discussing the three main areas outlined earlier (cancer, physical appearance and treatment), it has become obvious that one area is of major concern and this predominant concern or fear has determined the choice.

However, in some cases, patients find it very difficult to choose between a mastectomy and a lumpectomy. Of those women who have expressed this indecision, so far all have firmly rejected the trial ("I don't want to be a guinea pig") but have just been unsure about the other two options. Again, discussing the three main topics of the pre-operative interview has shown that one fear is usually predominant. A very basic decision analysis may be conducted with the patient. The patient is asked to think of all possible outcomes (given the two treatments) and it is possible to get the patient to assess her utility for each outcome (e.g., possible recurrence of cancer; loss of breast; attending radiotherapy sessions; possible sexual difficulties, etc.). Given the woman's assessment of the probability of each outcome, and the utility of each, it is easier for her to see her optimum course of action.

It should be mentioned here that although the interviewer may conceptualize the decision making process using this terminology, it is not always the case that the patient does so. Obviously, most women, feeling tense and anxious or depressed, do not want an introductory course in decision analysis before an operation for breast cancer. However, the decision analysis method, the logical sequence involved in drawing a decision tree, is followed. Patients find no difficulty in voicing possible outcomes for them, given the two different treatments; they can try to imagine how likely these outcomes actually are; and they can also say how important each of these outcomes is likely to be for them. Such a sequence has helped in clarifying their views and aided them in making their choice of treatment.

It is necessary to emphasize here that in many respects the project is new and therefore the results found so far are based on a small sample of subjects. Full data analysis will not be possible until a much larger number of patients has been seen.

Of course, there are no longer only the original two groups contained within the trial. There are, in fact, four major experimental groups:

1. Those who choose a mastectomy;
2. Those who choose lumpectomy and radiotherapy;
3. Those randomly allocated to have a mastectomy;
4. Those randomly allocated to have a lumpectomy and radiotherapy.

Also being investigated will be a more heterogeneous group of patients with more advanced cancer; they will be advised that mastectomy would seem to be indicated as the wisest course of action.

It appears therefore that the study is now much broader than originally intended. It should still be possible to resolve the original problems concerning the best treatment for a patient, given her particular psychological and social state. However, it seems possible that, independently of psychological predisposition, the act of the woman herself making a decision concerning treatment may result in different psychological adjustment from the situation where the woman leaves the choice to someone else. Hopefully the data should also make clear whether such a difference does exist, and if it does, elucidate its determinants.

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# HYPNOSIS: THEORY AND PRACTICE

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## AN INTRODUCTION

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There is an inherently fascinating quality about the topic of hypnosis. As a subject for scientific enquiry it has provided the stimulus for many a philosophical debate and numerous technical challenges. How is it defined? How is it produced? How is it measured? How can it be explained? How can it be used? For some, these and many other questions have proved too fraught with difficulties to be considered proper material for research. For others, it is the very existence of these problems that has attracted them to a study of hypnosis.

There is little doubt that for the lay public, too, hypnosis is intriguing and has long been associated with magic and theater. It is perhaps with a mixture of disappointment and relief that those in clinical settings discover that when using hypnosis their doctor, dentist or psychologist does not first fix them with an irresistible stare. Or swing a gold watch in front of their eyes. Or utter strange incantations in order to induce a coma-like state from which they awaken minus pain, teeth or conflict.

Confusingly, historical accounts of hypnosis do frequently begin with graphic descriptions of Franz Mesmer (1734 - 1815) and his dramatic performances. As will be pointed out elsewhere in this Section, there are important differences between mesmerism and hypnosis. It would seem a pity to omit such a gloriously flamboyant character such as Mesmer, however, and a brief discussion of his work is included here.

It is worth noting that even the great Mesmer had his predecessors, including Fludd (1574 - 1637) and in the third century A.D., Apollonius of Tyana (Ludwig, 1964). Some have commented on passages in the Bible which may be interpreted as alluding to hypnotic phenomena (Glassner, 1955; Wolberg, 1972), while Muses (1972) claims that the earliest references to hypnosis are three thousand years old and Egyptian in origin.

Most readers will be familiar with Mesmer's belief in "animal magnetism". He viewed this as similar to physical magnetism but existing in living bodies such as that of the Mesmerist. An invisible fluid, capable of being transmitted to the patient, it could also be passed first to objects and then drawn off. To this end, Mesmer employed such devices as the "bacquet" which was a large container of water and iron filings; trees; and a metal wand. Disease was presumed due to some maladjustment in the flow of magnetic fluid and could therefore be cured by correcting the flow. A magnificent showman, Mesmer apparently enjoyed much success with his techniques. Following an unfavorable report from the French Academy in 1784, however, he left France in disgrace. Other reports followed - favorable and then again unfavorable.

Set against this background of controversy may be seen the emergence of modern hypnosis, James Braid (1785 - 1860) being credited with the first use of the term, which he derived from the Greek for "sleep" ("hypnosis"). A comparison with sleep had already been drawn by the Marquis de Puysegur (1751 - 1828) who defined the trance state as "artificial somnambulism". This analogy is discussed later in this Section. Significantly, Mesmer's theory of animal magnetism was not accepted by Braid. His emphasis lay with "monoideism" (mental concentration) and suggestion.

Throwing off the mantle of Mesmer, hypnosis became respectable, owing much to the work of the distinguished neurologist, Jean Marie Charcot (1825 - 1893). Although his belief that hypnosis, like hysteria, was a result of disease in the nervous system would meet with ridicule today, Charcot's work attracted the attention of many. Amongst these, in 1885, was Sigmund Freud. Charcot's theory was rejected by other investigators such as Ambroise Auguste Liebeault (1823 - 1904) and Hippolyte Bernheim (1837 - 1919) by whom suggestibility was given greatest prominence. The hypnosis-sleep analogy and the suggestibility theory were noted by Freud.

The name of Josef Breuer (1842 - 1925) will be recognized by many readers. His work with the patient Anna O. was to prove of great historic importance. Using hypnosis in an attempt to achieve symptom removal, Breuer discovered that Anna O's response was inconsistent and improvement less than complete. It was evident that some symptoms had their origins in past events and attenuated when, under hypnosis, experiences were recalled. In this way, Anna O's refusal to drink water was revealed to be the result of a traumatic episode in which her maid had permitted her dog to drink from the same glass she used. This account represented the first acknowledgment of the benefits of abreaction, with hypnosis seen as enabling the re-experiencing of forgotten emotions. Published by Breuer and Freud in 1895 the material contained in "Studies in Hysteria" can be regarded as the origin of psychoanalysis.

Freud developed free association as a means of tackling those cases which did not respond well to hypnosis. He would permit all associations to become conscious, and believed that if a symptom continued to hold some meaning for the patient it should not be removed. Perhaps not surprisingly, Freud saw an unwelcome element of sexuality in the use of hypnosis, in that a patient could be considered as surrendering herself emotionally to the therapist. As it was also obvious that some patients were not amenable to hypnosis Freud eventually concluded that its use was inferior to his developing technique of psychoanalysis.

However Freud's disenchantment with hypnosis is viewed, there is little doubt that it was followed by a general decline in interest. Despite this, Pierre Janet (1859 - 1947) continued to study the use of hypnosis. Unlike the mechanism of repression suggested by Freud, Janet regarded dissociation as a primary defense. Other factors contributing to a reduction in investigation into hypnosis were the death of Charcot (1893) and the use of chemically rather than hypnotically induced anesthesia in surgery.

It was not until World War I that hypnosis enjoyed a recovery in interest, when it was employed once again as a method of abreaction, this time for the treatment of trauma resulting in "war neurosis". Performing something of a U-turn, Freud acknowledged this fact in "Turnings in the Ways of Analysis" (1959). He advocated combining analysis with suggestion (1959).

The period between the two world wars produced few studies in hypnosis. Prominent amongst these was the work of Clark Hull (1844 - 1952) in the United States and McDougall in Britain. The former produced experimental data that challenged Pavlov's belief that in hypnosis, like sleep, certain areas of the brain were selectively inhibited. The latter discussed hypnosis in a manner similar to Janet's dissociation theory.

During World War II hypnosis was again used in the treatment of wartime neurosis (Watkins, 1949). Following the war, numerous societies emerged for those interested in the practice and study of hypnosis in clinical and experimental settings. The British Society for Medical and Dental Hypnosis was formed after a resolution favorable to the use of hypnosis in dentistry and medicine was passed in 1955 by the British Medical Association. The British Society for Experimental and Clinical Hypnosis was set up in 1978, open to psychologists in addition to doctors and dentists.

It would be tedious to detail the theories and definitions of hypnosis that have been offered, but an overview should suffice to provide a background for the following chapters.

Hereditary theories lay emphasis on phylogenetic, regressive qualities. There are physiological theories which view hypnosis as the result of changes in brain activity. Learning theorists may choose to see hypnosis, in terms of their theory, as another form of learning. Social models compare hypnosis to role-playing. Psychoanalytic models are concerned with intrapsychic and interpersonal features such as dissociation, regression and the presence of transference in a hypnotic situation (Wolberg, 1962). Simply stated, there are physiological and psychological theories of hypnosis, with the latter group the most frequently held.

Definitions of hypnosis are as prolific as the theories and only a few will be given here for illustration.

For Erickson, hypnosis is "a state of intensified attention and receptiveness and an increased responsiveness to an idea or a set of ideas" (1958). Bartlett defines hypnosis as "a control of the normal control of input (information) for the purpose of controlling output (behavior)" (1968). For Barber (1972) hypnosis is not seen as a state to be differentiated from waking consciousness. Orne, on the other hand, does distinguish between normal behavior and hypnosis "... hypnotic phenomena can operationally be distinguished from non-hypnotic responses only when suggestions are given that require the subject to distort his perception or memory" (1972). As a final example, Spiegel (1967) describes hypnosis as "an altered state of intense and sensitive inter-personal relatedness between hypnotist and patient, characterized by the patient's non-rational submission and relative abandonment of executive control to a more or less regressed, dissociated state".

Crasilneck and Hall (1975) provide a more comprehensive account of the material discussed so far. They conclude that "any durable theory of hypnosis must relate the psychological and subjective factors with other, more measurable structural factors - hence our preference for 'psycho-structural' to describe the direction in which we feel the growth of a comprehensive theory of hypnosis will occur. 'Structural' is deliberately left unspecified in our terminology since it is our belief that the structural aspects of hypnosis will eventually be found to have a similarity of gestalt, whether expressed in terms of neurophysiology, of interpersonal relationship, of psychoanalytic concepts, or other conceptual languages".

Having examined some of the background issues, it may be concluded that even though there are difficulties in defining hypnosis and locating it within an acceptable theoretical framework, its use is nevertheless well worth further investigation. As Wadden and Anderton point out in their recent review article (1982) research into the clinical application of hypnosis has flourished in the last ten years or so.

As described in the following chapters, issues in cognitive-behavioral and hypnotic treatments may be considered together and hypnosis is frequently combined with other forms of treatment in order to augment their effectiveness. Some of the problems encountered in evaluating clinical research are that the term hypnosis has been used very loosely, therapeutic procedures differ and are seldom described in sufficient detail, while clinical populations and outcome criteria are also varied. All too often, single and group case studies of an inconclusive nature are to be found or the task of teasing out the unique contribution of hypnosis rendered impossible.

Wadden and Anderton's article is too comprehensive to be described fully in the space available here and the interested reader is recommended to the original. Briefly, they review the experimental data on the hypnotic treatment of alcoholism, asthma, cigarette-smoking, clinical pain, obesity, and warts. They conclude that: "although hypnosis may be effective with addictive behavior, the therapeutic success is attributable to non-hypnotic factors. In contrast, hypnosis appears to be of unique value in the treatment of clinical pain, warts and asthma". The data they present challenge the claims made by hypnotherapists that hypnosis: "(a) produces more profound bodily relaxation than do waking-state interventions; (b) elicits greater clarity of visual imagery; and (c) increases responsiveness to suggestions for therapeutic change". Furthermore, "if it were found that an induction significantly enhanced relaxation, clarity of visual imagery, and suggestibility, it remains questionable whether enhancement would lead to an improved outcome. Investigations of cognitive-behavioral therapies have found these process variables to be of limited importance". They conclude by recommending that future research should be more rigorous than in the past and endorse Lazarus' view that we should ask: "which types of hypnotic treatments, as delivered in what contexts, are successful in treating which individuals suffering from what disorders?" (Lazarus, 1973).

Those readers who already use hypnosis in their clinical work are no doubt familiar with the arguments presented above and remain convinced that hypnosis is of practical value to them. For those who were considering introducing it into their treatment of patients and who are now doubting the wisdom of this choice, the present writer would urge them to "try it and see". A short account of my own introduction to hypnosis may help.

Several years ago, having read the work of Barber and others, I was less than happy with the subject of hypnosis. For a start, it appeared almost impossible to penetrate the problem of defining it (if it existed) without the benefit of an advanced study in philosophy. There was the task of deciding which theory produced the best fit to the little decent experimental data that was available. Then the matter of finding out "how to do it" and how to convince myself, colleagues and patients that it was "respectable" and worth doing anyway. I examined these issues in a desultory fashion for a while, then finally abandoned the attempt and concentrated instead on behavioral and psychotherapeutic techniques - not without their problems, of course, but at least everybody else was using them.

I was then invited to a demonstration of hypnosis by an enthusiastic General Practitioner who had no doubt about its worth in his practice. Quite smug in my belief that I could debunk the proceedings and have fun at his expense, I went along. What transpired was hardly in the same category of experience as St. Paul's on the road to Damascus, but I was impressed by the fact that something took place and that the audience of intelligent health service professionals who observed and volunteered as subjects, were also sceptical at first but soon became convinced that they had witnessed quite genuine phenomena - rapid, profound relaxation; arm levitation/ rigidity; post-hypnotic suggestion and so on. He recommended Hartland's "Medical and Dental Hypnosis and its Clinical Applications" (1971) and offered to coach me. As a result, I became increasingly confident and gradually introduced hypnosis into my clinical work. At first, I restricted its use to relaxation - the speed and depth compared very favorably to plodding through the usual relaxation instructions and were what had immediately struck me as being of practical value. Reading Hartland's book I came across "ego-strengthening" and decided to add that - capitalizing on the patients' existing strengths and suggesting the positive effects of their new-found ability to relax.

Next, I used hypnosis to bolster behavioral treatment of obesity and cigarette-smoking. Finally, in pain-management. I have not yet had the opportunity to "charm away" warts with hypnosis, nor have I used it as an adjunct to psychotherapy.

As with any technique, there have been successes and failures. Notable amongst the former was an 80-a-day cigarette-smoker who enjoyed little improvement with a self-control program until hypnosis was added as an ego-strengthening measure.

Obviously, the foregoing account is anecdotal and such evidence as I possess would not stand rigorous scrutiny. Nevertheless, my clinical impression is that while hypnosis is by no means a panacea and indeed should never be used with some patients, when employed appropriately it can be a useful addition to other techniques and quite frequently appears to mean the difference between treatment success and failure.

I am concerned that I have not resolved the philosophical/theoretical dilemma yet, but as a clinician I am quite happy to continue to use hypnosis in treatment and let others perform the necessary experiments and mental gymnastics.

I would not advocate attempting to learn hypnosis from a book. First, find a tame expert who is prepared to impart his or her knowledge and expertise; volunteer to be a subject yourself; join an appropriate society; try it out on willing colleagues. Above all else, learn when not to use hypnosis, guard against developing a "Messiah" complex and warn others of the existence of "quack", self-styled hypnotherapists.

In the following chapters, both theoretical and clinical issues are explored.

Dr. Gibson traces the development of hypnosis and distinguishes it clearly from Mesmerism. He discusses the hypnosis-sleep analogy and considers some of the more modern theories of hypnosis. He describes the role-playing theory of Sarbin and Coe (1972) and challenges it in view of the existence of hypnotic analgesia. Barber's (1969) assertion that hypnosis cannot be operationally defined and should not be seen as a unique state is considered along with pain and sleep research, where similar remarks could be made. Dr. Gibson points out that despite these conflicting theories, most contemporary research in hypnosis does uphold the view that it represents an altered state of consciousness.

He proposes that we should continue to see hypnosis as an altered state of awarenesss. This altered state may be understood in terms of information theory (Broadbent, 1958). When in a state of hypnosis, the subject has altered his or her mode of perception, depending on the channel of information supplied by the hypnotist, instead of forming his or her percepts from "raw stimuli". He argues that hypnosis has now been integrated into general psychology, losing its former mystery and separateness.

Dr. Vingoe also addresses the question of "what is hypnosis?" and considers the subjective state view of hypnosis, with emphasis on the importance of imagination.

The use of scales of measurement in hypnosis research is described, for example the Stanford Hypnotic Susceptibility Scale (Weitzenhoffer and Hilgard, 1959; 1962); the Individual Profile Scales (Weitzenhoffer and Hilgard, 1967); Tellegen and Atkinson's Absorption Scale (1974); the Harvard Group Scale of Hypnotic Susceptibility (Shor and Orne, 1962); Wilson and Barber's Creative Imagination Scale (1978).

He reviews research supporting a cognitive theory of hypnosis and concludes that: "the role of imaginative involvement, vividness of visual imagery, absorption, and effortless experiencing in hypnotic behavior seem relatively well-established".

Dr. Vingoe recommends that further research is required to ascertain whether hypnotic procedures could be used to maximise creative performance. It appears that while much of the experimental data does support the relationship between hypnosis and cognitive (particularly imaginative) factors more work is required to provide further support for a cognitive theory.

The two remaining chapters examine the use of hypnotic techniques in the clinical field.

Mr. Kenworthy describes how hypnosis may be combined with behavior modification and psychotherapy. He uses hypnosis in all those behavioral techniques which employ imagery and gives examples of systematic desensitization, assertive training and covert sensitization.

In psychotherapy, Mr. Kenworthy advocates three methods of eliciting useful information by means of hypnotic techniques. These are: ideomotor finger signalling; age regression; induced hallucination. Repressed material can be uncovered by their use and strong emotions vented and understood.

In elaborating further, he refers to Cheek and Le Cron's "Clinical Hypnotherapy" (1968) and the seven caustive factors or "keys" in psychosomatic illness which they describe. These are:

1. Conflict
2. Motivation
3. Identification
4. Masochism
5. Imprints
6. Organ Language
7. Past Experiences.

He illustrates with case examples how hypnosis may be used to explore these factors and insight gained both by therapist and patient. He concludes by claiming that hypnosis is best seen as not a therapy in itself, but as a facilitating element in the therapeutic strategy. He, too, makes the point that it is not a panacea, but attributes much of his therapeutic success to the use of hypnosis.

The final chapter is somewhat unusual. Dr. Beacon is a General Practitioner with a long-standing interest in the use of hypnosis. His paper is an account of how anchoring, reframing and dissociation may be used as an aid to the treatment of phobic conditions.

The work of Milton Erickson and his colleagues, to which this technique is related, has been criticized by some as appealing to "ego-involved" therapists. Nevertheless, it has many adherents in the United States and offers an interesting contrast to the other procedures described in previous chapters.

Dr. Beacon refers to Leslie Cameron-Bandler's 1978 publication in which the technique is described in detail. He presents pictures and case examples in his chapter. He claims that it offers a quick method for dealing with some psychosomatic and phobic disorders and other behavioral problems.

It is hoped that this account of this hypnosis Section will be read with interest, albeit tempered with a degree of healthy scepticism.

There is a considerable amount of research yet to be conducted in hypnosis, but there is little doubt that its use in clinical work is worthy of serious consideration.

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# THE NATURE OF HYPNOSIS

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As is well known, the name hypnosis refers to sleep. It was coined in the mid-nineteenth century by James Braid who first referred to his practices by the inelegant name of neurypnology. The imagery of sleep is strongly associated with the whole practice and literature of hypnosis, and such imagery is still used today for reasons that I will examine later. In some respects such an association has been unfortunate and has led to some misapprehensions. For instance, some drugs are known as 'hypnotics' because they make patients sleepy, and so some physicians and others have fallen into the error of supposing that they can increase susceptibility to hypnosis by the administration of such drugs. Horsley (1952), on the basis of his clinical impressions, supposed that he could increase hypnotic susceptibility and depth by administering narcotic drugs, and Tetreault et al. (1967) refer to mebutamate as though it were able to increase the depth of hypnosis. Haward (1972) perpetuated the error and refers to 'barbiturate-induced hypnosis', giving some clinical examples and partly basing his observations on his misunderstanding of Weitzenhoffer (1957): for this he is taken to task by Vingoe (1973), who reviews the whole area. That the confusion is a semantic one is pointed out by Trouton and Eysenck who write, 'The term "hypnosis" is used to describe the states produced by different means, namely by drugs and by suggestion, and it is difficult to judge whether the similarities are merely superficial.' (Trouton and Eysenck, 1960, p. 663.)

We have to go back to the early nineteenth century to trace the original connections between what nowadays we regard as hypnosis and what we regard as sleep. Early mesmerists, such as de Puységur, in seeking to 'magnetize' patients according to the practices of Mesmer, would sometimes induce phenomena quite different from the mesmeric crises, and which had no place in his theory. In seeking a way to describe this unexpected state they hit on the metaphor of sleep, but with qualifying adjectives: terms such as lucid sleep and nervous sleep show recognition of the fact that it had properties different from ordinary sleep. The metaphor of sleepwalking was used to describe the phenomena of the active trance, hence the term somnambulism in this connection. Interestingly enough, the phenomena of sleepwalking are not well understood today after 30 years of modern sleep research with the EEG.

In hitting on the metaphor of sleep and sleepwalking the early mesmerists can be credited with some acute observation. The psychology of their time did not permit a better conceptualization, and we shall see how modern psychology is still somewhat inadequate because the two areas of hypnosis research and sleep research have largely proceeded in isolation, although there have been some notable exceptions, as in the case of Evans et al. (1970).

One of the earliest hypnotists was the Abbée di Faria whose book (Faria, 1819/1906) was republished nearly a century after his death. Faria was not a mesmerist but a hypnotist: he entirely rejected the theories and methods of Mesmer and sought to obtain the phenomena of lucid sleep by verbal methods with little resort to physical contact. Here I should mention a confusion that repeatedly appears in the literature of hypnosis, a confusion between mesmerism and hypnotism. Many modern writers, including some of the most eminent such as Hilgard (1965), Barber et al. (1974) and Chertok et al. (1977), write as though mesmerism was simply an old name for hypnotism. It is only rarely that we come across writers who realize and acknowledge that the two processes and the phenomena are fundamentally different. Shor points out that:

> "A consideration of the historic development of the issue makes it clear that Esdaile and the other mesmerists in the mid nineteenth century did not induce hypnotic anaesthesia in the modern sense.... Using mesmeric passes and relying on performed expectations of influence rather than verbal suggestion, they very slowly induced a state of profound stuporous slumber." (Shor, 1967, p. 554)

Profound stuporous slumber was what the mesmerists generally aimed at for therapeutic purposes, and their methods involved a long process of rhythmic physical stimulation. Contemporary accounts such as those given in the Report (1847-8) of the official observers at Esdaile's mesmeric hospital at Calcutta, by Esdaile (1846/1976) himself, and by Topham and Ward (1842), make it clear that the mesmerized subject was in a state comparable to that of the tonic immobility that can be induced in animals by physical manipulations, as described by Ratner (1967), and is sometimes referred to as 'animal hypnosis.' Indeed, the analgesia that commonly results from tonic immobility, and is attributed by Carli (1978) to the secretion of endorphins, may well be the mechanism that permitted painless surgery to be performed by the mesmerist surgeons. This is a complex question that has been fully discussed by Gibson (1982).

As the mesmerists produced a stuporous slumber and as mesmerism is frequently confused with hypnotism, the sleep-hypnosis connection has been strengthened further. Indeed, it is surprising to find modern writers on hypnosis such as Hilgard and Tart sometimes equating strong involvement in hypnosis with depth of a stuporous slumber. Thus Hilgard refers to a study by Tart (1970), and while admitting that some of the cases reported by Tart are unusual, writes, '...unless special precautions are taken, the subject loses contact with the hypnotist. At greater depths he no longer responds to suggestions. Only an implanted signal such as touching his arm to bring him back, restores contact.' (Hilgard, 1978, p.30). Such a condition would hardly be termed 'hypnosis' by most modern writers.

To return to the Abbe di Faria, who was one of the first hypnotists, let us consider his methods and his theories. To induce hypnosis he did the following, as reported by Perry:

> "Faria induced lucid sleep by having his subjects sit down, close their eyes, and focus their attention on sleep. After a period he would instruct them with one word: <u>Sleep</u>. If that failed, he would

> have his subjects fixate on his open hand which he would move slowly towards the person's face. If that failed he would touch the person lightly on the head, face and body. To terminate lucid sleep he would instruct the person:'Wake up.'" (Perry, 1978, p. 42)

It should be noted that Faria first attempted to get his subjects to try to go to sleep, but he followed this by engaging them in active pursuits by continually talking to them; and finally to terminate their activity he gave them the totally illogical instruction to 'wake up.' What do we do if we know that we are not asleep in the usual sense and we are instructed to wake up? This question will be pursued later. This sort of procedure is followed by many hypnotists today, except that the authoritarian commands of the hypnotist have gone out of fashion and induction procedures are generally very permissive. Even if hypnotists do not use the word 'sleep' in the induction procedure, as many do not, they often terminate the proceedings by giving the instruction to 'wake up' and the subjects respond appropriately.

Faria's theoretical basis involved some odd physiological assumptions, based as they were on the limited and often erroneous medical theories of his time, that hardly bear examination today. He was an empiricist, but a successful empiricist. He discounted the view that hypnotic susceptibility depended on favorable motivation and placed more emphasis on the large individual differences that exist in hypnotic susceptibility. In this respect he was a pioneer, and he attributed such differences to innate factors of personality, and in this he may well be correct.

The early hypnotists followed the technique of first trying to plunge their subjects in sleep and then progressing them to an active and sometimes lively somnambulism. De Puységue, in so far as he was a hypnotist as well as a mesmerist, demonstrated this very well with his subject Victor Race, and later in the nineteenth century other hypnotists including Faria, Bertrand, Braid, Charcot, Liébault and Bernheim followed this method, although with widely different theoretical assumptions. Braid was a partial exception, for in one of his several theories of hypnosis he mentions successive stages of 'slight hypnosis,' 'deep hypnosis' and 'hypnotic coma' but elsewhere he makes it clear that he expected actively responsive behavior from subjects deeply hypnotized (Braid, 1855/1970). The early depth scales show the progression clearly: level 4 on Liébault's scale is 'deep sleep,' and at this level on Bernheim's scale the movements of the subjects are inhibited. 'In this degree, the suggestive catalepsy is more pronounced and resists all efforts on the part of the subject to break it' (Bernheim, 1887/1973, p.11). But in the so-called 'deeper' stages of 7, 8 and 9, the subject can have his eyes open and be quite active, although his perceptions are largely determined by the suggestions of the hypnotist.

In Charcot's three stages of hypnosis there is first catalepsy, then, as expressed in his essay summarized by Binet and Féré:

> "2° État lethargique.... Fréquemment au moment où il tombe dans l'état léthargique le sujet fait entendre un bruit laryngé tout particulier, en même temps qu'un peu d'écume se montre aux lèvres. Aussitôt il s'affraisse, dans la résolution, comme plongé dans un sommeil profond." (Binet et Féré, 1882, p. 115).

This profound sleep was followed by the active state of somnambulism during which Charcot put his patients through their paces before his admiring audiences.

It seems that whoever we study in the history of hypnotism we come across this U-shaped progression, first down into a sort of sleep then up into a period of activity on a new plane of experience. But the early magnetists and hypnotists did not confuse sleep with hypnosis as is popularly supposed; they simply lacked an adequate vocabulary in which to describe the phenomena they observed. Edmonston (1981, p.28) quotes Wood, who wrote in 1851:

> "I think one great difference between natural sleep and that produced in magnetism is this - in the former, all nervous centers are tired out, and all repose; in the latter, those of sensations and volition are chiefly affected - and they being lulled to rest, the others retain their wonted activity."

Edmonston has also attempted to explain the immensely complex theories of Pavlov with regard to hypnosis. The latter is sometimes credited with having a completely over-simple theory of hypnosis, for he once wrote a paper entitled 'The identity of inhibition with sleep and hypnosis' (Pavlov, 1923), his theory being that in hypnosis the cerebral cortex is partially 'inhibited' and partially 'excited,' and this self-same mechanism of 'inhibition' spread all over the cortex in sleep. Before we examine these traditional ideas about hypnosis and sleep further, let us look at some of the modern paradigms of hypnosis such as are discussed by Sheehan and Perry (1976).

First, there is the role-playing theory of hypnosis as proposed by Sarbin and Coe (1972). In this, hypnosis is conceptualized as being one of the many conditions of social interaction in which we engage. Hypnotized subjects behave as they do and appear to experience their environment in a rather abnormal way simply because they are playing the role of a hypnotized person, a role that is defined by the hypnotist. These authors caution us against a facile assumption that hypnotized subjects are merely shamming and play-acting in a superficial sense: they are not, and they may genuinely believe that they are in a very special state of altered consciousness that accounts for their novel behavior and their unusual experiences and sensations. They propose that all human behavior can be viewed as being on a continuum from non-involvement, casual role enactment, technical acting, method acting, hypnotic behavior, hysterical and histrionic neurosis, ecstasy, and finally, being the object of witchcraft and sorcery.

Most of us will be familiar with the difference between technical acting and method acting. In the former the actor employs the technical skills they have learnt to register certain emotions by voice and gesture, but in method acting they so throw themselves into the part that while they are playing, say, Hamlet, the actor really does experience the stormy emotions of the Prince of Denmark, and in one sense he believes himself to be Hamlet until the curtain comes down.

Many people have challenged this role-playing paradigm of hypnosis, particularly with regard to the question of how, in some suitably disposed people, procedures that would normally engender extreme pain can be carried out with no analgesic other than hypnotic suggestion. We would all like to be able to play the role of a non-suffering person, say when undergoing surgery, but how is it that so few of us can do so despite extemely strong motivation for such role-playing? When I challenged William Coe in this matter, he replied as follows:

> "I believe that your statement... 'still left puzzling as to how someone can effectively play the role of experiencing no pain when he is undergoing a severe surgical operation, etc' - suggests that you have misinterpreted our model in the same way as so many others have. The implication I perceive is that we believe people are not involved in what they are doing, i.e. they are faking or dissimulating. Such

> an interpretation is unfortunate from our point of view because it is not at all our intention. What seems to happen is that role metaphor is easily reified by many persons. The proposition of role theory - 'It's as if people may be viewed as actors in a drama' - is reduced to, 'people are acting not really living.' In social psychology investigators do not seem to lose the 'as if' characterization of the drama metaphor, but in the area of hypnosis, probably because hypnosis has been associated with sham behavior, con-artists and quacks as you point out, legitimate investigators seem defensive and over-respond to anything which could suggest that fakery is involved." (Coe, 1978)

This may perhaps help to clarify the attitude of the role-playing theorists towards hypnosis in general, although it does not seem to answer the specific point about hypnotic analgesia.

Another influential theorist and critic is Barber. He has carried out a long series of experimental investigations, many of them showing that most of the classical phenomena associated with hypnosis can also be produced by psychological methods other than hypnosis. One of his favorite techniques is to give his subjects a somewhat intimidating pep-talk to the effect that unless they produce such-and-such phenomena in an experimental situation his experiment will be ruined and they will only succeed in making him look a fool. In these circumstances it it found that control groups given the so-called 'motivational instructions' pre-experimentally will produce the same observable phenomena as experimental groups that are given a standard hypnotic induction procedure. Critics have, of course, pointed out that although an unhypnotized control group may, for instance, <u>say</u> they have a great deal of post-experimental amnesia and can remember very little after a procedure designed to generate amnesia, their report may reflect very different psychological mechanisms from those responsible for generating amnesia in the hypnotized experimental group. In short, the control group have been cajoled, intimidated and bamboozled into lying to fulfil the expectations of the experimenter who gave them the pep-talk, but the hypnotized experimental group have had no such pressures put upon them. Or haven't they? For it can be argued that the whole process of hypnosis generates a subtle conspiracy between hypnotist and subject, so that the latter fulfills the expectations of the former.

But although the experimental methods of Barber are somewhat naive and can be easily criticised on a number of counts, his influence has not depended on his experimental work but on the arguments he has urged against conceptualizing hypnosis as an altered state of awareness. Most of his theorizing is summarized in one book (Barber, 1969). In effect, he points out that there are no unique observable and testable criteria by which the presumed hypnotic state can be identified, and therefore the concept is expendable. In short, we cannot give a satisfactory operational definition of hypnosis, and for this reason Barber generally writes the word 'hypnosis' in quotation marks. Some people who have been strongly influenced by Barber's writings have come to the conclusion that hypnosis is a myth and does not exist. To quote a recent writer, strongly influenced by Barber, 'In the absense of any single, definite characteristic of hypnosis, it would be scientifically sensible to abandon the term hypnosis' (Hearne, 1982). This viewpoint, depending as it does on our inability to formulate a satisfactory operational definition of hypnosis, is important, and I will return to it later.

Another influential body of theory that is perhaps the mainstream of research in hypnosis in the late twentieth century is associated with theroeticians such as Weitzenhoffer (1963), Hilgard (1965) and Orne (1959). They take the view that, in addition to all the artefacts of compliance and simulation that we get both in experimental research and clinical situations, there is nevertheless an essence of hypnosis and this can be viewed in terms of a real altered state of consciousness. Orne was responsible for initiating a long series of experiments in which, typically, there were three groups of subjects, A, B and C, and which follow the methodology of double-blind drug trials.

In such experiments group A is required to perform certain tasks after the induction of hypnosis; group B perform them unhypnotized, and group C after they have been carefully briefed to simulate hypnosis in order to try to deceive a particular experimenter who is naive to the identity of A, B and C. These experiments have shown that it is rarely possible for even the most experienced hypnotist to discriminate between subjects who are genuine or simulating (Orne, 1979). What differences there are can sometimes be detected by ingeniously contrived tests that depend upon what is known as the 'trance logic' of the hypnotized subject. Hypnotized subjects will accept manifest absurdities in the situation if they are introduced, such as a person and their hallucinated double being in the same room, but the simulator may try to rationalize such situations.

The mainstream of modern hypnosis is centered on the subjective experience of the subject and it is only rarely that we can reliably infer such experience from their observable behavior. There are many reasons why people choose to simulate hypnosis, especially in the clinical context. This may seem a most unsatisfactory situation that we have to depend ultimately on subjective report, and to put it in perspective I will turn to two other areas of research, pain and sleep.

Most people, other than Christian Scientists, acknowledge the existence of pain; but if we follow in the tradition of Barber we should write 'pain' in quotation marks, for his arguments against the legitimacy and usefulness of the word hypnosis also apply to pain. All the eminent modern theorists and research workers in the field of pain are agreed that we can have no satisfactory operational definition of it: it must be defined ostensively, that is, by citing instances in which the word is appropriate. I have referred to such authorities and their arguments elsewhere (Gibson, 1981). As with the state of hypnosis, there are no unique behavioral or physiological indices of the state of pain, and many of the indices associated with acute pain also apply to states of acute pleasure. It is therefore a fact that in research and clinical practice the measurement of degrees of pain is accomplished most efficiently by means of subjective assessments.

In the area of sleep research somewhat similar considerations apply. Over the past 30 years research workers have shown that the concept of sleep that is held by the layperson is not to be defined by unique behavioral and physiological criteria. The sleeping person may be passive or ambulant, vocalizing or mute; the eyes may be open or closed; the cerebral cortex may be excited or inhibited; skin conductivity may be very high or low; breathing may be slow and gentle or fast and irregular; the EEG record may show slow delta waves or fast waves of low voltage. But surely, some may say, the essential difference lies in that when we are awake we know where and who we are and what we are doing, but in sleep we do not. Alas, even that prop of certainty is denied to us in the 1980s, for La Berge et al. (1981) have shown that in sleep subjects can be aware of their condition and can communicate with those who are awake. Some, seeking a prop of certainty, cling to the old division between REM and non-REM sleep and say - we have three states of consciousness, REM, non-REM and wakefulness, and of course hypnosis belongs with wakefulness. But the two-state model of sleep is a little outmoded; alternative to the REM/non-REM dichotomy is the tonic/phasic dichotomy, and commenting on the position Pivik points out that:

> "One of the reasons that models and theories persevere in the face of glaring inadequacies is the apparent necessity of having something "better" with which to replace them. The 2-state model - the limitations of which were clearly evident even 5 years ago - had been languishing in a state of depreciated heuristic usefulness, and has only recently been laid to rest." (Pivik, 1978, p.268)

Pivik cited Dement (1973) in this connection, and the latter has upset all our cherished notions about what goes on in sleep by letting us know that, 'There is some speculation that REM sleep is not sleep at all, but a state in which the subject is awake but paralysed and hallucinating' (Dement, 1976, p.26). In view of all these uncertainties, if anyone is bold enough to declare categorically that 'hypnosis is not sleep' it is up to them to say precisely what they mean by the term 'sleep.' In fact, it is not improbable that in the 1980s hypnosis, along with a lot of other psychological phenomena, may come to be conveniently classed with some that are traditionally sleep phenomena. Let me recall the wise saying of Thomas Hobbes, 'Words are wise men's counters, they do but reckon with them, but they are the money of fools.'

The model of hypnosis that I propose really goes back to Bernheim (1888/1973) but expressed in terms of modern information theory as put forward by Broadbent (1958). Although stressing the importance of suggestibility, Bernheim did not regard hypnosis as being solely a matter of suggestibility; for him it was suggestibility in an altered state of awareness. He wrote, 'I define hypnotism as the induction of a peculiar psychical condition which increases the susceptibility to suggestion.' And what is this psychical condition? It is a sort of sleep: he states that:

> "Ordinary sleep does not differ from hypnotic sleep....But the <u>ordinary sleeper is in relation with himself only</u>, as soon as his consciousness is lost....The <u>hypnotized subject</u> falls asleep with his thought fixed, <u>in relationship with the hypnotizer</u>." (Bernheim, 1973, pp.117-8)

Theories of information processing occupy a very complex corner of modern psychology, but a very simple model can be derived from them to express Bernheim's ideas in modern terms. While we are awake we are continually working at the job of filtering, interpreting, processing the incoming stimuli and matching the new information against that already stored in our 'memory banks.' When we go to sleep we partly abandon the job. We close our eyes to shut out the visual stimuli; we cannot close our ears but we cease to attend so closely to auditory stimuli, that is, we process them at a much lower level and only attend to the most salient features in our sleep.Similarly, we try to get comfortable and to ignore tactile stimuli unless their meaning or their volume is very salient indeed. All this is expressed in Bernheim's sentence, 'the <u>ordinary sleeper is in relation with himself only</u>.'

What happens then, if a compliant subject is told to 'go to sleep,' but the hypnotist continues to talk to them urging them to attend to this, to think of that, to note the feelings in their feet, to listen to the metronome, to relax their forehead - all the usual patter of the hypnotic induction. The situation is preposterous to the extent that the subject cannot really shut down their information processing as they normally do when going to sleep because the hypnotist keeps supplying them with more and more information. But it is pre-processed information, so to speak; the subject does not have to work on it and can give up their filtering and interpreting just as they do when they go to sleep, an over-learned skill that they practice every night of their life. And when the subject has achieved a state of hypnosis, all that means is that they have altered their mode of perception and depend on the channel of verbal information supplied by the hypnotist rather than depending on their own efforts to build up percepts out of raw stimuli. Are they 'asleep'? I do not think the matter need concern us; at least they are not 'awake' in the ordinary sense of the word, for wakefulness implies reality testing and active organization of the whole chain of processes involved in building up percepts.

As the essential criteria for hypnosis, as for pain, are subjective, observers can only make inferences about the presence or absence of hypnosis from the observed behavior. This has led to an unfortunate vagueness surrounding the subject, particularly in the clinical field. Some clinicians become very ego involved with whether or not they have succeeded in inducing hypnosis. Thus the late Milton Erickson, who had a Jehovah complex, found it impossible to admit to himself that he failed to hypnotize some of his patients; therefore any transaction between himself and a patient was labelled 'hypnosis', so the word ceased to have any real meaning with him. Other ego-involved clinicians have followed him, and so organize their techniques that the patients have no opportunity of manifesting the fact they they may be totally uninfluenced and, indeed, uninterested in the proceedings that are alleged to be 'hypnosis.' We will learn nothing of the nature of hypnosis from these clinicians.

To understand the nature of hypnosis better we have to follow developments in research on a broad front in our own and allied disciplines. I have mentioned the areas of pain and sleep as fruitful research fields in which our greater understanding of the mechanisms involved in hypnosis have been advanced, and I have drawn particular attention to the theories of information processing generated by experimental psychology. Finally, I should like to quote the final paragraph of that seminal book by Barber written fifteen years ago:

> "Although research in "hypnosis" promises to provide a broader understanding of human behavior, the reverse is also true - as psychologists working on other topics develop general principles, their principles should help us attain a deeper understanding of the topic hypnosis. Finally the topic hypnosis may lose all of its aura, mystery, and separate status and become integrated into general psychology." (Barber, 1969)

I would say that the time of integration has already arrived, and in the 1980s there is little mystery or separate status about hypnosis. Its demystification should enable clinicians neither to pretend that it does not exist, nor to seek to endow it with almost magical powers and play the witch-doctor as did some of the psychiatrists of the old school. Knowing its nature we can use it sensibily.

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# TOWARDS A COGNITIVE (IMAGINATION-BASED) THEORY OF HYPNOSIS

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Wherever possible an experimental science proceeds by using objective observations as its main method in monitoring the changes in the phenomena under study. The scientist is, at first, implicitly directed to observe certain phenomena over others on the basis of his or her tentative ideas regarding the nature of those phenomena. While experimentation is directed implicitly or explicitly by theory, theory is, in turn, modified on the basis of the results of experimentation. There is, thus, an interdependence between experimentation and theory-building.

One of the major factors then, in outlining or describing a theory of hypnosis, is to determine what to observe, and how to observe it, as objectively as possible. The determination of what to observe is guided by the experimenter's tentative ideas as to the nature of hypnosis.

A person may be assumed to be hypnotized immediately following a hypnotic induction carried out by the hypnotist, although an induction may be unnecessary for high hypnotic responders (i.e., those people who readily experience what the hypnotist suggests to them). However, just as only about 40 percent of certain populations respond appropriately to morphine (Beecher, 1959), so only approximately 25 percent of a normal population are high hypnotic responders (i.e., score between 8 and 12 on a 12 point hypnotizability scale: Weitzenhoffer and Hilgard, 1959).

What then is hypnosis, or what characterizes a high hypnotic responder? Many characterize hypnosis as an altered state. Some stress the trait-like nature of hypnosis. Others consider environmental factors and/or interactional factors between the hypnotist and subject to be most important in hypnotic response (Sheehan and Pery, 1976). Although the trait and other views of hypnosis are by no means rejected by the writer, in view of the space limitations, only a 'subjective' state view of hypnosis which stresses the importance of imagination will be considered at any length in this paper.

It seems clear that hypnosis is neither sleep (Evans, 1979, p. 149) nor any other clearly differentiated physiological state (Barber, 1970; Vingoe, 1981). Frankel et al. (1979) indicated that only 'altered perceptions and alterations in memory are currently conceptualized as essential aspects of hypnosis'. Thus, these essential aspects of hypnosis would appear to be cognitive in nature. Neisser (1967) indicated that cognition refers 'to all processes by which the sensory input is transformed, reduced, elaborated, stored, recovered, and used' (p. 4). According to Mayer (1981), the information-processing model is the general framework forming the basis of cognitive psychology. Information or sensory input may be coded into visual or other types of images which may facilitate the subsequent storage and further use of this information.

Mischel (1976) reminds us that the individual is frequently unaware of certain cognitive processes. However, he points out that this unawareness is not sufficient justification for omitting these processes from consideration. He further notes that other sciences evaluate models by using analogies in order to postulate unobservable processes that may account for what we observe. Mischel stresses that the theory that postulates unobservable processes may be justified if this procedure leads to successful explanation and prediction.

Subjectively, and even physiologically, many states or conditions of the organism are quite similar. For example, many people who have practised Yoga and/or transcendental meditation (TM), and have experienced hypnosis, would agree that subjectively the states or conditions attained are very much alike. Astor (1977) stressed the similarities between TM and hypnosis. The so-called essence of hypnosis may be very difficult to communicate and, partly because of this, many people are sceptical of hypnosis. Even when a hypnotic induction is experienced by a person, the condition that follows may be labelled as one of deep relaxation or as a state of meditation. It is generally agreed that the ability to respond to suggestions is facilitated in the highly hypnotically responsive person with or without a prior hypnotic induction.

The attempt to convey the nature of hypnosis may be facilitated by the use of an analogy. Most people would probably agree that they know when they are anxious by feelings of uneasiness, being afraid, etc. More objectively, a person may be said to be anxious when certain types of behavior such as trembling, excessive sweating, and a tendency to withdraw can be objectively observed when certain physiological changes occur, such as increased heart-rate, respiration rate, etc. Some or all of these objective indicators may, however, be related to factors other than anxiety. For example, exercise changes in environmental temperature, etc. Therefore, different factors or procedures may lead to similar conditions being observed if one is restricted to objective measures. Further, many people may wish to use the term fear or stress rather than anxiety to refer to their condition. Thus, the same or a similar condition or state in different people may be labelled differently. There are many self-report scales of anxiety available, although the use of Behavioral Avoidance Tests (BAT's) and physiological measures are preferred by some. The more symptoms or indicators of anxiety checked by the subject, the more he or she is seen to be anxious.

In a laboratory setting, in which a subject is exposed to an objective stressor, such as an electric shock, there is more likely to be general agreement that, on average, the person would experience anxiety or stress. However, when a person reports being anxious but is unable to specify what elicits the anxiety, there is likely to be a great deal of scepticism from some observers who may believe that the person is malingering, is imagining things, etc., because there is no objective stimulus or situation present which could conceivably elicit anxiety. The person may say "my anxiety just appears for no apparent reason", or that "I am just afraid that something terrible is going to happen", although he/she is unable to specify the object of this anticipatory anxiety. In addition, it should be pointed out that an objective BAT, subjective report and psychophysiological recordings, are frequently inconsistent in indicating the presence of anxiety (i.e., response desynchrony (Rachman and Hodgson, 1974; Hodgson and Rachman, 1974) is a frequent finding). Some people may not be aware they are anxious, yet show many of the clinical or behavioral indicators of anxiety. Nietzel and Bernstein (1981) provide an excellent discussion of the problems involved in measuring anxiety and fear. In spite of response desynchrony and other problems of assessing anxiety, clinicians and experimenters alike continue to use the concept of anxiety as they see fit.

Hypnosis, like anxiety, can be measured by objective scales, and the more items or tasks successfully passed, the more hypnotically responsive the subject is considered to be. The behavior necessary to pass many of these tasks, such as those used with the Stanford Hypnotic Susceptibility Scales, Forms A and B (SHSS: A and B) (Weitzenhoffer and Hilgard, 1959) can be observed by the hypnotist or other objective observer. This is particularly true of ideamotor items such as arm rigidity. However, the experimenter is forced to rely on self-report in assessing whether or not the subject passes cognitive-type items, such as the hypnotic dream. Even if the subject meets the criterion for passing hypnotic tasks, it may be thought they are simply complying with the wishes of the hypnotist. Therefore, honesty in self-report must be stressed in order to determine the degree to which compliance may be a significant factor in hypnotic response. A hypnotic response is generally considered to have occurred only if the subject made the response or had the experience suggested to them on an involuntary basis. In other words, only if the classic suggestion effect can be demonstrated is the response or experience considered hypnotically based. Weitzenhoffer (1974) indicated that there are two characteristics of responses which follow the classic suggestion-effect: "(a) they are transformations of the essential, manifest ideational content of the communications [suggestions] into behavior, and (b) they have a non-voluntary quality". Interestingly, K. Bowers (1981), in comparing the degree to which the Stanford Hypnotic Susceptibility Scale C (SHSS: C) (Weitzenhoffer and Hilgard, 1962) versus the SHSS: A tapped the classic suggestion effect, found that with almost a quarter of failed items, a considerable degree of involuntariness was reported. Thus, to a degree, self-report regarding hypnotic behavior may be inconsistent with observed behavioral response. More generally, there is likely to be a greater consistency between subjective reports supporting the occurrence of the classic suggestion effect and objective behavioral performance on the tasks found on hypnotic susceptibility scales in those subjects of higher hypnotic responsivity.

Compared to the SHSS: A and B, the SHSS: C and the Individual Profile Scales (Weitzenhoffer and Hilgard, 1967) include more cognitive items, which are more difficult in nature and seem to demand a significantly higher degree of imaginative ability of the subject. It would probably be generally agreed that the subject needs to make significant use of their imagination and to think along with the suggestions from the hypnotist in order to reach the criterion necessary to pass these more difficult cognitive items. In support of this idea is K. Bowers' (1981) finding that the SHSS: C taps the classic suggestion effect significantly more than does the SHSS: A. Bowers (1981) noted that the only way to determine whether the hypnotic behavior is involuntary or not is to ask the subject. Evans (1979) indicated that the main criterion for determining whether a person is in a specific state is the subject's "verbal description of the subjective aspects of his experiences" (p.141).

In assessing a phobic or anxiety state, both objective (observable) behavior and subjective report are useful. Similarly, the determination of whether or not (or the degree to which) a person is hypnotized should be based on objective behavioral criteria, but more importantly, on subjective verbal report. The writer would consider a person to be in a subjectively different psychological state (labelled by some as hypnosis) if he/she obtained an objective score of 8 or better on the SHSS: A or similar scale and, perhaps more importantly, if self-report during the post-hypnotic inquiry indicated that the criteria for the classic suggestion effect could be demonstrated with reference to a majority of the hypnotic tasks. The writer's view is that 'hypnosis is best conceptualized as a psychological "state" of heightened attention, in which the subject is better able to focus upon suggestions made by the hypnotists, and to use his imagination to visualize and otherwise sense or feel aspects of stimuli or situations from the past, present, or future' (Vingoe, 1981, pp. 302-3).

Traditionally, hypnotic induction procedures have stressed calmness, relaxation, and a lethargic or sleep-like condition. However, as Hilgard (1975) indicated, the use of the sleep metaphor is becoming increasingly inappropriate. Nowadays, induction procedures may vary widely (Gibbons, 1979; Spiegel and Spiegel, 1978; Vingoe, 1977). However, the majority of inductions encourage and facilitate heightened attention to the hypnotist's suggestions. The use of imagery is frequently encouraged, especially in deepening procedures. Sheehan and Perry (1976) pointed out that imagery and imaginal processes are increasingly emphasized in hypnosis research. While many researchers have stressed the function of imagery, the balance of this paper will focus on J. Hilgard's work on imaginative involvement, P. Bowers and K. Bowers' research on creativity and effortless experiencing, and recent work related to Wilson and Barber's Creative Imagination Scale (CIS).

## IMAGINATIVE INVOLVEMENT AND HYPNOTIC RESPONSIVITY

Sheehan (1967) has found that there are basic individual differences in the ability to utilize imagery. In addition, Sheehan and Perry (1976) indicated that relatively consistent correlations are found between imagery and imaginative processes and hypnotic responsivity. More specifically, Sheehan (1979) surveyed the research relating to imagery and hypnotic responsivity and has found that there are consistently significant correlations between vividness of imagery and response to hypnosis. J. Hilgard (1979) has recently reviewed the work on imaginative and sensory-affective involvements and their relationship to hypnotic responsivity. Hilgard stressed that these 'involvements permit a temporary absorption in satisfying experiences in which fantasy plays a large role' (p. 483). It is clear that 'absorption' itself is a factor of significant importance in hypnotic responsivity (Tellegen and Atkinson, 1974). Tellegen and Atkinson constructed an Absorption Scale in order to measure the 'disposition for having episodes of "total" attention that fully engage one's representational (i.e., perceptual, enactive, imaginative, and ideational) resources' (p. 268). The correlation of this scale with hypnotic responsivity tends to be in the low forties (e.g., Roberts et al., 1975). O'Grady (1980) has factor-analyzed the Absorption Scale and five other personality measures and found that one factor, accounting for approximately 17 percent of the total variance, was considered to represent an absorption dimension and supports the idea that the Absorption Scale is measuring a significantly different personality dimension. However, Yanchar and Johnson (1981), in studying the ability to predict hypnotizability from the individual's attitude toward the hypnotic situation, and from the Absorption Scale, found that Absorption accounted for less than 9 percent of the variance. Attitude was a somewhat better predictor, accounting for about 12 percent of the hypnotizability variance.

J. Hilgard (1970) studied the relationship between esthetic involvement in nature (gathered from interview material prior to hypnosis) and hypnotic responsivity on the SHSS: C using about 200 subjects. From the 90 subjects who obtained high involvement scores, 53 obtained high hypnotizability scores. However, the remaining 37 subjects obtained low hypnotizability scores. Clearly, J. Hilgard's (1979) caution, in noting that while the relationship between esthetic involvement and hypnotizability is statistically significant, it does not enable one to make firm predictions on the basis of involvement alone, is well taken. J. Hilgard (1979) concluded that:

> "The experience of involvement is limited in time, and return to the demands of reality is prompt after the experience is over. The imaginative involvements and their related hypnotic fantasies are distinguished from psychotic delusions and hallucinations because of their limited duration and the simultaneous retention of adequate cognitive controls" (p. 491).

In a later study (J. Hilgard, 1974), subjects of high versus low hypnotic responsivity were interviewed following hypnosis, in order to assess areas of high involvement. The findings indicated that approximately 75 percent or more of the highly susceptible subjects were highly involved in (1) the ability to savor sensory experiences; (2) drama; (3) reading; (4) extensive childhood fantasies or daydreams, compared to 20 percent or less of the low susceptible subjects. While the above ability factors tended to be positively related to hypnotizability, it was suggested that attitudinal factors such as the following may inhibit hypnotic responsivity:

"1. apprehensiveness over any new and different experience;
2. unwillingness or inability to accept the hypnotist-subject relationship; and
3. a need for much activity in the reading material rather than an emphasis on a slower pace in content compatible with hypnotic relaxation." (p.493)

J. Hilgard (1979) discussed a study on imagery and hypnotizability reported by Sutcliffe, Perry, and Sheehan (1970). She noted that a nonlinear relationship was the most frequent finding between imagery and hypnotizability. In the Sutcliffe et al. (1970) study, it was found, for example, that of the 73 subjects who demonstrated high imagery, 53 were of low hypnotizability as measured by the SHSS: A. (Weitzenhoffer and Hilgard, 1959). On the other hand, of the 22 subjects of low imagery only 2 were of high hypnotizability. Thus, while one cannot be sure that those of high imagery will inevitably turn out to be highly hypnotizable, if a subject demonstrates low imagery, they are highly unlikely to be of high hypnotic responsivity. J. Hilgard (1979) suggested that those who demonstrate high imagery but low hypnotizability may use their imagery for more realistic purposes, while those people high on both variables may be more involved in fantasy production and other imaginative involvements.

Using this SHSS: C (Weitzenhoffer and Hilgard, 1962) as a source of items, J. Hilgard (1970) found that the more imaginative (higher imagery) subjects were much more likely to pass items of imaginative content that require the production of a positive-type experience such as the Taste Hallucination or Hypnotic Dream. On the other hand, there was far less difference between those high and low in imaginery in the ability to pass inhibition-type items such as Arm Rigidity and Anosmia to Ammonia.

More recent work on imagery and hypnotizability by Farthing, Venturins and Brown (1983) indicated that vividness of visual imagery and hypnotizability were significantly related. The Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS: A) (Shore and Orne, 1962) was used and items were divided into Ideomotor, Challenge, and Cognitive type. Two mental imagery questionnaires were constructed, one involving impersonal objective visual scenes (MIQ:VS), and one involving the imagination of personal actions (MIQ:PA) which, if performed, would give the subject kinesthetic feedback. However, the authors admitted that this second scale would also involve visual imagery. The subjects were told in a lecture that hypnosis was considered to be 'a condition of profound imaginative involvement.' The HGSHS: A induction was presented after subjects completed the imagery questionnaires and the Tellegen Absorption Scale. The results indicated that both imagery questionnaires were significantly correlated with hypnotizability; also, the correlation was higher for the visual scale. It was found that both the visual imagery scale and the Tellegen Absorption Scale correlated most highly with the cognitive hypnotic tasks (fly hallucination, post-hypnotic suggestion, post-hypnotic amnesia). The visual imagery questionnaire correlated significantly higher with the cognitive tasks than the 'Visual-Kinesthetic' questionnaire. Combining the Tellegen Absorption Scale and the MIQ:VS, a multiple correlation of 0.45 with the cognitive factor was found compared to 0.27 and 0.30 with the ideomotor and challenge factors respectively.

In summary, while imaginative involvement, absorption and visual imagery are important factors in hypnotic responsivity, other variables are also important. The work of Patricia and Kenneth Bowers on Creativity and Effortless Experiencing as related to hypnosis will now be briefly summarized.

## HYPNOSIS, CREATIVITY, AND EFFORTLESS EXPERIENCING

Bowers and Bowers (1979), in their chapter on Hypnosis and Creativity, regard hypnosis as a special mode of information processing, referred to as 'parallel processing.' This parallel processing includes both a rational, effortful mode of processing and an effortless or fantasy mode of processing simultaneously, although these modes of processing may more often occur alternatively. P. Bowers (1978) refers to the four stages of the creative process: preparation; incubation; illumination; and verification, indicating that the stages of incubation and illumination are far less tangible than either preparation or verification. The information processing takes place without the persons's awareness, the creative ideas appearing as if from nowhere. More creative ideas are likely when a person exhibits 'a relaxed consciousness' and is 'receptive to subconscious influences which have escaped the restriction effects of awareness' (p.186). An effortless experiencing is said to be characteristic of both the creative process and of a person when hypnotized. The experience of having creative ideas and responding to hypnotic suggestions is felt as involuntary. K. Bowers (1976) suggested 'that those people who experience suggested imagery effortlessly in the waking state are also more hypnotizable' (P. Bowers, 1978, p.187).

In an experiment in which 32 university students selected for hypnotic responsiveness were the subjects, P. Bowers (1978) found, as hypothesized, that the correlation between high versus low hypnotic responsiveness and a composite measure of creativity could be accounted for by the concept of effortless experiencing. The correlation of high versus low hypnotic responsiveness and effortless experiencing was 0.61, thus accounting for over 37 per cent of the variance. The analogous correlation of hypnosis with creativity was 0.55. These correlations were significant beyond the 0.1 per cent level of confidence. The concepts of vividness of imagery and absorption were also studied. The correlations of high versus low hypnotizability and absorption and vividness were 0.41 and 0.32 respectively, both of which were significant. P. Bowers suggested that imagery vividness may be related to hypnotic responsivity only through the common variance it has with effortless experiencing. She concluded that 'effortless experiencing of various mental events deserves a place in the domain of hypnosis' (p.199). However, she provided a note of caution in warning the reader that the results may not be generalizable to unselected populations.

Patricia Bowers (1979) provided a concise review of the studies which attempt to link Hypnosis and Creativity. She suggested:

> 'that creative solutions to certain problems and hypnotic responses are characterized by... an effortless processing mode rather than by the volitional, effortful control processes useful in other tasks. However, this effortless mode (fantasy) is apt to lead to creative solutions only when sufficient information is present in the structure of a problem to support a creative gestalt.' (p.570)

More recently, Patricia Bowers (1982) demonstrated that there was a quite significant relationship (0.8) between ratings of involuntariness and the passing of hypnotic tasks on a 10 item group form of the SHSS: C (Weitzenhoffer and Hilgard, 1962). Therefore, the behavioral score obtained on the standardized scales of Hypnotizability tends to reflect the classic suggestion effect to a large extent although, clearly, using the joint criteria would be best. During the last decade or so Barber and his colleagues have been promoting a 'cognitive-behavioral' view of hypnosis (Barber, Spanos and Chaves, 1974), and Wilson and Barber (1978) have developed the Creative Imagination Scale which has led to a fair amount of research which links hypnosis and imaginal processes. This instrument is discussed in the next session.

## THE CREATIVE IMAGINATION SCALE*

Noting that they wished to avoid test suggestions which imply hypnotist control of the subject, Wilson and Barber (1978) developed the Creative Imagination Scale (CIS), which includes ten test-suggestions which are client centred in the sense that clients produce the experience themselves by using their own thinking and imagination. A hypnotic induction is not required, although various types of instructions or inductions may be used to potentially facilitate response to the scale. The CIS may be as easily administered to a group as to an individual. This instrument is based on Barber's (Barber, Spanos and Chaves, 1974; Barber, 1979) Cognitive-behavioral model of hypnosis, which emphasizes that the subject focus their thinking and use their imagination creatively to go along with the instructions.

The ten test-suggestions are as follows: (1) Arm (Left) Heaviness; (2) Hand (Right) Levitation; (3) Finger Anesthesia (2 fingers of left hand); (4) Water Hallucination; (5) Olfactory-Gustatory 'Hallucination'; (6) Music 'Hallucination'; (7) Temperature 'Hallucination'; (8) Time Distortion; (9) Age Regression; and (10) Mind-Body Relaxation. Following test administration the CIS is then scored by the subject, who compares their 'imaginative' response to each suggestion to the 'real thing' using a 5-point scale from 0 to 4. Therefore, the total score may vary from zero to 40. It should be noted that the scoring criteria are directly based on the subjective experience of the subject.

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*I would like to thank T. X. Barber and A. Sigman for their kindness in providing me with reprints and other material related to the CIS.

The authors point out that there are 3 reasons for naming the instrument as the Creative Imagination Scale:

1. The subject is asked to use his or her thinking and imagination to create a specific effect.
2. There seems to be an increasing consensus among people who work in this field that the subject carries 'out a kind of goal-directed imagining or fantasy' in being responsive to test suggestions.
3. The label creative imagination scale enables the scale to be used significantly more widely than if it were referred to as a suggestibility or hypnosis scale.

Wilson and Barber (1978) provide standardization and normative data for each test suggestion from over 200 introductory psychology students. Fifty-two percent of the normative group obtain a medium-high or higher score (i.e., 20 or more from the possible 40). Both test-re-test and Split-Half reliability were assessed and found to be satisfactory. Factorial validity was considered established, since each item was significantly correlated with the total score. All items, with the exception of Finger Anesthesia and Music 'Hallucination', correlated in the 60's with total score. All items loaded on one factor. A counter-balanced study indicated that the CIS correlated significantly with the Barber Suggestibility Scale (BSS) beyond the one percent level. Finally, Wilson and Barber discussed the clinical application of the CIS.

McConkey, Sheehan and White (1979) assessed the extent to which the CIS was related to hypnotizability by correlating the scores of over 200 subjects on the CIS with their scores on the HGSHS: A (Shor and Orne, 1962). McConkey et al. (1979) noted that it is important to determine if the CIS can be viewed as an alternate way of measuring hypnotic responsiveness. The CIS was administered via tape recorder, and subjects were asked to think-with and to imagine the suggestions. The HGSHS: A was also administered via tape, using standard instructions. The results suggested that the scales were measuring different dimensions, since the correlation, while significant, was only 0.28, thus indicating only a small amount of common variance. A more complex factor analysis was carried out which also indicated the essential independence of the two scales. McConkey et al. (1979) concluded that their results 'indicate the importance of acknowledging that although imagination may be related to hypnotizability, imagination alone is insufficient to account for ... [subjects'] capacity to respond well to hypnotic test suggestions on test scales such as HGSHS: A' (p. 273). However, it should be remembered that different instructions were used for the two scales and that the CIS items may be more related to the SHSS: C, which has many more cognitive items than the HGSHS: A.

Hilgard, Sheehan, Monteiro and MacDonald (1981) have studied the factorial structure of the CIS and criticized the factor analysis reported on by Wilson and Barber (1978) in which only one primary factor was found. Data was obtained from Stanford and from Queensland on the HGSHS: A, the CIS., a revision of the Betts Imagery Scale (QMI) and from the Tellegen Absorption Scale (TAS). Two main factors were found which accounted for most of the variance. Hilgard et al. (1981) concluded that the 'Hypnotic Responsiveness factor is represented most clearly by HGSHS: A and CIS., while the Absorption/Imagery factor is represented by CIS., TAS., and QMI' (p. 72). The Stanford correlation between HGSHS: A and CIS was significantly higher than the analogous Queensland correlation (0.55 compared to 0.28). The authors were unable to account for this difference.

Myers (1983) obtained group norms for the CIS from children of ages 8-17. Interestingly, she found that females obtained higher scores than males at all ages. It was also determined that responsiveness was greatest at ages 9-11 years. In view of peer pressure, which is said to be highest for 12 and 15 year-olds, Myers recommended testing these two groups individually. Unless the procedure is revised, Myers would not recommend the CIS for 8 year-olds.

McConkey and Sheehan (1982) studied the influence of the degree of effort expended in experiencing the tasks suggested on the CIS. Their study was based on P. Bowers' (1978) findings, that hypnotically responsive subjects report an effortless experiencing when involved in hypnotic tasks. McConkey and Sheehan asked their subjects the degree to which they expended effort during CIS testing, and tested the extent to which this effort related to CIS performance. The findings indicated that effort ratings and CIS scores were unrelated. When subjects were divided into low, medium-low, medium-high, and high CIS responsiveness groups, their mean item-effort scores were not significantly different. In attempting to explain these results, McConkey and Sheehan strongly argued that, when requested to rate the degree of effort expended in responding to each CIS item, subjects probably differentially interpreted the use of the term 'effort' perhaps related to their specific type of response. Further research into the factors which influence subject's relative effortless experiencing in imaginatively involving themselves in CIS or hypnotic-type tasks is needed.

Barber and Wilson (1979) reported on an experiment comparing Barber's Cognitive-Behavioral Theory with the traditional Trance State Theory. Sixty-six subjects were randomly assigned to Trance-Induction, Think-With Instructions and a Control Treatment which involved responding to a series of tests. Following the Induction, Think-With Instructions or Tests, all subjects were assessed on the CIS. The results indicated a significant difference in CIS scores between the three groups. More specifically, when subjects in each group were dichotomized at the over-all mean score of 23, it was found that 100% of the Think-With subjects scored above the mean compared to 55% and 45% for the Control and Trance Induction groups respectively. Barber and Wilson (1979) also reported on the results of two unpublished doctoral dissertations (De Stefano, 1976; Katz, 1975), which provided independent confirmation of the above results.

Barber, Wilson and Scott (1980) compared the use of traditional trance induction and a control (no-induction) treatment. Half of each group were tested on the Barber Suggestibility Scale (BSS), a 'hypnotic-centered' scale, and half of each group on the CIS, a 'subject-centered' scale. The results indicated that responsiveness to instructions above the control level was obtained when 'the test suggestions were worded in a hypnotist-declares-it-is-happening way'. Control subjects were, however, as equally responsive to the suggestions as those subjects exposed to the traditional trance induction when 'the test suggestions were worded in a subject-is-asked-to-make-it-happen way'. Essentially, an equal percentage of subjects scored high and low in both treatment groups. Barber et al. (1980) concluded that the effectiveness of hypnotic induction in increasing scores on the BSS, yet not on the CIS, may be attributed to the different ways in which the suggestions on the two scales are worded.

Straus (1980) assessed clients' response to the CIS following a short 5-minute induction procedure as compared to a control group who did not experience the induction. He found no difference in response to the CIS between those two groups of clients. Both groups were given a pretest which involved imagining a balloon tied to one hand and a heavy weight in the other. Responses were scored according to both objective movement response and self-report of vividness of imagery. In addition, all clients were involved in a discussion of hypnosis following which they were informed that 'hypnosis involved a process of cooperation between operator and ... [subject] in which ... [subject's] role was to think, feel, and imagine along with the suggestions, and ... [subjects] were urged to neither wait passively for something to happen nor to try to make anything happen or test for reality' (p. 220).

While Straus concluded that 'a traditional hypnotic induction is unnecessary to enhance responsiveness to CIS in a clinical setting' (p. 221), it is possible that the nature of, and the limited extent of, the induction used would hardly have been expected to increase response to the CIS. Whereas Straus indicated that various reports had confirmed that CIS scores are not increased by a conventional induction, these 'supporting' studies were all carried out using a sleep-type induction procedure which would not be expected to facilitate CIS responding. It is possible, although this has not been investigated, that a more 'alert' induction procedure would be more useful in facilitating the sort of imaginative processes tapped by the CIS.

## CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER RESEARCH

This paper has reviewed the literature on research which is supportive of a cognitive theory of hypnosis. While it is clear that there is much to recommend other approaches to hypnosis (e.g., the importance of attitudes toward hypnosis), the role of imaginative involvement, vividness of visual imagery, absorption, and effortless experiencing in hypnotic behavior seem relatively well established.

In reference to predicting hypnotic responsiveness from high imagery involvement, we are reminded by J. Hilgard (1979) that '... imagery itself cannot be thought of as predicting hypnotizability, although absence of reported imagery is a negative factor' (p. 497). J. Hilgard goes on to recommend studies 'on the type of factors that diminish hypnotic responsiveness in cases where imaginative involvement appears to be present in greater degree than the hypnotic score indicates' (pp. 494-495). J. Hilgard (1979) concludes that 'the claim has never been made that the relationship between involvements and hypnotizability is a simple one, because the correlations obtained, though positive, are universally small and many other factors may contribute to the determination of hypnotic susceptibility' (p. 496).

Sheehan (1979) has shown that consistent and significant correlations are found between vividness of imagery and hypnotic responsivity, and this has essentially been replicated by Farthing et al. (1983). However, Patricia Bowers (1978) in her work on effortless experiencing obtained results which suggested that vividness of imagery may be related to hypnotic responsiveness only through the variance it has in common with effortless experiencing. McConkey and Sheehan (1982) found that effort-ratings and performance on the CIS tasks were unrelated, but they admitted severe difficulties in using the term 'effort'. In addition, their method of measuring effort was much simpler than Patricia Bowers' assessment of effortless experiencing (P. Bowers, 1978). It would, of course, be most helpful if the same method of measuring effortless experiencing were used by different experimenters.

In regard to the recently developed CIS (Wilson abd Barber, 1978) the most serious problem is its apparently relatively low correlation with hypnotizability (at least as measured by the HGSHS: A) (McConkey et al., 1979). However, the Stanford data, referred to in Hilgard et al. (1981) accounted for more than twice as much hypnotizability variance as did the Queensland data and, as suggested above, the SHSS: C may prove to be more highly correlated with CIS because of the greater preponderance of cognitive items.

Much more research needs to be undertaken in determining if and how hypnotic procedures could be used in maximizing creative performance. While a great deal of research supports the relationship between cognitive (especially imaginative) factors and hypnosis, more needs to be done in providing the necessary support for a cognitive theory of hypnosis.

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# CLINICAL HYPNOSIS: A DESCRIPTION OF SOME USES OF HYPNOSIS IN BOTH BEHAVIOR MODIFICATION AND PSYCHOTHERAPY

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This paper is a personal account of how I use hypnosis in my clinical work. As the title suggests, there is some conflict between clinicians who use hypnosis purely as an adjunct to behavior therapy and those who are interested in the therapeutic integration of hypnosis into contemporary psychotherapy. As a practising clinician I find the distinction unnecessary and only subscribe to it here as an aid to explanation.

I am aware that current research is casting doubt on some long held beliefs that hypnosis enhances relaxation and increases the vividness of visual imagery both of which have been claimed to be necessary features of treatment methods using imaginative techniques. My own experience suggests that the use of hypnosis saves time in achieving relaxation and more importantly saves time in completing a treatment program.

## BEHAVIOR MODIFICATION

I use hypnosis with all behavior modification techniques which use imagery as the pivot of behavioral change. The total list is formidable and I have selected three as examples: systematic desensitization; assertive training; and covert sensitization.

### Systematic Desensitization

This is the procedure most often associated with behavior modification. It is used to treat any condition involving anxiety reactions to situations or objects which the patient fears. The procedure consists of constructing a hierarchy of events arranged in a gradually ascending order of severity. The patient is then instructed to imagine themselves in the least anxiety arousing situation and is told to feel relaxed, confident and unafraid. This technique combines the use of reciprocal inhibition and the particular effectiveness of suggestion which hypnosis facilitates. I will say more about suggestion and hypnosis later. If this first attempt is not completely successful the patient is asked to indicate by signalling with a raised forefinger and is then instructed to stop imagining this scene. The patient is then given instructions to further the relaxation which may be augmented by the imagining of a previously arranged relief activity in which it is known that they will feel completely at ease. Once this is accomplished they are again instructed to imagine the first item, with the same suggestion of feeling relaxed, confident and free from anxiety. This process is repeated as often as necessary for the patient to feel that they can accomplish this act with ease when it is possible to move on to the second item on the hierarchy, and so on through the progressively more difficult items until the list is completed.

Object phobias can obviously be treated using this method as can feared situations such as public speaking or sitting examinations. Less obvious uses are in treating sexual dysfunction and obsessional and compulsive behaviors.

## Assertive Training

Patients frequently mention problems they are having with other people and such problems can usually be restructured in terms of situation-specific interpersonal anxiety. If the patient is unable to express feelings in a way which is satisfying to them as well as being socially effective, then assertive training can be useful. Examples might be refusing a request that the patient does not want to be coerced into complying with, putting forward their own point of view, making a complaint about defective goods or unsatisfactory service, or possibly in giving or receiving compliments.

Treatment involves the imaginal rehearsal of specific activities while feeling calm and confident. As with systematic desensitization, repetitive presentation is used until the patient is satisfied that they can imagine giving appropriate and direct expression of their feelings in the situation.

## Covert Sensitization

Cautela developed the technique known as covert sensitization which has been applied to the treatment of alcoholism, overeating, hair-pulling, the elimination of sadistic fantasies and other compulsive or addictive behaviors. The technique relies on the aversive quality of imagining nausea or other noxious feelings and sensations in contiguity with the high probability behavior. Hypnosis, in my opinion, is particularly effective in that the negative experience is reported as having greatly increased realism.

The method involves having the patients imagine a scene in which they are committing the act they wish to eliminate. They are told that they will experience the situation realistically and the scene is described in detail with reference to the use of as many of the senses as is appropriate. They are then instructed that as the act proceeds they will experience nausea or vomiting or possibly an increase in feelings of anxiety. The image is allowed to continue for some time at the discretion of the therapist who will often be assisted by the facial or bodily reactions of the patient. The patient is then told that they may reject the behavior and as they do the aversive feelings will immediately decline and become eliminated.

I have used this method with considerable success in some cases of obesity.

## Overview

Most clinicians using behavior modification methods will have incorporated a specific technique into an overall treatment program and this is also applicable when using hypnosis.

For example, in systematic desensitization, the covert program can be followed by in vivo experience, first in a controlled environment and then in life situations. In assertive training, the covert procedure could be followed by in vivo modelling or role playing. And in aversion therapy treatment of say, obesity, it might be combined with group treatment.

## Suggestion

Many years ago I used to deride suggestion as a therapeutic technique. I had read that Freud had rejected hypnosis and said that he gave up the suggestion technique and with it hypnosis because he despaired of making suggestion powerful and enduring enough to effect permanent cures (Klein, 1958).

Three things persuaded me to re-think my attitude. The first was an article in The Lancet, 3rd October, 1959, titled 'The Evaluation of Treatment of Warts by Hypnosis' by Sinclair-Gieben and Chalmers, where considerable success was claimed for the suggestion method. The second was an article in the British Journal of Psychiatry, October, 1968, by Marks, Gelder and Edwards, titled 'Hypnosis and desensitization for phobias: A controlled prospective trial.' The patients treated by hypnosis were simply told that their phobia would gradually disappear and that they would feel relaxed in the previously phobic situation. I was extremely surprised to find that the patients in the hypnosis group, while not improving as much as those in the systematic desensitization group, did in fact make considerable progress.

The third, and perhaps most important, was reading Hartland's book 'Medical and Dental Hypnosis' and being particularly impressed with his Ego-strengthening technique. He states that symptom removal will be most successful it it is preceded at each session by a sequence of simple psychotherapeutic suggestions designed to remove tension, anxiety and apprehension, and to gradually restore the patient's confidence in themselves and in their ability to cope with their problems. He indicates that particular attention should be paid to such significant factors as 'rhythm', 'repetition', the interpolation of appropriate 'pauses' and the 'stressing of certain important words and phrases.' Following this he gives a typical ego-strengthening routine which indicates to the patient that they will begin to feel a gradual change in their thoughts, feelings and actions as a result of the suggestions they are about to receive. He then proceeds to give the actual ego-strengthening suggestions which are intended to improve the patient's general condition, to strengthen their weaknesses, to increase their confidence and to allay their anxieties. He also points out that, provided the general principles are followed, the process can be shortened or adapted and specialised suggestions can be added in accordance with individual needs. The procedure may appear simplistic but I am convinced that it does have a beneficial effect and I use it myself as part of the treatment with a wide variety of cases.

## PSYCHOTHERAPY

I do not subscribe to the view that symptoms removed by behavioral methods will result in substitute symptoms occurring. Nevertheless, I have found, on occasions, that symptoms re-occur when treated either by behavioral methods or just by suggestion.

Many techniques have been developed to aid the therapist in understanding the factors which underlie the development and maintenance of psychosomatic illness and other symptoms of neurosis. They may also allow the patient to develop insight into their condition. Most of them imply some recognition of unconscious mental functioning but, in my opinion, this is not a necessary philosophical conviction for them to be useful in clinical practice. If preferred they can simply be thought of as a type of projective technique which allows useful information to be elicited.

I have chosen to describe three methods which I find particularly useful. I shall then proceed to consider how they might be usefully employed in therapy.

## Ideomotor Finger Signalling

When hypnotized the patient is instructed that it is the intention to develop a system of communication with the subconscious part of their mind. They are told that their subconscious mind will be able to respond to the questions of the therapist by indicating the answers yes or no. These answers are not to be given verbally but by physical movements which will be selected by the patient's subconscious mind. They are then told that their subconscious mind will first select a finger to represent the answer 'yes' and it will then cause this finger to lift involuntarily as a signal to the therapist. Once this has been accomplished a different finger is to be selected for the answer 'no'. If thought necessary further fingers can be chosen to represent the answers 'I don't know' or 'I do know but I am not prepared to release this information just now'.

This method can save a great deal of time and effort in bringing repressed material into awareness. It can at times cause a great deal of amazement to the patient who will either at the time or later sometimes exclaim that the answers given are in direct contradiction to the answers they would have consciously volunteered. Some patients will dissociate the hand during this technique and are not aware of any movement of their fingers.

Once ideomotor finger signalling has been developed we need to consider what questions to ask. I will consider this later but just mention here the problem of semantics. A question must be clear as to its meaning and you should avoid using idioms. I remember treating a young woman and the history suggested some psychosexual problem. Acting on this assumption I asked if the problem involved sex and got a yes answer. I then spent some considerable time trying to find out more until I eventually realized I was on a false trail. In fact, the sex indicated by the ideomotor finger signalling referred to sexual discrimination at work and involved the promotion of a male colleague who was both less qualified and less experienced than she was.

## Age Regression

The use of this technique will depend very much on the orientation of the therapist. It may be used as a convenient way of ascertaining information about the patient's past history; or it may be used by the more psychodynamically interested therapist to abreact deeply repressed material.

It can be a useful tool when looking at the onset of a phobic condition, for while the uncovering of a traumatic incident which started the condition will not produce immediate relief from it, the fact that the patient is able to accept that their behavior is a learned response can act as a powerful motivating force in their treatment program. I have also found it useful in conditions such as psoriasis, asthma and stridor especially when the patient can put an approximate date on the onset of the condition. Regression to this time sometimes allows the expression of strong emotions present at the time to be vented and understood. If the patient can be taught satisfactory methods of dealing with the situation which is often still ongoing, it can be extremely helpful in relieving the symptoms.

## Induced Hallucinations

Repressed material can often be revealed by suggesting positive hallucinations wherein the patient in hypnosis visualizes their underlying problems on a television or on a theatre stage or by looking into a crystal ball. Here time must be spent in 'setting the stage' as it were. If they are to watch a theatre stage they are told to imagine the part of the theatre they are sitting in, to imagine the lights being lowered, the curtains being drawn. Then they are instructed to watch the play which will be directly relevant to their own problems.

Another method in this category which I personally favor is the Jigsaw technique. I tell the patient to imagine that they are sitting at a table and that I am placing by them four cardboard boxes, each of a different plain color, a red box, a blue box, a yellow box and a green box. Each box contains a special jig-saw puzzle which, when completed, will show a picture which will reveal to them the source of the stress which is causing them to experience their symptoms but which at the moment they are unaware of. I then ask them to select one of the boxes, to open it and empty the pieces of jig-saw onto the table, and then to proceed to fit the pieces together to make a picture. I then instruct them that when they have made the picture this will show the source of the stress and they can proceed to describe to me what the picture shows and what they understand from it.

## THERAPEUTIC APPLICATIONS

In now turning to more specific detail of how these techniques may be used I must acknowledge the book 'Clinical Hypnotherapy' by Cheek and Le Cron (1968) and, in particular, a chapter headed 'The Hypnotherapy of Psychosomatic Illness.'

They state that there are seven causative factors which might be termed keys to the genesis of these conditions. With these seven keys the door to the understanding of these ailments can be opened and insight gained by both patient and hypnotherapist.

## The Seven Keys

1. Conflict. Conflict is a situation where we want something or want to do something, but are prevented by our moral code or the taboos of society or other restrictions. There are many sources of conflict, one of the most common concerns sex. A conflict may originally be at a conscious level but later may be repressed and the person then is consciously unaware of it. While in hypnosis a patient can more easily talk of their conflicts and problems. And if the conflict is repressed, ideomotor signalling can often pin-point the problem. I usually begin by asking if there is some emotional reason why the patient has the symptom. If the ideomotor signal indicates 'yes' I proceed to check what the reason might be, or I might use ideomotor signalling to find at what age the conflict dates back to.

It never ceases to amaze me that a patient can strongly deny that they have any problems which could be responsible for their developing their symptomatology because, often, the conflict is of a relatively mundane nature although, of course, important to the patient. Common sense suggests that if the conflict were such as to cause intense guilt, or shame, or embarrassment, it would be acceptable that we might in some way push it out of our minds to avoid the discomfort that continual remembrance might bring. I find that often the conflict involves the patient making a choice between two equal unacceptable alternatives and, the choice being impossible, the situation seems to be squeezed out of consciousness.

Case example: A patient, aged forty, was referred to me after having been discharged from the coronary care unit. He had apparently suffered a collapse at work, the ambulance had been called and he had been admitted to hospital for investigation of chest pain and extremely irregular heartbeats. He had been monitored and investigated by the consultant who was able to tell him that he had no organic impairment at all, that his symptoms were entirely due to stress and that he would be advised to accept a referral to myself.

When he presented himself and I questioned him he denied that he was under any stress at all. Ideomotor finger signalling revealed that the stress was at work, the place where he had collapsed. Further investigations, some using the ideomotor signalling method, revealed the following information. He had an extremely well-paid job and was one of three senior managers in a manufacturing company. He had joined this company when he left school, had devoted his considerable talents to the company but had neglected to make much further academic progress. The two other senior managers were related to the managing director, looked on the company as a family business, considered him to be an interloper and tried to make life as difficult as possible for him. His personal life was normal. He was happily married and had four children, all of whom had grown accustomed to a high standard of living.

The conflict here was that he was extremely unhappy at work but if he resigned and looked for a different job, he would have had to take a huge drop in salary, a condition which he felt he could not impose on his family. Treatment involved assertive training and stress control techniques.

2. Motivation. Does the symptom serve some purpose? Is there a secondary gain? A simple motive would be if the ailment or symptom gained sympathy or attention. A motive in hysterical blindness or blepharospasm, for instance, could be that the condition prevents the person from seeing something unpleasant or could serve as a punishment for having seen something about which they feel guilty.

The motive behind a symptom is frequently defensive, the condition acting as a protection. An example would be migraine headaches which are used as a defence against unacceptable feelings of hostility and aggression, emotions which almost invariably are found in migraine patients.

Motivations are sometimes deeply hidden but can often be located with the questioning technique. Often insight alone is enough to overcome the condition.

Case Example: A woman was referred suffering from agoraphobia. Initially I did not use hypnosis but started her on a straightforward behavior modification program. This brought some initial improvement but she then reached a stage where this improvement ceased and I began to use hypnosis to find out the reason for this.

Investigation revealed that when the agoraphobia started, her husband had been having an extra-marital affair and she became very anxious that he was going to leave her. She became severely debilitated and the husband felt that he could not be so selfish as to leave her while she was apparently so ill. The motivation thus became clear; she could not recover from the anxiety state and agoraphobia because this would provide the opportunity for her husband to leave her.

Further investigation revealed that her husband's infidelity was brought about through her own sexual dysfunction. Treatment was provided for this in which hypnosis was combined with a behavioral approach and when this was successful the anxiety quickly resolved.

3. Identification. Children tend to identify with a parent and often try to copy appearance, behavior or mannerisms. Obesity is a case in point. Often the obese patient will say that one of their parents is greatly overweight. There may be some hereditary tendency for obesity but, certainly, identification plays a role.

This is certainly true in one particular case of a patient in an Obesity Group which I currently hold weekly.

4. Masochism. Self-punishment due to strong guilt feelings is a very common form of unconsciously damaging behavior. Extreme masochism can bring suicide or fatal illness. The alcoholic frequently uses his or her drinking as a means of self-destruction. The accident prone individual can be considered to be self-punishing. The housewife who frequently cuts or burns herself can be punishing herself.

In painful psychosomatic diseases, masochism frequently will be a factor in the genesis. It can be uncovered by questioning in such conditions as migraine, chronic headache of other types, in dysmenorrhea, neuralgias and other painful conditions. When self-punishment is located as a cause, insight is not usually sufficient to end the symptoms. The reason for guilt feelings must be explored. These often center on sex, though many other reasons for guilt can be present. The therapist needs to reassure the patient and have them understand that their feelings of guilt are unwarranted.

Case example: Guilt was the underlying emotion in the case of a woman referred suffering from dysmenorrhea. Investigation revealed that the guilt related to just one incident which occurred when she was aged five. Apparently she had a birthday party and her favorite uncle was unable to attend because of illness so she had sent him a piece of her birthday cake. The next morning her aunt came to tell them that her uncle had died late the previous evening and remarked that he had eaten the birthday cake just before he died. Somehow she got the idea that it was the cake which killed him and that she must be responsible for his death.

I have used this example to show that sometimes the guilt can be caused by something which to the adult mind can be trivial or due to a misunderstanding but can nonetheless have extremely severe and long-lasting effects. In such cases it can be removed relatively simply.

In other cases, where there has been some obvious avoidance of responsibility, perhaps due to fear of illness or hospitals, it is much more difficult to persuade the person that the punishment they have already suffered more than compensates for any neglect that they perpetrated. I am thinking here of a case of a woman whose mother had been put into the care of an old-people's home by her four adult children, one of whom was my patient. The woman had visited once only and had then felt incapable of going again because of the distress she had felt there. Later the old lady died. She had then been the recipient of several anonymous letters accusing her of terrible neglect and lack of concern for her mother which had resulted in a severe state of anxiety and depression and, of course, intense guilt feelings.

5. Imprints. An imprint can be said to be an idea which has become fixed in the unconscious part of the mind. They usually occur when the patient is in an emotional state and the statement is always made by an influential person. Such a statement may be made by a doctor along the lines of "You'll never get over this" or "You'll have to learn to live with it."

Case example: Rather than give an example from my own experience, I am going to use one given by Cheek and Le Cron as it beautifully illustrates the investigative method.

It concerns a middle-aged woman with a cough which had plagued her as long as she could remember. Every few moments she would have a bout of coughing. She said no treatment had ever helped her. Some explanations were made as to imprints, identifications and other possible factors which might be present as causes. Then questions were asked.

Q. Is there some emotional or psychological reason why you have this cough.
A. Yes.
Q. Does the cough serve some purpose?
A. No.
Q. Are you identifying with someone who, in your childhood, had a similar cough.
A. No.
Q. Is organ language involved? Are you trying to cough up something, some idea or memory which is unpleasant, trying to get something out of your system?
A. No.
Q. Is there a fixed idea working in your inner mind that makes you cough?
A. Yes.
Q. Is there more than one idea involved?
A. No.
Q. Is that the only reason why you cough?
A. Yes.
Q. An imprint or idea has to have an origin. Is there some past experience where this fixed idea developed?
A. Yes.
Q. Is there more than one such incident?
A. No.
Q. Let's find out when it happened. You've had the cough for many years, ever since you can remember. Did this past experience take place before you were ten years old?
A. Yes.
Q. Was it before you were five years old?
A. Yes.
Q. Was it before three?
A. No.
Q. Was it when you were three?
A. No.
Q. Was it when you were four?
A. Yes.
Q. Is the cough associated with some illness?
A. Yes.

The patient then verbally volunteered that she had had a bad case of whooping cough at that age and had nearly died from complications.

Q. Was this whooping cough the experience we are trying to locate?
A. Yes.

Q. Did someone say something at that time that set up this imprint or fixed idea?
A. Yes.
Q. Was it one of your parents?
A. No.
Q. Was it a doctor?
A. Yes.

The patient was then regressed to four years old, to the time she was ill with the whooping cough. She related that she was in bed and her mother and father were standing by the bed. The doctor was also there. Her mother was crying and the physician was saying to them, "She'll never get over this." She heard and was frightened.

Here was her imprint. The physician represented authority. While still in hypnosis it was pointed out to her that she had recovered from the illness but the cough was a major part of it. With this imprint in force her inner mind had carried out the idea, causing her to retain the cough. She was then questioned further.

Q. Now that you see why you have continued to cough and since you really did get over the illness, do you think that this false idea the doctor planted need continue to affect you?
A. No.
Q. Can you now be free of the cough permanently?
A. Yes.

A checkup with her some weeks later showed that she had not coughed again after this one session.

6. Organ language. An interesting source of physical difficulty at times is what has been termed 'organ language' in psychology. It is based on sayings such as "He makes me sick," "I can't swallow that," "He is a pain in the neck," "He is a real headache," "I can't stand the sight of him."

Treatment would start as before by asking for ideomotor signalling to the question "Is there some emotional or psychological reason why you have this symptom?"

Case example: A middle-aged woman was referred to me suffering from stridor. Investigation revealed that she was 'choking with rage' because none of her siblings would help her to look after her ailing mother.

7. Past experiences. These are usually traumatic and can lead to the development of many conditions. When the past experience is located, the patient can be regressed to the time. Much emotion may be involved. Repeated regressions to the experience may succeed in removing the emotion and the patient may then look back on it with regret but no longer be upset by it. In some cases this does bring relief from the symptom but in my experience, in many cases it does not.

It may still be worth doing as it does educate the patient to the knowledge that the symptom began or was learnt at this point and that subsequent avoidance responses have maintained or increased it.

Case example: A young woman of twenty was referred to me suffering from a bird phobia which she had had as long as she could remember. Using hypnosis I found that the problem began before she was two. Regression indicated that her parents had decorated her bedroom using wallpaper with lots of birds on it and she reported that all the birds were looking down at her with piercing eyes and she felt very frightened. Subsequent regressions seemed to reduce the emotion that she experienced to this event but did not have any effect on the phobia.

I then proceeded to use a covert systematic desensitization program which appeared to allow considerable progress in that I was able to work completely through the hierarchy successfully so that she was able to imagine every item without experiencing any anxiety. Unfortunately, this method also did not bring about any reduction in the fear she experienced when in proximity to a live bird.

I have used this example to remind me to inform you that a covert systematic desensitization program is not invariably successful in that the patient may eventually report freedom from anxiety when imagining the top item on the hierarchy but still report little or no improvement in the anxiety aroused by the live situation. Treatment then has to proceed by working through a hierarchy in vivo. This obviously involves a great deal more time and difficulty. In this case the patient did successfully overcome her fear of birds and this was maintained after a lengthy follow-up.

## CONCLUSION

It has been my intention to convey to you that hypnosis is not in itself a therapy, but can be used to facilitate a therapeutic strategy. It is not a panacea and failure can be experienced as with any form of therapy. I am, however, convinced that whatever success I have achieved as a therapist is in large measure due to the use of hypnosis as part of my treatment methods.

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# ANCHORING AND REFRAMING - AN AID TO THE TREATMENT OF PHOBIC DISORDERS

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Hypnosis, to many people, is a form of fringe medicine, even a form of magic. To some therapists it can convey a feeling of omnipotence, a feeling that they have the ability to change things in a direct fashion, taking away symptoms and miraculously curing the patient. However, to other therapists, myself included, hypnosis is an approach that one uses as a vehicle that enables you to uncover subconscious material responsible for illness, a vehicle that will enable you to convey psychotherapeutic techniques and approaches at a conscious and at a subconscious level.

A person may consciously want to get rid of their illness. However, their unconscious may be so strong that no matter how consciously aware they are of their life situation, no matter how hard they try or what medication they take, the illness is retained and they find themselves with their skin problem, a situational phobia, a migraine or some other psychosomatic or psychiatric type of illness. It would appear that these people have formed and developed fixed frames of reference to what they see or hear or have thoughts about, so that they automatically always react in the same way, in the same pattern to the same type of situation. One learns and develops the habit of putting one's foot on the footbrake when one sees a red light. Learning and experience teach us patterns of behavior and feeling and these patterns then occur automatically; they have been learned and once learned the unconscious will automatically give the appropriate response without a conscious effort of the individual.

In many circumstances these patterns of behavior and feeling are satisfactory and enable us to deal adequately with our life situation. In other circumstances these learnings and experience lead to poor patterns of response, poor attitudes and feelings. So that, an illness develops; it may be a phobic disorder, a behavior disorder or some other type of psychiatric or psychosomatic illness. In many cases of agoraphobia one finds that the panic feeling or behavior has been learned as a result of a severe traumatic or even maybe a mild experience (The Nucleating Situation). Yet while many of us have very traumatic experiences, most of us do not develop agoraphobia. The thought occurs to me that it is possible that those of us who do develop this illness may develop it as a result of going into "shock and bewilderment" at the experience, so that we have an "altered state of attention" as in an hypnotic trance, and thus learn altered behavior patterns in feelings which then occur spontaneously every time we are in the same sort of situation which was associated with the nucleating incident. The patient has now learned to experience panic and bad feelings automatically when he or she sees those same situations. In actual fact, instead of just reacting to the original problem which caused the panic, they now react to the 'associated' situation they were in when they had the original panic feeling. Rather like the dog in Pavlov's experiment which now salivates every time it hears the bell and it does this automatically even though there is no food presented. The bell has become an associated signal the dog reacts to, just as the "bus" or "being away from home" is the associated signal for the agoraphobic to react to, even though the original problem is no longer a problem.

Quite often, the giving of insight and behaviour therapy in imagination (in trance) and in actual fact, together with ego-strengthening and deconditioning to anxiety will eventually overcome the behavior pattern and will enable the patient to learn new ways of response. However, success seems to take quite a long time on average and I have found that it may be about eighteen months before one can terminate therapy. In the last few years, as a result of taking an interest in Milton Erickson's techniques and teachings and attending the workshops of Carter and Gilligan in the U.S.A., and as a result of reading Leslie Cameron-Bandler's book called "They Lived Happily Ever After", I have learned to use the 'quick method' they describe of dealing with certain psychosomatic and phobic disorders and other behavior disorders. Many workers in the United States are now using these methods and we in England are starting to learn the techniques.

Erickson himself has taught us many ways of communicating with the patient at a <u>subconscious</u> level so that the patient is <u>not aware</u> and does <u>not gain insight</u>, notably by his use of metaphor, benevolent ordeal and the double bind, as well as by use of humor and puns. And one can teach the patient to automatically, <u>without being consciously aware</u>, respond in a better and more strong and resourceful way to the situations which trigger off their illness. Thus, these situations no longer trigger off panic feelings, but feelings of safety and security. These situations no longer trigger off maladaptive forms of behavior, but can lead to more normal behavior. Indeed triggers no longer trigger off anxiety, but have become "anchors" for the person to have feelings of security and well-being and confidence.

## Anchoring and Reframing Technique

This technique is very well described in Leslie Cameron-Bandler's book "They Lived Happily Ever After." The therapist sits opposite the patient; he or she is then in a position to hear and to observe any body language and to watch for eye movements. The therapist asks the patient to access a memory of a particular time in his or her life when he or she was happy, content or loved, cared for or had a feeling of security, a feeling of confidence (whatever resources are appropriate for the patient to have in context with the illness). The patient can choose whether this was an early memory of their childhood or a more recent event, any time in fact in their life, and one particular memory. If this is a very private memory or occasion they need not even talk about it. If he or she cannot remember any such incident in his or her life (and this is occasionally so), they can choose a situation in the future that they would find pleasurable, safe and secure.

The patient is encouraged to <u>visually</u> remember the incident - how they were dressed, the other people who were taking part in the situation and the activity that was going on that gave them the feeling of security and pleasure. Close observation of the client's eye movements, facial expression, smoothing of the muscles of his face, the client's smile or the verbal information that the client gives you - the nodding of his head -

will give the therapist the information that the client is actively involved in accessing the situation. The client can even be asked, not only to picture the situation, but to feel and to picture themselves as if they were actually taking part in the situation at this moment, as if it was actually happening now. The client is then asked to remember any sounds associated with the remembered incident, whether it is the gist of the conversation or how things were said, any associated noises or absence of noises that can be associated with the remembrance of the incident.

Finally, the client is asked to remember the feeling, all of the good feelings that occurred in the situation - the feeling of pleasure or comfort or security that was associated with that incident. One can also ask the client to enhance the intensity of that feeling, as you count from one to five, to intensify the feeling more and more as you count. To imagine and to feel as if the incident was happening right now. The client is encouraged to remember the feelings by the tone and quality of the therapist's voice and the client can be seen to be accessing by the tone of their own voice and their facial expression. As the client is showing that he or she is really intensely reliving the experience or the event, the therapist anchors the feeling by just touching or pressing or holding the client's wrist (Figure 1). The therapist has only to touch the client in the exact same way in the future for the client to have the same feelings again. An the client can be shown how to use this positive anchor him or herself in order to decrease their feelings of tension and to deal with the situation in a more adequate manner.

Fig. 1

The patient is then asked to access a situation in which he or she feels tense or upset or frightened and the same procedure of accessing this situation visually, auditorally and kinesthetically, is gone through. At the moment of most intense response, which can be seen by the change in the client's voice, their facial and body movements and their breathing, the therapist touches the patient, say on the shoulder or the knee, and anchors the negative feeling (Figure 2).

Fig. 2

The patient is asked to evaluate on a scale from 1 to 10 the degree of bad feelings experienced in the remembered situations. In the next stage of reframing, the client is asked to go through the negative experience in the same manner, but this time the therapist holds the positive anchor all the time. The client will then notice that there has been a decrease in the feelings of tension experienced and will be able to evaluate this on a scale from 1 to 10. He or she will then be able to practise this themselves. Obviously, the use of this reframing technique can be used in other situations (e.g. psychosomatic disorders, obsessional illness, stammering, sexual problems) as one becomes more adept at using this method.

In situations where there are deep and severe traumatic events underlying the unwanted feeling or behavior, it may be necessary to use the Visual, Kinesthetic and Dissociation technique. This technique is also described by Leslie Cameron-Bandler in her book "They Liver Happily Ever After" and was evolved by Bandler, Grinder, De Lozier and Leslie Cameron-Bandler herself. For a more detailed account of the technique the reader is recommended to Leslie Cameron-Bandler's book. For the purpose of this paper I summarize the steps as follows:-

1) Establish an anchor for comfort, as previously described, and have the client sitting in front of you. Use this anchor during the whole of this therapy.
2) Have the client visualize themselves as they were maybe two or three years before the traumatic incident took place.
3) When they can see themselves clearly have them dissociate themselves by floating out of their body and standing behind their chair looking at themselves sitting in the chair in which they are watching that picture of their younger self. Anchor this dissociation by, for example, holding their elbow with your other hand (Figure 3).
4) Inform the client that the picture will become a moving picture and they will see themselves go through the traumatic event. When it is all over they should inform you by either nodding their head or saying "I've seen it."
5) Ask the client to go back inside their body. Remove the dissociation anchor. Then have the client go up to their younger self and "taking all the time in the world" comfort their younger self, telling them that they are the only person in the world who knows just how much they have suffered, what they went through - and that the same thing

Fig. 3

will never happen again. And when they are comforted to both their satisfaction and their younger self's satisfaction, they should let you know by nodding their head or saying 'Yes.' If there are any problems in comforting their younger self you can deal with these before continuing with the next phase of the exercise.

6) When they have fully comforted their younger self, ask them to integrate their younger self back into their body, "he (she) is your younger self, he (she) is part of you." You can then remove the positive anchor and ask the client how he or she feels. The client often will have a smile, will look relieved and say that they feel "so much better."

Mrs R.G. had anxiety state symptoms following her inability to get on with a colleague at work. The colleague would not even talk to her and was quite obstructive in her manner. When the colleague was on holiday for a week, Mrs. R.G. was fine, but on her return she became so ill that she could not go to work or even go local shopping. After three sessions using a simple anchoring technique together with ego strengthening and deconditioning to anxiety, she was enabled to get back to work and her anxiety symptoms were considerably diminished.

Mr. W.T., a West Indian, had an affair outside of his marriage 20 years ago. Since the break-up of this affair he had feelings of guilt and an inability to communicate with his family or his wife; moreover, he had feelings of unreality, he used to "talk to people" but felt that "he had not talked," he saw them yet he felt he had not. He was given a simple anchoring technique, anchoring him to the feeling that he had had, of confidence and ability to communicate and care, when he first met and courted his wife and was able to communicate with her. He was also given an anchoring, reframing and dissociation approach. Both these approaches alleviated his symptoms tremendously and enabled him to start communicating with his wife. Therapy is still proceeding.

Mrs Y. could not wear a seat belt and had obtained a special exemption certificate. Putting on a seat belt automatically caused her to have terrible feelings of panic and inability to breathe properly. She abreacted to her earlier marriage situation many years before when the same sensation was suffered each time her husband "lay on top of her." There was rapid improvement and ability to wear the seat belt following abreaction under hypnosis, ego strengthening and the use of a simple anchoring technique.

Mr B. had an inability to visit the doctor in case a severe illness was discovered; he could not tolerate even an ordinary examination or having his blood pressure taken. The sensitizing situation seemed to be the behavior and example given by his mother during his childhood years. He rapidly improved with a simple anchoring technique, ego strengthening and deconditioning to anxiety.

Since my learning of the Anchoring, Reframing and Dissociation Technique from my American colleagues and reading some of the literature concerning this approach, I have adapted the approach to a variety of patient problems and I have found that therapy has been made a lot easier and quicker.

It is hoped that this brief description of anchoring techniques will encourage therapists in this country to use these methods and to make a more detailed study of the American literature.

## REFERENCE

Cameron-Bandler, L., 1978, "They Lived Happily Ever After," Meta Publications, California.

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