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Counselling Psychology Review

Counselling Psychology Review is the Division of Counselling Psychology's quarterly peer-reviewed research publication. It brings together high quality research pertinent to the work of counselling psychologists. It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

- papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
- case studies, provided these are presented within a research frame;
- theoretical papers, provided that these provide original insights that are rigorously based in the empirical and/or theoretical literature;
- systematic review articles;
- Methodological papers related to the work of counselling psychologists.

For more information about the peer review process for this publication please contact the Editor.

Notes for Contributors

1. Length:

Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:

- The front page (which will be removed prior to anonymous review) should give the author(s)'s name, current professional/training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
- Apart from the front page, the document should be free of information identifying the author(s).
- Authors should follow the Society's guidelines for the use of non-sexist language and all references must be presented in the Society's style, which is similar to APA style (the *Style Guide*, available from the Society, or downloadable from www.bps.org.uk/publications/submission-guidelines/).
- For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.
- Approximately five keywords should be provided for each paper.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc., for which they do not own copyright.
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- Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add 'CPR Submission' in the e-mail subject bar. Please expect an e-mail acknowledgment of your submission.
- Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.

3. Submissions and enquiries should be e-mailed to:

Dr Terry Hanley. E-mail: terry.hanley@manchester.ac.uk

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14–16 July, Thistle Grand Hotel, Bristol

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CALL FOR SUBMISSIONS – DEADLINE 23 FEBRUARY

Keynote Speakers

Professor John McLeod, *University of Abertay, Dundee*
Professor Carla Willig, *City University, London*
Dr Jeremy Holmes, *Psychoanalytic Psychotherapist*

Public Lecture Speaker

Dr Richard House, *Roehampton University*

Pre-conference Workshop Day

Patricia d'Ardenne *on Trauma Counselling; New Directions for A World on the Move*
Elena Manafi *on The Necessity of an Existential Attitude in a Pluralistic World*
Mick Cooper *on Developing Pluralistic Practice*

For full details including how to make a submission, please visit

www.bps.org.uk/dcop2011

Editorial: Ramblings of a dogmatic pluralist?

Terry Hanley

AS I write this editorial there is snow on the Mancunian ground outside of the window. By the time it reaches you it will most probably be Springtime of 2011. Those of you who have course reading material piling up, or just through an over excited festive shopping spree in the local book store, may only get to this in the summer. Some of you, I am sad to say, will never read it at all (these people literally do not know what they are missing). This contribution, therefore, already has multiple contexts that will potentially impact upon the way that you, the reader, perceive and make sense of it. Furthermore, the nature of the context in which this is read does not even scratch the surface of the multitude of individual differences that shape the lenses through which we each view the world. Such subjective vantage points are likely to lead to a variety of responses to each paper presented and it is the plurality of possible interpretations that act as the focus of my warm up act for the main event of the papers which follow in this issue.

The Division Annual Conference 2011, in Bristol from 14–16 July, is entitled 'Celebrating Pluralism in Counselling Psychology? (more information can be found on the Society website). Therefore the notion of 'pluralism' is developing interest in the world of counselling psychology, but what does it really mean? Rescher (1993) provides a useful beginning point by noting that pluralism is the belief that 'any substantial question admits of a variety of plausible but mutually conflicting responses' (p.79). Thus, the view that there is one mutually exclusive response to a problem is open to challenge and, from this position, it could be argued that one size fits all approaches to therapy or research are unlikely to ever be appropriate. Such sentiments fit well with my present conceptualisation of the world and are a major reason for my decision to become a counselling psychologist.

Here, as I have brought myself into the equation, I feel the need to stop briefly to clarify my pluralist positioning. Although I warm to the view that there are a multitude of responses to significant questions, personally I do so within some rather conventional parameters. Richard Dawkins playfully challenges social scientists' convictions towards some extreme pluralist viewpoints by confronting them with gravity:

> 'Show me a cultural relativist at 30,000 feet and I'll show you a hypocrite … If you are flying to an international congress of anthropologists or literary critics, the reason you will probably get there, the reason you don't plummet into a ploughed field, is that a lot of Western scientifically trained engineers have got their sums right.' (Dawkins, 1995, p.17)

Now I am pretty sure that I cannot fly by my own means and do not have any wish or desire to test the alternative to this viewpoint. Thus, without doubt there are times when I would shirk the view that there are a multitude of possible responses to pragmatically acknowledge that some responses are more useful than others in certain situations (maybe I'm not a dogmatic pluralist after all). However, I would question the notion that psychological interventions are ever an exact science, and with that in mind I continue.

In returning to the world of pluralism and counselling psychology I reflect upon the value that the profession places upon the intersubjective experiences and the collaborative nature of therapy (e.g. see BPS, 2010). Such an emphasis often helps to situate counselling psychology within a humanistic frame that challenges medical model conceptualisations of psychological

difficulties/problems with living (e.g. Woolfe, 1990; Strawbridge & Woolfe, 2010). Thus, there is a core identity perpetuated by training programmes and supported by the Division of Counselling Psychology in the UK that could be perceived as pluralist in nature. Could such a way of thinking provide a means for negotiating the numerous conflicting philosophical foundations to research methodologies and psychological theories that we often encounter?

Despite the optimistic sentiment suggested in the question posed above, it could be claimed that the notion of a pluralistic approach to counselling psychology has remained a minority sport. This proves an almost understandable occurrence as it is difficult to conceptualise such a stance without a substantial body of literature behind it. Historically, integrative frameworks have been created and eclectic methods have been bolted together (see Hollanders [2003] for a useful discussion on this) but to date there has been little explicit focus upon pluralism as major influencing/ underpinning factor itself. The focus of this year's DCoP conference, alongside the recent publication of a new text by Professors Mick Cooper and John McLeod (2011), *Pluralistic Counselling and Psychotherapy*, therefore places such a stance firmly on the therapeutic map. For those interested in following this up I would heartedly recommend the book and do not miss the conference keynote presentations. Professor McLeod will be introducing 'Pluralism as concept and ethical standpoint: implications for counselling psychology' and Professor Carla Willig will present 'What makes a 'good' interpretation? Pluralism, ethics and the search for meaning'.

In bringing the idea of pluralism back to research, it is worth noting that *Counselling Psychology Review* has a pluralist view of research. As is evident in the pages that follow, research that inhabits and represents different world views is presented. Therefore, the primary concern of the publication is to publish excellent research that is useful to counselling psychologists. Once again I should note the rather conventional parameters to my thinking here (I really do not wish to be pushed out of a plane by Richard Dawkins) as, in stating that the publication has a pluralist outlook, I do not mean that anything goes and everything goes into the review. Whether the work is qualitative, quantitative or mixed methods in nature there are models of good practice that should be followed unless good reason is provided to the contrary. Those who undertake peer reviews for the publication therefore assess submissions with such criteria in mind and are encouraged to be formative in their feedback (see Hanley, 2010 for an overview of guidance for reviewers). After all, one person's acceptance for publication may be another's rejection – although it should be noted that the reviewers for this publication often come to similar conclusions.

For the continued support of the individuals who undertake reviews for *Counselling Psychology Review* I am very grateful as this provides the basis for the quality of its content. In addition to all of those from the Editorial Board who have supported these activities, I would like to thank Dr Clare Lennie, Matt Shorrock and Dr Tony Ward for their work during 2010. Finally, I would also like to thank all of the authors who have taken the time to contribute and would like to take this opportunity to invite individuals to contribute to future editions.

Overview of this edition

On to more concrete and less meandering thoughts – what is in this edition? There are four major components to it.

First, there are details of four DCoP awards in 2011. More details about all of these awards can be found on the Division's web pages (www.bps.org.uk/dcop). I would encourage you all to consider taking part in one or other of them.

The next section consists of three original research papers. The first by Dr Peter Martin reflects upon the histories that people might bring to a therapeutic career. This exploration of the phenomenon of the wounded

healer utilises a heuristic research methodology and reports the potential implications of owning and embracing one's own experiences within the therapy room. The second paper, by Marina Skourteli and Dr Clare Lennie, uses a mix of quantitative and qualitative methods to examine the therapeutic relationship from an attachment theory perspective. This raises some thought provoking questions about how past/current relationships may manifest in therapeutic encounters. The third and final research paper, produced by Dzintra Stalmeisters and Professor Chris Brannigan, enters into quantitative waters. It explores the prevalence of early maladaptive schemas in a small sample of people with Myalgic Encephalo-myelitis/ Chronic Fatigue Syndrome when compared to a group of individuals from the broader population. The paper raises some interesting practical suggestions for working with this client group and future research.

Then come three theoretical papers addressing cutting-edge issues relevant to the world of counselling psychology. The first is by Dr Lewis Blair (a familiar figure from the last issue as the winner of the Trainee Prize 2010) and focuses upon ecopsychology. In particular this paper reflects upon the way in which ecopsychology overlaps with the person centred approach to therapy and provides a discussion of an interesting arena for counselling psychologists to potentially diversify into. The second paper, by Clare O'Brien, explores the literature regarding pathological gambling and its link to depression. As this becomes more commonplace in society it will be a useful paper for individuals encountering clients with such complexities in their lives. The third paper in this series, by Lisa Corbett and Dr Martin Milton, examines the potential of existential therapy, providing a useful approach to working with trauma. It reviews the literature and provides an overview of how such contributions might prove helpful to the work of counselling psychologists.

The final section of this edition introduces the book review pages on the Division's website. This is a trial contribution to *Counselling Psychology Review* and one that will hopefully point readers to the developing online resource. It includes an introduction to the purpose of reviews by Caroline Knott and a book review by Isabel Gibbard which I hope you will find useful in showing the type of contribution that you will find on the website. If this proves popular it will be something I will look to develop in future, so do feel free to drop me a line with feedback.

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References

British Psychological Society (2010). *Standards for Doctoral Programmes in Counselling Psychology.* Leicester: BPS.

Cooper, M. & McLeod, J. (2011). *Pluralistic counselling and psychotherapy.* London: Sage.

Dawkins, R. (1995). *River out of Eden: A Darwinian view of life.* New York: Basic Books.

Hanley, T. (2010). *Counselling Psychology Review*: Information about the review process. *Counselling Psychology Review, 25*(4), 74–77.

Hollanders, H. (2003). The eclectic and integrative approach. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.277–300). London: Sage.

Rescher, N. (1993). *Pluralism: Against the demand for consensus.* Oxford: Oxford University Press.

Strawbridge, S. & Woolfe, R. (2010). Counselling Psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, Douglas, B. & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp.3–22). London: Sage.

Woolfe, R. (1990). Counselling psychology in Britain: An idea whose time has come. *The Psychologist, 3*(12), 531–535.

DCoP Excellence in Research Prize

Closing date: Friday 13 May 2011

THE Division of Counselling Psychology is pleased to announce the Excellence in Research Prize. This annual prize of £500 will be given in recognition of the importance of research in the development of field of counselling psychology. This is a reflection of the Division's commitment to promoting research of international excellence and given with the intention to stimulate high-quality psychological research and dissemination.

The Excellence in Research Prize will be awarded to an individual submitting an unpublished research paper that has a direct application to the practice of counselling psychology (max. 7000 words – including references). Submissions will be due by Friday 13 May 2011, with the recipient announced at the Division's AGM. A condition of accepting the prize is that the recipient must agree to make appropriate amendments to the paper and submit it for publication in *Counselling Psychology Review*. The candidate (first author) must be the individual primarily responsible for the project described in the report. Where relevant, any co-authors of the report (for example, a research supervisor) must confirm the above in writing. The Excellence in Research Prize will be presented to the first author of the report only. The names of co-authors may be mentioned on the submission and in any future publication.

Once the deadline for submissions has passed, each submission will be circulated to three evaluators. The evaluator's decision on the successful candidate will be final. An individual may submit one entry per year.

Submissions should include the following:

1. Proposal covering letter (stating title of paper, lead researcher, co-authors, lead researcher address, e-mail and telephone). You should also offer proof of dissemination and/or plan of dissemination of research findings.
2. Abstract: Include a 200- to 250-word abstract.
3. Body of paper: Should include sections for introduction, method, results/findings, discussion, conclusion and references. This should not exceed 7000 words including references.
4. Your paper should discuss the relevance and implications of the research for counselling psychology. Papers outside this format will not be considered.

Papers will be judged on the following criteria:

- Whether the paper adds significantly to the knowledge base of counselling psychology;
- Originality;
- Clearly making epistemological standpoint;
- Make use of relevant up-to-date literature (regarding subject matter and methodology);
- Research design clearly explained;
- Analysis clearly explained;
- Appropriate ethical considerations;
- Appropriate use of references.

Proposals should be submitted electronically to: DCoPawards@bps.org.uk

For additional information, please contact Dr Terry Hanley, Research Lead.
E-mail: terry.hanley@manchester.ac.uk

DCoP Trainee Counselling Psychologist Annual Prize 2011

Closing date: Friday 13 May 2011

THIS AWARD is designed to encourage excellence in the study of counselling psychology. The first prize winner will be awarded a prize of £300 with two runner-up prizes of £100.

Winners will be decided through a process of peer review.

To be eligible you must be currently training to be a counselling psychologist, or have completed training (via the accredited route or Society Qualification) within the preceding 12 months.

Your entry should be a piece of course work which has been assessed as part of your counselling psychology training.

- Trainees are allowed to edit work for submission to the Prize; this can include editing work to the required word length (5000-word maximum).
- Submission can be of any piece of course work except for research papers (which students are encouraged to submit to the research prize). This would include potentially case reports, theoretical essays, and literature reviews.

For judging criteria and further information, please consult the trainee prize information sheet, which is available on the DCoP website under the traininbg tab (www.bps.org.uk/dcop/training/the-trainee-prize/trainee-prize-2011.cfm).

Proposals should be submitted electronically to: DCoPawards@bps.org.uk. Prizes and certificates to be awarded at the Division's AGM in July 2011.

For further information please contact Dr Naomi Moller, Training Representative (naomi.moller@uwe.ac.uk).

DCoP Award for Distinctive Contribution to Counselling Psychology Practice

Closing date: Friday 13 May 2011

THIS new annual prize of £500 will be given in recognition of the importance of practice in the development of the field of counselling psychology. This is a reflection of the Division's commitment to promoting counselling psychology practice

The award is aimed at counselling psychologists who have made a distinctive contribution to professional practice, as interpreted in the criteria listed below. It is hoped that the award will be made every year but in the event of there being no suitable submissions, no award will be made.

The award is open to any current practitioner in any area of professional counselling psychology who is a full member of the Division. It is anticipated that those who submit will be employed or self-employed for the majority of their time as a practitioner counselling psychologist engaged in the delivery of a service to the public. The award will not be made to psychologists whose main area of work is within an academic department.

It is acknowledged that some members may be hesitant to put themselves forward for such an award, despite a strong contribution to practice. Where this is the case, the Committee would like to encourage you to discuss entry for the award with a colleague and to consider doing so if in discussion you are aware you might meet the criteria.

Submissions should include the following:

1. Proposal covering letter (stating nature of practice and the practitioners address, e-mail and telephone).
2. A narrative (1000 words maximum) highlighting the candidate's achievements and the grounds for proposing the candidate.
3. Full curriculum vitae.
4. The names and addresses of two potential referees, to include at least one work colleague of the candidate who may be an employer and not necessarily a psychologist.
5. If appropriate, relevant supporting documentary evidence (e.g. an account reported in the media of a professional unit for which the candidate is responsible) may be included.
6. Proposals should be submitted electronically to: DCoPawards@bps.org.uk by the closing date of Friday 13 May 2011. Once the deadline for submissions has passed, each submission will be circulated to three evaluators. The evaluators' decision on the successful candidate will be final. An individual may submit one entry per year.

The formal criteria for the award are limited to any 'distinctive contribution' to the practice of counselling psychology. It is intended that this criterion will be interpreted broadly and might include any of the following, by way of example.

- An innovative contribution to the development of what has proved to be an effective therapeutic technique.
- A major contribution towards developing a psychological service that has become a model for the delivery of professional services which others have followed.
- Leadership of an initiative which has resulted in policy relating to services.

The Counselling Psychology Division Committee will appoint an Award Panel to select the recipients of the Award. The panel will consider all submissions on the basis of:

- originality;
- implications for counselling psychology as a body of knowledge;
- implications for counselling psychology as an applied science;
- implications for the candidate's field of professional practice;
- implications for the welfare of the people being served;
- the personal contribution of the candidate within their field of expertise;
- the degree of difficulty overcome in achieving development within the field of expertise;
- overall evidence of achievement.

A commemorative certificate along with the £500 prize will be presented to the recipient at the 2011 Division of Counselling Psychology Conference to be held in Bristol on 14 to 16 July 2011.

DCoP Research Support Fund

Closing date: Friday 20 May 2011

THE Division is pleased to announce the creation of a new annual research award scheme to support full members of the Division (i.e. those who are Chartered) and registered with the Health Professions Council as a practitioner psychologist to undertake and disseminate practice-based research. During 2011 the total sponsorship is set at a maximum of £6,000 and this be will be spread across two or three projects of no more than £3,000 each (e.g. three projects costing £2,000 each or two projects costing £3,000). Final decisions about the allocation of funding will be taken in light of submissions received.

Applications for consideration in 2011 are now welcome using the application form available on the Division's website. The application should provide a clear outline of the research work to be undertaken or the dissemination activities that are being suggested. Additionally, the application should explicitly note the impact and timescales of the work. All proposals will be anonymously assessed by a minimum of three counselling psychologists and monitored by the Division Committee. Where a member of the Division Committee applies for this support fund, that member will not be involved in the assessment procedures for this award.

The assessment criteria for the award are as follows:

1. The applicant/s must be a full member of the Division (i.e. Chartered), registered with the Health Professions Council as a practitioner psychologist and must be a practicing counselling psychologist.
2. The applicant should be able to demonstrate competencies in an area of applied research through the research proposal.
3. The proposal must state explicitly the theoretical underpinnings of the work, the research questions or hypothesis under investigation and the methodology (including evaluation), with projected time-scale.
4. The research area identified must clearly relate sound psychological theory to a significant aspect of applied practice.
5. The research proposal must demonstrate direct potential benefit to the practice of counselling psychology in the UK.
6. The proposal must identify at least one avenue in which the work will be disseminated.

On completion of the project a minimum of one research paper regarding the work in question must be submitted to *Counselling Psychology Review*. Additionally, any publication or conference presentation which arises out of this work should acknowledge the funding provided by the Division.

Applicants should be aware that the award will be made to the successful applicants in two financial instalments. Up to the first 50 per cent of the award will be paid against submission of receipts in no more than two tranches, to support work in progress. The second 50 per cent of the award will be made on submission of relevant receipts once a paper has been accepted for peer review in *Counselling Psychology Review*. If the research project does not proceed other than for reasons demonstrably and in the sole view of the Division of Counselling Psychology Committee beyond the control of the researcher, stage payments of the award may need to be returned to the Division.

Please note that funding is not available for direct contribution to any course fees, nor for corporate bids.

Original Research Paper

Celebrating the wounded healer

Peter Martin

Aims: *For many therapists woundedness is a hidden secret. This deceit is sometimes masked as 'professionalism'. We need to unravel the mystique which we unawarely embrace, and examines the cost of this illusion. This paper unusually begins by discussing these issues which emanated from specific research. It is contended that we stand a better chance of making an authentic relationship with those we seek to help if we are prepared to celebrate our scarred, glorious, mis-shapenly successful, and often faulty selves for what we are.*
Method: *The heuristic research conducted by the author explores the lives of 17 self-selected therapists and how their own life crises affected their work with clients. The stance is phenomenological qualitative method which is an adaptation of Moustakas's (1990) protocol. The method used develops Moustakas's methodology, here privileging a co-constructed account of each co-researcher's (participant's) story.*
Findings: *The outcomes of this research were predictably idiosyncratic and this accords with the post-modernist stance of the researcher. There were commonalities too: many co-researchers found it was better to celebrate our shared but faulty humanity, while protecting our clients from the worst of our failings. Co-researchers indicated that the power and the peril of being more nakedly human is worth it.*
Implications for practice: *The research appears to make a case for the theory that life is the best teacher, if only we are prepared to learn. It challenges the reader to find within themselves something akin to the wisdom which can come only from the examined life.*

Keywords: *wounded-healer; heuristic research; professionalism; examined-life; breakdown; humanity.*

IN THIS PAPER I shall examine the concept of the wounded healer, discuss some of the assumptions and research that predicate it, describe my research and then look at the implications of this 'journey' in terms of the way we view professionalism. Unusually this paper is a reflection, the 'fruits' of research done some five years ago, so much of the discussion and repercussion comes first.

The wounded healer and the illusion of perfection of the human condition

Why would we want, as psychologists to admit to any kind of weakness? Why, above all, would we want to *celebrate* such a self-description? We could indeed consider the concept of the wounded healer a deficit model. In order to answer these questions, we need to turn to some basics about *who we are* and *what we are*. We need to ask ourselves if the achievement of the status of Chartered Psychologist really does transform us beyond the prosaic limitations of ordinary mortals; or is it a badge that says that, as ordinary mortals we try to do a job that will help other people a bit, and in so doing help ourselves to live meaningful, if short lives?

The reality of our common bonds

As psychologists, we share most phenomena with every other being born of women. We experience birth, life, death and *incompletion*. Not many people would deny the birth, life, death components but what about 'incompletion'? We live, as Freud says, 'to love and to work', but not usually, in my observation, to complete. In a spare moment, when feeling skittish on a Friday afternoon, write down the great statements that you would like to leave to posterity, to gasp to impatient waiting legatees surrounding your bed. Will it be 'I leave the world a better place', or 'Thanks to me, you no longer need to worry

about global warming?' What you are likely to *think* (as opposed to say) is 'I never did paint that gate' or 'I think the gas may be on a higher setting than it need be.' I remember my father when dying, poking his finger into the pattern on his knitted hospital bedcover – still trying to make sense – 'still crazy after all these years.' Perhaps we shall all be the same? Maybe birth, death and incompletion is the picture.

What does avoiding essential features of our humanity do to us all?

Why is avoidance dangerous; and why do we all need to lose some of our grandiosity, and start celebrating what we indeed are? It seems to me that whatever direction psychology has taken us, we get waylaid. We lose the vision. We forget that we, as professionals are simply participant observers. We live in competitive climate where the roots of learning and the excitement of psychology can easily be lost so every now and then we need to retrench and find ourselves again.

As clinicians and practitioners we forget that we are first of all *in relationship* with our clients, with our colleagues, our students and even with our organisation. As academics we forget that knowledge is about provisional truth, and make it, instead into a commodity. We neglect teaching, the oldest profession (even including that one – because she too is a teacher of a kind!), in favour of proving our credentials as researchers. Research is very important as a safeguard against complacency, and a way of moving forward. But acquiring new learning is essentially an act of humility not of commodification.

When we lose touch with what matters we become hubristic and competitive in a way that denies our selfhood, our community, and the enormous possibilities of living our lives powerfully. We find we cannot admit to a less than perfect model, to perfect service. We delude ourselves with grandiose vocabulary, with 'management-speak'. We proffer allegiance to foolishness such as the notion of 'total quality'. We edge our discourse around with phrases like 'ensuring' a service to this or that grouping. Somehow we strive to make ourselves safe, however vain that attempt is. We get to believe that insurance, safety assessments, targets, litigation, obsessional or compulsive religiosity is the substance of the lived life – we thus meekly embrace modernity as the now-happening version of eternal life.

When this mirage signally fails in the face of some disaster we say that 'lessons will be learned'. In fact they often are not learned because the priority of a crisis becomes crowded out with the obsessional detail meant to cure it. We invent another tick-list: supposedly the panacea for all ills. We lose courage and look for the safety of numbers. We lose ontological perspective. We convince ourselves that the only thing that matters is outcomes, and forget the basic context of all our lives mortality.

Our mortality and, therefore, our human condition as the touchstone for our professionalism

It is our lack of connection with our mortality which I claim deprives us of our true spirituality we lose sight of the *functionality* of our wound, and in the end of perspective which breeds compassion. The evidence is all around us that this life can sparkle, be ravishing in its bounty, and yet is also characterised by pain and suffering and finitude. Our lives are often touched or sometimes configured by one of these huge interventions by the universe in which we live. Yet we are urgently encouraged to 'return to normal' by our friends, by the media, and often by psychology itself. Attempts at prioritising one aspect of our humanness, happiness like Positive Psychology (Seligman, 1990) have their place, but can also be a potent form of holistic denial.

I am asking the important question: 'Just how valid are so-called "healthy defences" to a full engagement in a meaningful life?' Do we as psychologists join the rush to declare as 'normal' should-be-happy life when in truth this state is *exceptional*? When we return to

the anchors of birth, life and death and incompletion, we value what is possible. We then refuse to go into a cultural sulk about the failure of our environment to provide us with what is after all a mirage.

So how can a sense of our woundedness rescue us from superficiality? How can we be freed from a kind of ghost life dictated by the ubiquitous and unhelpful professionalisation of our humanness? Perhaps 'woundedness' is just another metaphor for our humanness? Yet it is a very potent metaphor. For we do indeed all know what it is like to feel pain associated with a physical wound. We know what it is like not to be able to do the things that we could do before, or that other people can do, and we can't. We know a lot about the frustrations associated with the limitations that we set upon ourselves in psychological, emotional, or relationship terms. We know, most of us, what it is like to live with the wound of fear, or of lack of courage, or of the sure knowledge that we have done another person some harm, and will do so again. Yet for most of us, most of the time, this awareness is a secret, something to be apologised for and quickly forgotten in favour of a quick return to so-called 'normal life'.

Embracing woundedness – a history of ideas

The therapist as an object of research

Wosket makes a convincing case for the use of self as a therapist although her concentration on impairment and boundary issues does not explore wider issues. Mackay (2004) is more specific and expands on the idea of what may happen to the therapist in spiritual terms and uses the motif of a 'passion narrative'. Rowan (1989) recognises that the wound needs attention and encourages therapists to continue with their own therapy after qualification, but this 'sacred cow' is questioned by Coupe (1999). Similarly Norcross and Prochaska (1986) challenge therapists to attend to their own restoration in 'Psychotherapist heal thyself'. Wilber (1991) claims that the psychoanalyst is worse off than her client in many cases of trauma because she is not able to use denial as effectively as a non-practitioner

What happens to therapists and their clients 'when the wheels come off'?

Fine (1980) reviews what he calls 'despair and depletion' in the therapist and its repercussions on client work. Bayne (1997) makes a general case for the 'survival' of the therapist, though the possible 'victim' assumption begs several questions. Coltart (1992) emphasises that the therapist is 'surviving' for the patient as well as for herself. Antonas (2003) reports briefly from his own experience of close bereavement. The connection with the crisis and client work is not, however, deeply explored. He surveys the coping strategies of therapists in a similar predicament. He quotes Boice and Hertli (1982) who contend that therapists attempt to practice what they preach, but do so in a weakened form.

Practitioners do reflect on the crisis as it affects their clients. Thoreson and Kranskopf (1989) also investigate the relevance of the 'distressed' psychologist to treatment. Deutsche (1985) deals directly with therapists' personal problems and treatment of clients using a feminist paradigm. This subjective account seems to give little purchase for the reader to make sense of it in terms of incisive analysis. It is not very well internally connected, although there are some arresting case studies at the beginning. More specifically Persons (1990) writes on the dual identity of 'Psychotherapist and widower' while Orlans (1993) talks about the impact that a breakdown in her marriage had on her counselling. Self-knowledge and experience is celebrated in Sternberg and Horvath's (1999) 'Tacit knowledge in professional practice'.

Although there is an attempt in most of the foregoing sources to link life-experience to practice, it is hard to sense the intrinsic nature of human suffering to the life and work of the therapist. For that we must turn to the master!

The wounded healer

Jung (1963) captures the centrality of suffering to human restoration when he characterises the wounded healer as an archetype. In order to make use of this archetype, a deep self-knowing on the part of the analyst is needed (see also Frank, 1995; Knight, 1986; Maeder, 1989). Kerenyi (1959), a colleague of Jung, defines the identity of the wounded healer as the capacity

> *…to be at home in the darkness of suffering and there to find germs of light and recovery with which, as though by enchantment, to bring forth Asclepius, the sunlike healer.*

Henri Nouwen (1972) developed these ideas, much influenced by a visit to L'Arche community in France. This was the first of over 130 such enterprises around the world where people with developmental disabilities lived and shared life together with those who cared for them. This lived-experience communicated quickly with Nouwen. Following Jung he removed the idea of woundedness *out* of the common discourse of exception, or accident, or some kind of punishment *into* an understanding of the wound as *essential component* of compassion and healing.

Martin Lipp (1980) investigated the related theme of the failed expectations of the clinician (or perhaps of all professionals) thus:

> *…my wounds become my spectacles, helping me to see what I encounter with empathy, and with a grateful sense of privilege* (p.107).

As I demonstrate below in my research, many practitioners conceptualise the incursion of pain or distress as an essential part of the therapists' ability to be available to others. The realised or acknowledged wound is seen as a *'boon'* (Etherington, 2000). As psychologists we are *whole people* and a holistic scan leads us back *not only* to our woundedness, but in that context to our strengths and the glory of human imagination and ingenuity, to a better and fuller expectation of the human condition.

My own research

The research method

My research method (Martin, 2005) takes seriously the claim of counselling psychology to privilege the intersubjective (see Martin, 2010). Intersubjectivity and its philosophical umbrella phenomenology do not necessarily question the existence of the real world. Instead it concentrates on the world of meanings and of meaning-making. It remains agnostic about the so-called 'real world'. The examined life is the place from which we view this world. Thus, for me, at least some research has to be *about how people experience and make sense of their lives* rather than attempt to say something about some presumed objective 'truth' which emanates from a close investigation of phenomena

The method espoused by Moustakas (1990) is perhaps over-keen to prove itself and at times seems quasi-positivist. The protocol is rather severely prescriptive (pp.51–52). I spent a long time wrestling with the protocol, wanting to keep its intentions, but wanting also to privilege the uniqueness of the stories I had been told by the co-researchers, and to honour the journey of understanding that the co-researchers and I travelled during the course of the research. Moustakas's pioneering method posited that there were predictable stages to processing subjective data. They are initial engagement; incubation; illumination; explication and (instead of 'results', creative synthesis (Moustakas, 1990, pp.27–33). In essence the subjective of the co-researcher and the subjective of the primary researcher strive for intersubjectivity. That is the only claim to truth. This is how the 'data' (I prefer 'stories') are processed. They are not analysed as such (Sela-Smith, 2002).

I increased the heat in the search for intersubjectivity by writing 'depictions' to arrive before my second visit to the storytellers. I travelled round the country talking with these people listening to the taped-interviews again and again in my car, and then sat down and tried somehow to have a

conversation in my head and heart with what they had told me. I knew that I mustn't just write a report of the facts. Somehow I had to catch the uniqueness of what each experience meant to each one of these people.

We corresponded often, before we were finally ready to agree that the 'photograph' which would go into the study represented our joint experience of their story being told. It was a painful process for us all. Ethical considerations had to be carefully examined since there was a real possibility of emotional upheaval in this long process. Complete openness and clear boundaries made this encounter possible. The Bristol University ethical process is rigorous as indeed it should be, but I saw the need to go further. I was dealing with an intervention in people's lives that could have a serious impact. Consequently informed consent became a part of our relationship, as well as a briefing and a form to be signed. I took great care to see if people wanted to use their own names (as some did) or if they preferred a pseudonym. Whichever they chose the integrity of their story and of our relationship as co-researchers was paramount.

Personal involvement; an essential component of heuristic research

Moustakas began his seminal work on 'Loneliness' (1961) with a painful experience trying to make a decision about his very sick daughter. The genesis of my research was in a sharp reminder of my own humanness. Mid-career and in successful practice both as a psychodynamic practitioner (in jack boots) and as a management consultant, I had a 'breakdown'. So I saw no clients for six months, and for about a month looked at the wall in my lounge. I just gradually, gradually began to reassemble my life as a person, and with it, myself as a professional.

It was a returning long-term client who made me realise and own what had happened. She kept saying 'You are different – you are different.' I am afraid I probably patronised her to begin with saying something like 'So you see me as different' (Please allow yourself a little moment of cringe – I do). Then I started respecting this shrewd woman, and really listened to her. She was right: I was different. The experience of my own frailty had changed me. I have revisited and re-owned aspects of myself that a narrow vision of professionalism had pared away.

She had noticed that I was a whole person in the room with her. I was using whatever might be of help to her, within the limits of her capacity and mine. Thereafter, my work has been much more difficult to categorise, but much easier to live. I was better but my wound was still there; I was no longer 'broken down' but my health existed in the context of my woundedness. My wound enabled the kind of therapeutic work in which two people are engaged in a mutual task of discovery. Ullman calls this 'two-person therapy' (2007).

Most of us when we are ill, or sad, or have been bad, like to think that there is something very special about ourselves. But when I looked, really looked, I saw that they my colleagues too were very troubled souls at times. I realised yet again that they were no nicer to each other than are plumbers or union brothers, or priests or partly-trained mud wrestlers. In spite of training, of personal therapy and of 'working through' we were all a pretty rum bunch.

Yet these same people were also magnificent. Depressed therapists often do help people more severely depressed than they are. I pondered on how mean life can be to them as well as how wondrous. Currently, one of my loved sons is hopefully recovering from leukaemia – the randomness of the universe continues to ricochet through all our lives, yet we go on. Woundedness, it seemed to me is not about personal pathology, but also about the way we are in communities, the way we relate to our planet, and the way that we experience the very laws of physics as they repercus on our lives.

I wanted to find out more about my fellow therapists and the way that life taught

them to relate differently with their clients following 'events' (Martin, 2005). My story of a depressive breakdown was published in the *British Association of Counsellors and Psychotherapists Journal* (Martin, 2001). It produced responses from therapists who wanted to 'come out' of the false closet of professional immunity and talk about their lives more holistically. I interviewed 16 other such people, each of them twice so that we could build up a co-constructed account of their intriguing and illuminative stories.

My co-researchers and their stories

My co-researchers were powerful to listen to, and hard to be with. Their pain didn't go away when the session was over for me, and at one point I felt the need to protect myself from trauma by proxy. One was a priest who was an only child who nearly got thrown off his course because of his then unaware narcissism; another was a widow who had an exciting series of sexual encounters after her loved but sexually distant husband died; a man who worked tenderly with a client with 'fragile process' who was then taken to a disciplinary by that client in a hostile employment environment; a woman who so very nearly died, was tricked into recovery by her friends and returned for a vivid season of therapeutic and familial relating with other people before she eventually did succumb to death's disinterested embraces, just as my research was finishing. There was a woman who loved her counselling fiercely, but whose body kept letting her down. Can you spot a part of yourself in this mêlée of human experience? I expect so. I could. They were all practising therapists. They all somehow wove these enormous experiences into their lives and work.

I wrote to them each in a different style before I visited a second time. I conceive of a human conversation as making-do with a flawed construction of another person's meaning, yet somehow, in that intentional action creating something anew. Levi-Strauss (1966) attractively calls this a 'bricoleur' activity ('do-it yourself'). I think that this effortful communication is what intersubjectivity is about. In such an encounter my woundedness contributed to the break down of subject/object divide. We were in this together.

Tina

I am now going to give you a flavour of some ways in which I was able to be creatively imaginative in my response to their stories. Tina, a woman whose sister was murdered has written herself of this event (Bracegirdle, 2007) so I can use her real name. I listened to her story with horror, compassion and a steely determination to stay beside her as she told her story. So I wrote her a letter as if from her dead sister:

> *My sister loves me even though I am dead. She will love me forever and that will keep me safe because everything about my sister is huge and I am very tiny, even in death… She is enormous in her grief. She lets everyone know about me… My story goes on… (The man with the tape-recorder) wanted to know how my murder affected Tina's work. Well what did he expect? Of course, she just got on with it. She actually used the clients to get away from me for a minute, and I can't say I blame her… Must go now. Things to do.*

So how did Tina work with her clients alongside this wound? I wrote to her:

> *When you went into counselling sessions with your clients soon after the murder it was a time in which you were able to enjoy normality. You knew you could still do the business. Of course, you would be all right. You had a sense that here you knew your ground. This was the place where you would choose not to be mad. Perhaps this was the place where it all made sense.*

I have written elsewhere (Martin, 2003) about the appropriate gratification we need to get from our encounters with clients. In many of the interviews I did, I came to see how grateful to our clients we should be for their provision of a kind of 'refuge' from the storms of our own lives. This is different from living vicariously; that is to let someone else do your living for you. In the truly human encounter we are in it together.

Jane

'Jane' is a therapist working with severely afflicted people and the mother of a beautiful child but who developed a mighty problem. He is called 'Andrew' here. When Jane described herself as a child, she said she had been a 'bewildered little girl'. When she saw what was going wrong with her son, she was again bewildered, and for a time, in denial. Eventually through horror-filled experiences waiting in car parks for drug dealers with her now adolescent son, through being lied to, cheated and defeated, she accepted his complete addiction to heroin. Only then could she draw upon all that she was to face her reality, and all that it meant to her.

I wrote this poem for her, in an attempt to get inside this will to survive (for some reason using the metaphor of a house, which she later told me meant such a lot to her):

I stand alone, in this house bewildered by the size of it all.
They never told me that chaos was built in such massive proportions
Nor that the doorways go on and on all the way to the back of the building.
That there is more basement and dark cellar than rooms for the living.
They did not know themselves that laundered beds and cosy parlours are by night,
Full of needles and illegals, and bleeding, and knee-deep in death.

I did not know that you, my darling boy, would lead me to such a house.
I thought your secrets were innocent as your tear-stained face
And that once you lived, you would fill the house with your life.
But not so.
So as it is dear child we must live two lives.
I will visit you in the basement and rock you in my arms
And weep for what might have been.
But I must also ascend by night the stairs to the starlit room
Where I can glimpse the skies and listen to the rhythms of the poets breathing
Lest in the chamber of your heart I mistake you for me, or me for you.

And I must travel out to the world beyond the house, to the Wild Wood
Where I live and breathe my own air and where I tell the earth's secrets learned of you
And for an instant, understand that the house has many connecting corridors
And is all home to me.

Jane continued to work and to enjoy her clients. She recognises again her counselling of others operated as a kind of refuge for her. This activity was something she could do, something she was used to and where normality reasserted itself. Her work, which was originally skills-based, has, however, radically deepened. Much of her work is now suffused with the notion that staying with the client, *'however bad it gets'*, is what is important. This phrase might seem almost prosaic, but when seen in the context of her experience, becomes pregnant and poignant. She believes now that the worst is endurable. She sees her battle for some necessary detachment from Andrew paralleled in her work with clients. The battle continued to rage between a mother's instincts and a 'rational approach'. She wins but only just. That is what it is like for her clients, and she knows that.

Debbie

Debbie is a Person-Centred Counsellor, who lost her daughter twice. She has written about this experience movingly in her book *A Candle for Lisa* (Ruskin, 2002). Her agony seemed complete when the machine that sustained her little girl's life was switched off very soon after the birth. When the grief was assuaged to a degree, it was redoubled by the news that the promised and so-called 'death-with-dignity' had been followed by the unauthorised removal of some of the little girl's organs. Debbie took time off from counselling in response to both of these events. She insisted on her right to grieve.

It was important to her that I, as researcher, feed back as nearly as possible what she had told me – a need for almost complete attunement, a necessary condition for inter-subjective encounter. This is some of what I wrote to her:

> *'You told me about one of the ways in which you kept your private grief to yourself when you returned to counselling…' I'm doing it, staying with it as it happened, not denying this experience with myself. It was really, really painful. But I knew that pushing it away it would only come back and slap me in the face later on… I wasn't going to dissociate myself from it… I just take my vulnerability and sensitivity (with me)… I hold pain and uncertainty in the counselling room if it appears. I do feel this enhances connection with the client.'*

Debbie sees the experience as one which has changed the quality of her encounter with her clients in this and other ways:

> *'I do feel like out of the sadness, the trauma, the horrendous thing, I have been enriched as a person and as counsellor, and that's like a treasure that I salvaged from the wreck … that I was. I feel very connected to people in my humanness.'*

Our encounter was changed in quality by my own willingness as a researcher to be painfully part of the intersubjective understanding that her story engendered. She says:

> *'I was touched by your honesty about initially wanting to both engage yourself and protect yourself from 'the horror of the story'… I am heartened that (you say) this 'irresistible force' made its claim and prevailed in you and that you are 'the richer for it'. e… I really appreciate your realness in sharing something so deep of yourself with me. It is this* ***realness*** *(which I give or am given) that is for me so connecting, precious and enriching'.*

So is this enough evidence of the powerful effect of embracing our woundedness in order to become more alive to one another. I have plenty more stories, but like our lives not enough time to tell them. There were many, many more so-called 'clinical outcomes' which the co-researchers identified arising from the examined life.

A need for balance

The safeguard of supervision

The stories are moving. They exhort us to individual journeys. They tend to minimise the distance between client and therapist. This could be dangerous ground for the non reflective practitioner. There is a need for balance. There must be safeguards. We need to keep the focus on our clients, but never to lose the original vision of counselling psychology as being about 'Two-Person Therapy' (Ullman, 2007). Sue Wheeler (2004) explores supervising the 'wounded healer' recognising the pitfalls yet seeing a powerful but unobtrusive balancer. She characterises this activity as:

> *'…a safety net that affords the client and the public some protection, a safe environment where the countertransference, an unconscious rich mix of therapist and client, can be unravelled and explored.'*

But the phenomenon of supervision should never be eviscerated by complacency (Martin, 2010, p.562). The philosophy outlined in the first part of this article and illustrated in the outcomes of my research suggests that all colleagueship including supervision is informed by our own humanness. A sense of birth, life death and incompletion and openness to our woundedness could change all our professional discourses. It would change the way in which we experience, interpret and interrogate our professionalism especially in relation to those we seek to help or teach.

Implications for professionalism

There are other implications about the way in which we construe professionalism. We need to distinguish between safe-practice and certainty. We need to live better with fluid states. March (1984, p.91) regards unintended consequences, or what he calls uncertainty and ambiguity, as a normal phenomenon in all areas.. The practice of therapy, as in all professions, can be seen as

contingent upon mystery (House, 2003; Spinelli, 1994, 2001). Part of this arcane quality depends on seeing therapists as in some way 'different'. My close and relational research involvement with the co-researchers in this study has by the nature of the revelations they chose to make, revealed these therapists first and foremost as people. By my choice to privilege the story in which their professionalism is embedded, the public face of professionalism is de-accentuated. The more visceral roll and rise of living has predominated.

Perhaps all that life can offer the therapist is a deepening of 'tacit knowledge' which we visited earlier in this paper. The idea was proposed by Polyani (1985) and expanded later by Sternberg and Horvath (1999). Perhaps tacit knowledge is a thing in itself. Perhaps with diligence it can be increased. At any rate it does seem to be another way of construing that non-psychological notion of 'wisdom', without which our culture would be infinitely the poorer.

Concluding thoughts

This article has led us through a long journey. I wonder what stories have arisen for you as you have been reading the stories my co-researchers told. I wonder if you with me see mortality, and its precursor, our woundedness, as something to celebrate, as a way to be more human; as a way of exploring compassion and life-affirming joyous action and human intercourse.

Carolyn Ellis and Arthur Bochner (2000) characterise the purpose of research as 'to encourage compassion and to promote dialogue' (p.748). I hope that this article has contributed to both of these life-giving energies. This is why I have begun with discussion. What is the use of research unless it sparks thinking and understanding? My research began a journey of reflection for me. Experience has taught me that sometimes we must let the heart lead and proceed in more-or-less orderly manner to the head, and then back again…

I conclude with a little poem that I wrote (with almost no regard to grammar) at the end of my research. It is about subject and object, and how they don't really exist where there is a consciousness of the wound which is the boon, and the bloom of our humanity.

Let us go, just you and me
Down to the woods and the wind-blown sea
Let us dance, and sing, and weep
Share our hearts as the shadows creep
Towards the time when me and you
Are I and thou, and others too.

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References

Antonas, V. (2003). *The effects of bereavement on psychotherapists and their client work.* Paper presented at the AHPP Conference, Regent's College, London.

Bayne, R. (1997). Survival. In I. Horton & V. Varma (Eds.), *The needs of counsellors and psychotherapists* (pp.183–213). London: Sage.

Boice, R. & Hertli, P. (1982). Do psychologists practice what they teach? *Teaching of Psychology, 9*(2), 86–88.

Bracegirdle, C.E. (2007). *Beauty and the Beast: Clients' experience of counselling within a narrative framework, considering concepts of containment and freedom.* University of Hertforshire thesis collection.

Coltart, N. (1992). *How to survive as a psychotherapist.* London: Sheldon.

Coupe, A. (1999). *What is the extent of the relationship between personal therapy issues and the therapeutic work of the psychotherapist?* Unpublished MA in Integrative psychotherapy, Sherwood Psychotherapy Training Institute, University of Derby.

Deutsch, J.J. (1985). A survey of therapists personal problems and treatment. *Professional Psychotherapy: Research and Practice, 16*, 305–315.

Ellis, C. & Bochner, A.P. (2000). Autobiography, personal narrative, reflexivity: Researcher as subject. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp.733–768). London: Sage.

Etherington, K. (2000). *Narrative approaches to working with adult male survivors of child sexual abuse.* London: Jessica Kingsley.

Fine, H.J. (1980). Despair and depletion in the therapist. *Psychotherapy Theory, Research and Practice, 17*, 15–28.

Frank, A.W. (1995). *The wounded storyteller, body, illness, and ethics.* Chicago: Chicago Press.

House, R. (2003). *Therapy beyond modernity: Deconstructing and transcending profession-centred therapy.* London: Karnac.

Jung, C.J. (1963). Only the wounded physician heals. In *Memory, dreams and reflections* (pp.107). London: RKP.

Kerenyi, C. (1959). Asklepios: Archetypal Image of the Physician's Evidence (*Archetypal Images in Greek Religion*, Vol. 3, R. Manheim, Trans.). Princeton: Princeton.

Knight, J.A. (1986). The religio-psychological dimension of wounded healers. In L.H. Robinson (Ed.), *Psychiatry and religion: Overlapping concerns* (pp.34–49). Washington, DC: American Psychiatric Press.

Levi-Strauss, C. (1966). *The savage mind.* Chicago, OH: University of Chicago Press.

Lipp, M. (1980). *The bitter pill – doctors, patients and failed expectations.* New York: Harper Row.

Mackay, F. (2004). *Sacred stories: Counsellor passion narratives.* Paper presented at the 10th Annual Counselling and Psychotherapy Research Conference, London.

Maeder, M. (1989). Wounded healers. *The Atlantic Monthly*, January, 37–47.

March, J.G. (1984). Theories of choice and making decisions. In S.B.R. Paton, R. Spea, J. Chapman, M. Floyd & J. Hamwee (Eds.), *Organisations – cases, issues, concepts.* London: Paul Chapman Publishing Ltd., in association with The Open University.

Martin, P. (2001). The therapist as a person. *Counselling and Psychotherapy Journal, 12*(10), 10–12.

Martin, P. (2003). Lopsided loving: Envy and gratitude inside and outside the therapeutic relationship. *Journal of the Psychology and Psychotherapy Association, 3*(2).

Martin, P. (2005). *The effects of current life-events on the work of therapists.* Bristol, Unpublished.

Martin, P. (2010). Training and professional development. In R. Woolfe, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed.). London: Sage.

Moustakas, C. (1961). *Loneliness.* Englewood Cliffs, NJ: Prentice Hall.

Moustakas, C. (1990). *Heuristic research.* London: Sage.

Norcross, J.C. & Prochaska, J.O. (1986). Psychotherapist heal thyself – the self-initiated and therapy-facilitated change of psychological distress. *Psychotherapy, 23*, 345–356.

Nouwen, H.J. (1972). *The wounded healer.* New York: Doubleday.

Orlans, V. (1993). The counsellor's life crisis. In W. Dryden (Ed.), *Questions and answers in counselling in action.* London: Sage.

Persons, R. (1990). Psychotherapist and widower. *The Psychotherapy Patient, 6*(3/4), 71–80.

Polanyi, L. (1985). *Telling the American story: A structural and cultural analysis of conversation storytelling.* Norwood, NJ: Abbey.

Rowan, J. (Ed.). (1989). *A late developer.* London: Tavistock/Routledge.

Ruskin, D. (2002). *A candle for Lisa.* Hebden Bridge, West Yorkshire: Pennine Pens.

Sela-Smith, S. (2002). Heuristic research: Review and critique of the Moustakas method. *Journal of Humanistic Psychology, 42*(3), 53–86.

Seligman, M. (1990). *Learned optimism: How to change your mind and your life.* New York: Free Press.

Spinelli, E. (1994). *Demystifying therapy.* London: Constable.

Spinelli, E. (2001). The psychotherapist's magic feathers. *Counselling and Psychotherapy Journal, 12*(6), 6–9.

Sternberg, R.J. & Horvath, J.A. (1999). *Tacit knowledge in professional practice.* Mahwah, NJ: Lawrence Erlbaum Associates Ltd.

Thoreson, R.W., Miller, M. & Kranskopf, C.J. (1989). The distressed psychologist: prevalence and treatment consideration. *Professional Psychology Research and Practice, 20*, 153–158.

Ullman, C. (2007). Commentary on special issue of relational psychoanalysis in Europe: How is this dialogue different? *European Journal of Psychotherapy & Counselling, 9*(1), 105–116.

Wheeler, S. (2004). *Supervising the wounded healer.* Paper presented at the BACP Research Conference.

Wilber, K. (1991). *Grace and grit.* Boston. MA: Gill & Macmillan.

Original Research Paper

The therapeutic relationship from an attachment theory perspective

Marina Christina Skourteli & Clare Lennie

Aim: *The present study examined the view of the therapist as an attachment figure and the relationship between client adult attachment in close relationships and client attachment to the therapist.*
Method: *27 clients in ongoing therapy were asked to complete measures of adult attachment and client attachment to their therapists. In addition, five participants were interviewed with regard to their perceptions of their therapist and the therapeutic relationship.*
Findings: *Quantitative analysis suggested that client attachment may be activated in the context of the therapeutic relationship. In particular, 'Need for Approval' was significantly associated with both 'Fearful/Avoidant' and 'Preoccupied/Merger attachment to the therapist'; 'Preoccupation in Relationships' was positively correlated to 'Preoccupied/Merger attachment to therapist'. Qualitative findings further suggested that the therapist serves as an attachment figure for clients.*
Implications for practice: *The therapeutic relationship contains features of an attachment relationship and therapists are often seen by clients as a secure basis for exploration. In this context, the behaviour that clients present in therapy is seen as meaningful and its exploration can contribute to the deconstruction and re-appraisal of internal working models of self and others. Implications for the practice of counselling psychology are discussed.*

Keywords: *client attachment; therapist as attachment figure; transference; psychotherapy.*

ACCORDING to attachment theory, infants develop relational patterns directly in response to the caregiver's availability and consistency with the view to maximise closeness, security and ultimately survival (Bowlby, 1988). Attachment patterns impact significantly processes of affect regulation and cognitive processing (Goldberg, 2000), the development of internal working models (Bretherton & Munholland, 2008) and inner representations and are further implicated in adult psychopathology and psychotherapy (Bateman & Fonagy, 2004; Dozier et al., 2008). Attachment patterns are thought to persist throughout life and to be activated by any close relationship, including the therapeutic relationship. Attachment theory has marked a significant shift from a one-person to a two-person psychology and has had a profound influence on psychological and psychotherapy research (Beebe, Jaffe & Lachmann, 1992; Stephen & Pelham, 2000).

By adopting an attachment theory perspective, the present study aims to understand the client's experience of the therapist and the emerging dynamic between them as meaningful in the context of the client's past and current relationships. This relational framework seems particularly relevant to the practice and knowledge-base of counselling psychology as it de-pathologises client difficulties and highlights the role of the therapist, ultimately promoting reflective and ethical practice. Within the context of attachment theory, both client and therapist are thought to contribute to processes of transference and countertransference and the emerging dynamic in therapy, yet relatively few studies have explored client attachment within the therapeutic relationship (Parish & Eagle, 2003; Woodhouse et al.,

2003). Overall, counselling psychological research seems to employ mostly qualitative methods whilst few attempts have been made to systematically assess the client-therapist dynamic (Mallinckrodt, Gantt & Coble, 1995). The present research uses a mixed methodology to explore the ways in which client attachment orientation may influence perceptions of the therapist and the therapeutic relationship. Within this context, my research questions are formulated as follows:

1. How is client attachment orientation activated or enacted within the therapeutic relationship?
2. Is there a relationship between client adult attachment in close relationships and client attachment to the therapist?
3. How closely does the therapist fit the role of an attachment figure?

Background and literature review

Self and Object representations

Attachment theory accounts for the ways in which early child-parent interactions become abstracted into inner representations; in other words, it maintains that everything that is intrapsychic was once interpersonal (Maroda, 2010). From early studies like Ainsworth et al.'s (1978), it emerged that mere physical absence of the parent did not appear to be key to separation anxiety; rather it was the child's evaluation of the mother's departure on the basis of previous experience of her that was central for understanding responses to separations. Internal working models emerge as early attachment-related experiences become transformed into inner representations (Grossman & Grossman, 1991; Bretherton & Munholland, 2008).

Transference

Internal working models are essentially the mechanisms by which early attachment experiences are carried forward and organise subsequent social experiences. Within this context, Westen and Gabbard (2002) discuss the concept of transference in terms of inner representations existing as potentials for activation. Internal representations of self and others exist in a latent state awaiting to be activated with varying intensity either consciously or unconsciously, particularly so within close relationships. Within therapy, transference is viewed as a template of early experience that can influence the client's emotional relationship with the therapist (Casement, 1991; Bateman & Holmes, 1995).

Mallinckrodt (2000) maintains that early experience is central not only to the development of schemas (implicated in view of oneself and others, conflict resolution style, affect regulation and cognitive appraisal) but further to the perception of events and people as stressful, rejecting or supportive. The above parameters are central to interpersonal processes (or themes) within relationships, including the therapeutic relationship (Luborsky & Crits-Christoph, 1998; Connoly et al., 2000). In considering interpersonal processes, Mallinckrodt (2000) suggests that people's attachment style and thus their relatedness dispositions may be interacting with that of others in ways that maintain existing relationship patterns, posing thus interesting implications for the transference-countertransference dynamic in therapy.

Attachment to the therapist

The attachment organisation established in early life appears to be robust and can be activated by any close relationship, including the therapeutic relationship. The counselling relationship contains many features which may activate the client's ingrained expectations; similar to a caregiver, the therapist is emotionally available, offers a comforting presence, affect regulation and a sense of a secure base from which the client can explore inner experience (Holmes, 1999). Attachment concepts can provide considerable insight into what happens in therapy, particularly the relationship aspects of therapeutic change (Bender, Farber & Geller, 1997; Woodhouse et al., 2003, Jordan, 2007).

Mallinckrodt, Gantt and Coble (1995) developed and validated the Client Attach-

ment to Therapist Scale (CATS), which explores the ways clients relate to their therapist. In their study clients who scored high on the CATS Secure subscale perceived their therapists as emotionally responsive, accepting and promoting a secure base from which they were able to explore their emotional experience; these clients seemed to have positive working models of self and others. Clients who scored high on the Preoccupied-Merger subscale displayed a desire for dissolution of boundaries in the therapeutic relationship. These clients appeared preoccupied with their therapist and had a tendency to become dependent. Overall, preoccupied clients seemed to maintain a negative working model of themselves but a positive working model of others. Finally, clients who scored high on the Avoidance subscale tended to mistrust their therapists and were fearful of rejection. These clients reported a sense of alienation, mistrust and hopelessness and seemed to maintain negative working models of both self and others. Mallinckrodt later tied the above dimensions of the CATS with constructs of anxiety and avoidance with hyperactivation being reflective of anxiety and deactivation of avoidance (Mallinckrodt, 2000).

Parish and Eagle (2003) further explored the ways in which therapists function as attachment figures for clients and concluded that the relationships formed in long-term psychotherapy share many qualities of an attachment relationship. Mallinckrodt, Porter and Kivlighan (2005) explored the role of attachment in therapy and in particular the relationship between client attachment to therapist, depth of in-session exploration and object relations. Consistent with the view of the therapist as a secure base, results indicated that security in attachment to the therapist was significantly associated with greater session depth and smoothness. Insecurity in attachment was mirrored within the therapeutic relationship; avoidance was associated with weaker working alliances, a sense of alienation and social incompetence (Mallinckrodt, Porter & Kivlighan, 2005).

Assessment of adult attachment

Narrative measures

Narrative approaches have emerged from the developmental and psychoanalytic traditions within psychology and are broadly considered to be tapping into unconscious states of mind with regard to attachment (Hesse, 2008; Bifulco, 2002; Shaver & Mikulincer, 2002). There seems to be a close relationship between attachment classifications in childhood and narrative style in adulthood and narrative assessment in attachment is based on the notion that representational processes are reflected in language (Crowell, Fraley & Shaver, 2008).

Secure attachment in adulthood is thought to be mediated by a single, consistent working model, which is communicated through coherent and collaborative narratives characterised by meta-cognitive monitoring (Bateman & Fonagy, 2004). On the other hand, inconsistent or incoherent narratives are thought to be indicative of multiple, often contradictory models of the same aspect of reality, consistent with the perceived insecurity and inconsistency underlying the experience of early attachment figures. (Main, 1991, 1993; Slade, 2008).

Self-report measures

Self-report measures have emerged from the social psychology tradition and outline the individual's conscious experiences with regard to current attachment relationships. From this perspective, attachment styles are conceptualised as enduring patterns of needs, expectations and affect-regulation strategies that emerge from earlier relationships with caregivers. Attachment classification according to self-report measures is best represented as regions across two dimensions, attachment-related anxiety and attachment-related avoidance (Shaver & Mikulincer, 2002). Security of attachment is the region where both anxiety and avoidance are low, whilst preoccupation corre-

sponds to a region where anxiety is high and avoidance is low. Avoidant attachment in adults seems more complex, as there is a further distinction (resulting thus in a four-category model of classification) based on the individual's working model of self and other. Fearful-avoidant attachment is defined by negative working models of both self and other, indicating high anxiety over abandonment on one hand and high avoidance of intimacy on the other. In contrast, a dismissive-avoidant attachment is characterised by a positive self-model and a negative other-model, indicating low anxiety but high avoidance of intimacy (Feeney, 1999; Shaver & Mikulincer, 2002).

Basis for present study

The present study employs both quantitative and qualitative methods to promote balance and integration in the research process (McLeod, 2003). As attachment, transference and internal working models often seem nebulous and abstract concepts, they are assessed quantitatively in an attempt to capture them more clearly. A possible limitation of self-report measures is their openness to distortion by participants lacking in self-awareness whilst defences such as denial or idealisation, may be further biasing participant responses (Bifulco, 2002). Nevertheless, self-report measures were deemed as ethically more appropriate for the purposes of the present research, as they promote a greater sense of control over responses and informed consent for participation (BACP, 2010; BPS, 2006).

In addition to the quantitative part of the study, semi-structured interviews were conducted with five psychotherapy clients, in order to enrich findings generated through the use of questionnaires. Such qualitative analysis promoted a more thorough exploration of client responses and a greater understanding of the personal meanings and experiences of individual participants. Findings generated quantitatively and qualitatively are brought together through the use of researcher reflexivity.

Method

Research settings and participants

The present study took place within two small counselling organisations. Counselling practitioners receiving ongoing supervision were approached through staff meetings and were informed about the nature of the research. The practitioner's contribution to the study included accessing clients who were in ongoing therapy with them and identifying clients interested in participating. Their contribution thereafter was limited to the distribution of questionnaires supplied in a standardised manner by the researcher. It was explained that therapists would not be involved any further in the study and they would not be made aware of individual client responses in order to guard client confidentiality and anonymity. In approaching potential participants, therapists were advised to take into account that clients were not in a particularly vulnerable state and that, in their judgement (as informed by the supervision and personal experience of their clients) were not likely to be adversely affected as a result of participation.

Individual practitioners maintained the right to refrain from participation; their role however, was central in assessing the level of vulnerability of their clients, ensuring that no harm was caused to clients and sensitively recognising client reluctance to participate. Consistently with relevant literature, therapists were asked to approach clients with whom they had worked for a minimum of three sessions and who were in ongoing therapy with them. Overall 18 therapists agreed to participate who were seeing between two and eight clients per week. Prior to collection of data, full ethical approval was granted by the directors of both organisations and the University of Manchester's ethics committee.

Measures

- Attachment Style Questionnaire (ASQ) (Feeney, Noller & Hanrahan, 1994)
  This is a 40-item self-report measure of adult attachment based on models of

positive versus negative view of self and positive versus negative view of others. These constructs cover the major features described across different models of adult attachment, together with basic themes of infant-attachment theory. The three-factor solution yields factors labelled as Security, Avoidance, and Anxiety. The five-factor solution yields the factors of Confidence (in self and others), Discomfort with Closeness, Need for Approval, Preoccupation with Relationships and Relationships as Secondary. These five attachment scales define four attachment groups based on the notion of model of self versus model of other, resulting in Secure, Preoccupied, Dismissing-Avoidant and Fearful-Avoidant classifications. (Feeney, 1999)

- Client Attachment to Therapist Scale (CATS) (Mallinckrodt, Gantt & Coble, 1995)

  This is a 36-item, three-factor measure of client attachment to their therapist. 'The labels and interpretations of the three subscales are as follows: (a) Secure, experiencing the therapist as responsive, sensitive, understanding and emotionally available; feeling hopeful and comforted by the therapist; and feeling encouraged to explore frightening or troubling events; (b) Avoidant-Fearful, suspicious that the therapist is disapproving, dishonest, and likely to be rejecting if displeased; reluctant to make personal disclosures and feeling threatened, shameful and humiliated in sessions; and (c) Preoccupied-Merger, longing for more contact and to be 'at one' with the therapist, wishing to expand the relationship beyond the bounds of therapy and being preoccupied with the therapist and the therapists other clients' (Mallinckrodt, Gantt & Coble, p.310).
- A brief semi-structured interview exploring clients' perceptions of their therapist and the therapeutic relationship. The interview was developed after reviewing the literature on attachment, particularly so with respect to the therapist as an attachment figure (Farber, Lippert & Nevas, 1995; Mallinckrodt, Gantt & Coble, 1995). Items include 'How would you describe your relationship with your counsellor?', 'In what ways do you find that your counsellor helps you explore difficult feelings or experiences?', 'What are the aspects of your relationship with your counsellor that you find most/least helpful?', 'What qualities of your counsellor do you find most/least helpful?', 'What are your feelings towards your counsellor?' and 'How do you find that these feelings may have changed over time?'

Procedure

After identifying clients willing to participate, therapists provided participants with identical, sealed and unmarked envelopes containing a participant information sheet explaining the nature and aims of the research, the two self-report measures described above and a participant debriefing form. In order to preserve client anonymity no written consent was obtained; participants interested in participating in further interviews were asked to provide contact details. Research packs were to be completed immediately after a session with the therapist, but procedure also allowed for them to be taken away. Although this possibly carries some methodological limitations over the immediacy and proneness to distortion of responses, it was deemed more ethical, as it could minimise coercion to participate and would promote greater autonomy over responses and right to withdraw consent.

Results

1. Quantitative analysis

Descriptive statistics

All participants were female and they were all in ongoing therapy with female therapists. Overall 55 research packs were distributed, of which 29 were returned, indicating a response rate of 52.2 per cent. Of the

29 returned packs, two were excluded from analysis, as participants had failed to complete all the questions. Therefore, in total 27 packs were retained for analysis. Of the 27 participants that successfully returned their questionnaires, 11 volunteered for further individual interviews, indicating a response rate of 40.7 per cent. Of those, five participants were randomly selected for individual interviews, in the order in which they returned their research packs.

Inferential statistics

In completing the ASQ (Feeney, Noller & Hanrahan, 1994), participants obtained a score in the following dimensions corresponding to working models of self and others. These included Confidence (indicating low anxiety and low avoidance), Discomfort with Closeness (high anxiety and high avoidance), Relationships as Secondary (low anxiety, high avoidance), Need for Approval (low avoidance, high anxiety) and Preoccupation in Relationships (high anxiety, low avoidance).

In completing the CATS (Mallinckrodt, Gantt & Coble, 1995) participants produced a score describing their relationship to their therapist in the following dimensions; Secure Attachment, Avoidant/Fearful Attachment and Preoccupied/Merger Attachment to Therapist. Statistical correlations were performed with regard to dimensions between the ASQ (Feeney, Noller & Hanrahan, 1994) and CATS (Mallinckrodt, Gantt & Coble, 1995), using Spearman's *r*.

Need for Approval was positively associated with both Avoidant/Fearful Attachment to Therapist (r=0.56, p=0.002, p<0.01) and more weakly with Preoccupied/Merger Attachment to Therapist (r=0.41, p=0.03, p<0.05). A significant positive correlation was found between Preoccupation in Relationships and Preoccupied/Merger Attachment to Therapist (r=0.41, p=0.03, p<0.05). Contrary to expectation, no significant relationships were found between length of therapy (Number of Sessions) and Secure Attachment to Therapist. Further, no significant relationships were found between Discomfort with Closeness (that can be indicative of both avoidance and anxiety) and Preoccupation in Relationships, Preoccupied/Merger or Avoidant/Fearful Attachment to Therapist.

To summarise, the statistical conclusions from this study suggest that some features of client attachment may be re-enacted within the therapy relationship.

Table 1: Summary of correlations between ASQ and CATS.

	Confid.	Discomfort with Closeness	Need for Approval	Preoccup. in Relations.	Secure Attach.	Avoidant/ Fearful Attach.	Preoccup./ Merger Attach.
Number of Sessions	.076				.207		
Confidence		−.486*	−.521**				
Need for Approval						.565**	.415*
Preoccupation in Relationships							.414*
Discomfort with Closeness				.111		.166	.051

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

2. Qualitative analysis

The purpose of the interview was to explore participant's perceptions of their therapists and their therapeutic relationship at the time of the interview and possible variations of these perceptions over time. Participant transcripts were analysed using Content Analysis (Patton, 2002; McLeod, 2003). The resulting categories were imposed on the data by the researcher primarily in accordance to the literature on the therapist as an attachment figure (Farber, Lippert & Nevas, 1995; Mallinckrodt, Gantt & Coble, 1995; Parish & Eagle, 2003); these categories were kept intact and have not been divided further in order to maintain consistency and congruence with the existing attachment literature. A further category was created to capture a pronounced construct that emerged from participant data and using researcher reflexivity. Overall, five categories emerged that appear indicative and consistent with the notion of the therapist as an attachment figure.

1. The therapist as a secure base for exploration (82 items)

The notion of the therapist as a secure base for exploration is consistent with attachment theory; within the security of the therapeutic relationship clients have the opportunity to explore their relationship with self and others (Farber, Lippert & Nevas, 1995; Holmes, 1999, 2001). This is the first most pronounced category emerging from participant interviews. Client perceptions of their therapists' constancy, availability, sensitivity and responsiveness can be viewed as supporting of the notion of the therapist as a secure base for exploration.

> 'She was helping me along by being there.' (P2)
>
> 'The fact that she's predictable, it would make me feel very uncomfortable if that was to change from week to week.' (P3)

2. Transference – relatedness (32 items)

Transference within the therapeutic relationship is thought to be mediated through clients' internal working models of how the therapist is viewed or experienced.

This category, the second most pronounced within participant interviews, refers to the notion of the therapist as a specific focus of intense affect, cognition and behaviour (Bowlby, 1988; Farber, Lippert & Nevas, 1995). The notions of transference and internal working models suggest that clients may respond to the therapist in ways that are similar to previous or other current relationships outside therapy.

> 'I did at first worry about her, cause when I meet new people I tend to want to look after them.' (P3)
>
> 'I didn't trust her at all when I first met her, not because of her but just because I don't until they prove me wrong.' (P3)

3. The therapist as containing and as providing a holding environment (26 items)

The notion of the therapist as containing and as providing a holding environment (Casement, 1991) refers to processes of holding, metabolising and feeding back affective material to the client. The therapist's survival and robustness provides a sense of felt security and trust as s/he is neither destroyed nor responds anxiously in an attempt to rescue clients from their distress (Casement, 1991).

> 'Sometimes I feel really negative about myself … and she just stays there, she doesn't try to show me the opposite.' (P5)
>
> '… she is not just giving in to my feelings.' (P5)

4. The therapist as wiser and stronger (24 items)

The notion of the therapist as wiser and stronger refers to clients' perception of the therapist as knowing more than they do, as being able to be more objective and as having greater clarity but also as being understanding and sensitive to client experience. In addition to clients' expectations, the view of the therapist as wiser and stronger may further emerge from the thera-

pist's skill, knowledge, education and social status (Farber, Lippert & Nevas, 1995).

> '… I think she actually picked up that the time was right for her to back down but it wasn't what I wanted at the time, but it was actually what I needed.' (P1)
>
> '… she has a lot of insight and an ability to read between the lines and sort of, coax things out of me.' (P2)

5. Therapeutic boundaries (5 items)

The notion of a boundaried relationship emerged as an important element facilitating security in addition to previous categories that were informed by relevant attachment literature (Farber, Lippert & Nevas, 1995). This is the least pronounced category across participant accounts yet the notion of therapeutic boundaries appeared to be particularly important for clients in the interview population.

> '… I've got the boundaries really there in place … I think you do need to know where the line is.' (P1)
>
> 'And she is very respectful of that boundary and that makes me trust her even more.' (P3)

Discussion

The purpose of the present study was to explore the ways in which client attachment orientation in close relationships may be enacted within the therapeutic relationship and the extent to which the therapist may serve as an attachment figure for clients. Consistent with expectation, it appears that some of the features characterising client adult patterns of relatedness outside therapy manifest themselves within the therapeutic relationship.

1. Quantitative analysis

A positive association was found between Need for Approval and both Avoidant/Fearful and Preoccupied Attachment to the therapist. Whilst Need for Approval is indicative of anxiety and implies a negative internal model of self, it seems to be implicated in different patterns of relatedness. Mallinckrodt, Gantt and Coble (1995) maintain that fearful/avoidant clients in their study tended to mistrust their therapists and be fearful of rejection; in spite of these clients maintaining negative working models of themselves and others, they displayed a strong need for emotional closeness on one hand, but were uncertain over their capacity to establish supportive and fulfilling relationships on the other, due to their negative expectations of themselves and others. In this context, the association between Need for Approval and Avoidant/Fearful attachment in this study is consistent with Mallinckrodt, Gantt and Coble's (1995) findings and may be important in demonstrating that the avoidance dimension in relationships may be particularly complex, often mediated by a degree of anxiety or ambivalence.

The positive association between Need for Approval and Preoccupied Attachment to therapist is less surprising; preoccupation is thought to be mediated by a negative working model of oneself but a positive working model of others. From this may follow a tendency for preoccupied individuals to idealise others in relationships, including the therapeutic relationship and to view others as sources of self-validation. It appears then that anxious individuals' perception of others may be biased by their own need for connectedness, which in the context of therapy may be translated as a wish for dissolution of boundaries and a tendency towards dependency (Feeney, 1999; Shaver & Mikulincer, 2002). These results are consistent with previous studies that report that both the Avoidant/Fearful and Preoccupied/Merger subscales in the CATS are negatively associated with self-efficacy (Mallinckrodt, Gantt & Coble, 1995; Mallinckrodt, 2000).

Finally, a positive association was found between Preoccupation in Relationships and Preoccupied attachment to therapist. This finding appears significant for the notion of a re-enactment of clients' patterns of relatedness (the anxiety dimension in particular) within the therapeutic relationship and is in

line with previous attachment and inner representations literature. Bender, Farber and Geller (1997) reported that clients' representations of parents were significantly correlated with representations of the therapist, although the latter could be modified over time, as a result of therapy. Connolly et al (2000) similarly reported a significant relationship between the most prominent interpersonal themes in client pre-therapy narratives and later those relating to their perception of their therapist. Taken together, these studies are supportive of the notion that client patterns of relatedness outside therapy may be replicated to some extent within the therapeutic relationship.

2. Qualitative analysis and Triangulation of findings

The qualitative analysis in this study appears to yield support for the hypothesis that the therapeutic relationship contains features of an attachment relationship and is consistent with relevant literature (Farber, Lippert & Nevas, 1995; Parish & Eagle, 2003; Holmes, 2001). Participants in this study perceived their therapists as consistent and emotionally responsive, attentive and available and generally as reliable and trustworthy figures they could return to during the exploration of their emotional experience. Therapists were generally perceived as being wiser or stronger than clients and further as providing a containing and holding environment and a safe space that enhanced clients' sense of felt security. Therapists overall served as figures, which clients sought emotional proximity to and were further the specific focus of intense emotional responses that often paralleled clients' experiences in other relationships. Some of the participants in the study acknowledged that their relatedness to their therapist, particularly during the earlier stages of their therapy was determined by previous positive or negative experiences with others and that their perceptions of their therapists were initially formed on the basis of internalised expectations of others' behaviour. The themes emerging from client transcripts suggest that the therapeutic relationship can provide the necessary relational conditions for a corrective emotional experience for clients, which they can utilise as a secure framework for the exploration of their presenting difficulties (Holmes, 1999).

Whilst findings indicate that the therapist may serve as a secondary attachment figure for clients, there has been no systematic attempt in this study to establish a link between individual clients' attachment orientation (as assessed by self-report measures) and their perception of the therapist or the therapeutic relationship; yet it seems important not to overlook a brief discussion of a possible relationship between the two primarily through means of researcher reflexivity. Whilst some of the participants reported relatively high scores in the constructs of confidence and secure attachment to therapist, closer examination of their interview transcripts revealed some inconsistencies or conflict with regard to the relationship with their therapist. For example, in describing an experience with a previous therapist, one participant reported feeling uncomfortable with her therapist's self-disclosure but later on expressed frustration towards the therapist for not revealing enough about herself; the participant herself seemed unaware of contradictions in her account. Such a flavour of preoccupation was often manifested in the subjective experience of the researcher during the process of conducting interviews. For example, some participants produced narratives that seemed excessively long and disorganised; these clients appeared to have difficulty in keeping a clear focus on the interview process whilst constructing narrative accounts of their experience. Although such reflection on participant transcripts in the present study is highly speculative and unsystematic, it nevertheless appears in line with the literature utilising narrative assessment of adult attachment that considers meta-cognitive functioning or the ability to

reflect on current or past experience whilst simultaneously maintaining a coherent discourse with the interviewer, as indicative of security (Main, 1993; Hesse, 2008).

It may be interesting to consider the additional theme of a boundaried relationship within this context. A strong need for a boundaried relationship for clients who may be experiencing anxiety in relationships may shed some light in the often-obscured avoidance dimension within preoccupation; this may further be relevant to the understanding of avoidant/fearful attachments. For clients experiencing high need for approval and closeness, relationships themselves (although high in the hierarchy of psychological needs) may also be a source of considerable anxiety, as self and others may be viewed as demanding, overprotective, unreliable or dependent. The intense emotional experience accompanying relationships may lead to a sense of exhaustion and a desire for greater emotional distance, as a respite from anxiety; these clients may be finding themselves feeling either suffocating or being suffocated by others in relationships. Within the therapeutic relationship this desire for distance may indeed manifest itself through a strong need for clarification of the boundaries between client and therapist, as something that could possibly counteract the element of ambivalence. For these clients, an awareness of formal, external boundaries may be reassuring as their capacity for establishing boundaried relationships from within (through well differentiated representations of self and others) may be depleted.

The possible discrepancies between self-report and interview measures in the present study may be highlighting the role of defence mechanisms, particularly so for clients with insecure patterns of attachment. Shaver and Mikulincer (2002) report that attachment security, as assessed by self-report measures has been repeatedly found to be negatively associated with the function of defensive distortions in participant perceptions of themselves and others. Similarly, Bifulco (2002) comments that self-classification measures of attachment may be prone to distortions emerging from defence mechanisms such as denial or idealisation and further '…by the very cognitive biases constituting vulnerability…' (p.183) for clients' presenting difficulties (Bifulco, 2002). It appears then that whilst self-report measure may be useful in assessing attachment security, they may be limited in accurately reflecting insecure patterns of attachment; such limitations may further account for the lack of significant relationships between the constructs of Discomfort with Closeness and Preoccupation in Relationships, Avoidant/ Fearful or Preoccupied/Merger attachment to therapist within the present study. This suggests that narrative approaches may indeed be more sensitive in capturing aspects of attachment insecurity and the defence mechanisms that underlie them.

3. Implications for Practice

If the therapeutic relationship contains qualities of an attachment relationship and the therapist acts as a secondary attachment figure for clients, this holds considerable implications for case conceptualisation and clinical practice. Research suggests that therapy can facilitate security in clients' attachment through a deconstruction and reappraisal of their internal working models with regard to perceptions of themselves and others (Mallinckrodt, 2000; Slade 2008). Therapy essentially provides the emotional arena within which the transference-countertransference dynamic takes place; this unfolding relational exchange between client and therapist can lend a valuable context for an in-depth understanding of the former's presenting difficulties and the latter's therapeutic use of self (Wosket, 1999; Steven & Peltham, 2000).

Clients' patterns of relatedness manifest within the therapy relationship, often along with potential responses that the client attempts to pull from the therapist, in order to confirm or perpetuate their working

model of self and others. For example, clients with deactivating attachment strategies may seek avoidant attachments with their therapist and to increase interpersonal distance; this may elicit disengaging or distancing responses in the therapist's countertransference where s/he may feel locked out or hopeless about the prospects of attaining emotional contact with the client. In contrast, clients with hyperactivating attachment strategies may display preoccupied attachments to their therapist by seeking to reduce interpersonal distance through communicating their sense of helplessness and dependency; this in turn may elicit rescuing responses in the countertransference or may leave the therapist feeling swamped or overwhelmed by the client's experience (Mallinckrodt, 2000; Shilkret, 2005). Within the framework of attachment theory, such client behaviour is seen as meaningful, aiming to maximise emotional safety in the relationship with the therapist; on the other hand therapist attentiveness to countertransference responses similarly may provide insight into the client's early emotional experience. Importantly, the therapist's awareness of such countertransference responses can be used therapeutically, facilitating empathy and offering insight into appropriate ways of being with clients. Many theorists suggest that a corrective emotional experience may often involve the therapist's withholding of responses that the client may seek to obtain and instead providing counter-complementary or contrasting responses (Dozier, Cue & Barrett, 1994; Bernier & Dozier, 2002; Slade, 2008). For example, with clients who seek to increase interpersonal distance and are dismissive of closeness, the therapist may attempt to gently increase their awareness of emotional processes and deepen their emotional engagement in therapy, while sensitively monitoring their tolerance for anxiety and cognitively containing them. On the other hand, for clients with a tendency to exaggerate their attachment needs in relationships, the therapist may attempt to increase clients' sense of autonomy and self-efficacy by resisting pulls for rescuing and maintaining appropriate boundaries, again whilst sensitively monitoring and containing client anxiety (Bernier & Dozier, 2002; Shilkret, 2005). In short, a corrective emotional experience may be achieved in therapy by introducing dissonance in client's stereotyped expectations for others and subsequent self representations.

The present study has focused solely on client's patterns of relatedness, yet it is important to acknowledge that therapy is a mutual process of exchange that involves both the client's and the therapist's internal working models. In that respect, the therapist's own experiences and areas of unresolved conflict may influence the therapeutic relationship in ways equally significant to those of clients (Maroda, 2010; Meszaros, 2004). In their study, Dozier, Cue and Barrett (1994) found that securely attached clinical case managers tended to provide more balanced counter-complementary interventions in their work with clients whereas those less securely attached tended to confirm or perpetuate their clients' working models by either gratifying preoccupied clients' attempts for closeness (and thus their perceptions of themselves as fragile and needy) or by working more superficially with deactivating clients thus reinforcing their belief in others as unavailable or unresponsive. Further research suggests that therapists' unresolved attachment issues may be confounding countertransference reactions (Mallinckrodt, 2000). It seems critical, therefore, that counselling psychologists are aware of their own patterns of relatedness in order to be able to identify and distinguish between areas of personal conflict and genuine countertransference responses and ultimately to ensure ethical and competent practice. In this context, supervision and personal therapy gain great importance for the training and practice of counselling psychology.

4. Limitations and further research

Within the present study, no significant relationship was found between length of therapy (i.e. number of sessions) and Secure Attachment to therapist. Although the variance in participants length of therapy was considerable (between three and 100 sessions) and could have provided sufficient conditions for documentation of significant effects, the lack of a unified theoretical approach employed by participating therapists and their varying level of training and experience may have been problematic in observing linear effects of time in therapy. Therapist attachment was not explored within the present study, although it has been shown to influence ways of being with clients and neither were client perceptions of the therapist and the relationship (Dozier, Cue & Barrett, 1994). The use of self-report measures in this study was deemed as more ethical, however, this may have posed considerable limitations particularly so for clients who were less secure and thus more prone to defensive distortions or bias in their self-classification. Further research utilising narrative measures of client attachment such as the AAI (Hesse, 2008) or the CCRT method (Luborsky & Crits-Cristoph, 1998) may be more sensitive in capturing unconscious processes underlying attachment classification. The contribution of the therapist's patterns of relatedness should not be overlooked when exploring the relational dynamic unfolding in therapy; it would thus be interesting for future research to explore possible interactions between processes of client transference and therapist countertransference.

5. Conclusion

In conclusion, it appears that attachment theory can provide an invaluable framework for an understanding of what happens in therapy. It can serve as a basis for integration in counselling psychology practice, as it facilitates the use of narrative, cognitive and psychodynamic approaches whilst remaining essentially humanistic and relationship-oriented (Holmes, 2001; Jordan, 2007). Attachment theory can provide a framework for practice that although unified, it can remain flexible and adaptable to particular client needs, as these are informed by their unique attachment experiences. It seems important for practitioners and researchers informed by attachment theory to remain critical, reflexive and sensitive to the particular contexts, such as cultural factors, that may determine the formation of relational patterns (both their clients' and their own), nevertheless attachment theory seems to be a particularly rich and constructive theoretical framework in informing clinical work in counselling psychology.

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References

Ainsworth, M.D, Blehar M.C., Waters, E. & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

BACP (2010). *Ethical framework for good practice in counselling and psychotherapy*. Rugby: BACP.

Bateman, A. & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalisation-based treatment*. Oxford: Oxford Medical Publications.

Bateman, A. & Holmes, J. (1995). *Introduction to psychoanalysis – contemporary theory and practice*. London: Routledge.

Beebe, B., Jaffe, J. & Lachmann, F.M. (1992). A dyadic systems view of communication. In N.J. Skolnick & S.C. Warshaw (Eds.), *Relational perspectives in psychoanalysis*. London: The Analytic Press.

Bender, D.S., Farber, B.A. & Geller, J.D. (1997). Patient's representations of therapist, parents and self in the early phase of psychotherapy. *Journal of the American Academy of Psychoanalysis, 25*(4), 571–586.

Bernier, A. & Dozier, M. (2002). The client-counsellor match and the corrective emotional experience: Evidence from interpersonal and attachment research. *Psychotherapy: Theory, research, practice, training, 39*(1), 32–43.

Bifulco, A. (2002). Attachment style measurement: A clinical and epistemological perspective. *Attachment and Human Development, 4*(2), 180–188.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

British Psychological Society (BPS) (2006). *Code of Ethics and Conduct*. Leicester: BPS Publications.

Bretherton, I. & Munholland, K.A. (2008). Internal working models in attachment relationships. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York: The Guilford Press.

Casement, P.J. (1991). *Learning from the patient*. New York: The Guilford Press.

Connoly, M.B., Crits-Cristoph, P., Barber, J.P. & Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive expressive psychotherapy for depression. *Psychotherapy Research, 10*(3), 223–233.

Crowell, J.A., Fraley, R.C. & Shaver, P.R. (2008). Measurement of individual differences in adolescent and adult attachment. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York: The Guilford Press.

Dozier, M., Cue, K.L. & Barrett, L. (1994). Clinicians as caregivers: The role of attachment organisation in treatment. *Journal of Consulting and Clinical Psychology, 62*(4), 793–800.

Dozier, M., Stovall-McClough, K.C. &Albus, K.E.(2008). In Cassidy, J. & Shaver, P.R. (Eds.). Handbook of Attachment: theory, research and clinical applications. NY: The Guildford Press

Farber, B.A., Lippert, R.A. & Nevas, D.B. (1995). The therapist as attachment figure. *Psychotherapy, 32*(2), 204–212.

Feeney, J. (1999). Adult romantic attachment and couple relationships. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York: The Guilford Press.

Feeney, J.A., Noller, P. & Hanrahan, M. (1994). Assessing adult attachment. In M.B. Sperling & W.H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives*. New York: The Guilford Press.

Goldberg, S. (2000). *Attachment and development*. London: Arnold.

Grossman, K.E. & Grossman, K. (1991). Attachment quality as an organiser of emotional and behavioural responses in a longitudinal perspective. In C.M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment across the life cycle*. London: Routledge.

Hesse, E. (2008). The Adult Attachment Interview: Historical and current perspectives. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York: The Guilford Press.

Holmes, J. (1999). Ghosts in the consulting room – an attachment perspective on intergenerational transmission. *Attachment and Human Development, 1*(1), 115–131.

Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy*. Hove: Brunner-Routledge.

Jordan, L. (2007). Attachment-based counselling. Could this be an ABC of psychological therapies? *Counselling Psychology Review, 22*(1), 58–61.

Luborsky, L. & Crits-Cristoph, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme method*. Washington, DC: American Psychological Association.

Main, M. (1991). Metacognitive knowledge, metacognitive monitoring and singular (coherent) vs. multiple (incoherent) models of attachment-finding and directions for future research. In C.M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment across the life cycle*. London: Routledge.

Main, M. (1993). Discourse, prediction and recent studies in attachment: Implications for psychoanalysis. *Journal of the American Psychoanalytic Association, 41*, 209–245.

Mallinckrodt, B., Gantt, D.L. & Coble, H.M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counselling Psychology, 42*(3), 307–317,

Mallinckrodt, B. (2000). Attachment, social competencies, social support and interpersonal process in psychotherapy. *Psychotherapy Research, 10*(3), 239-266

Mallinckrodt, B., Porter, M.J. & Kivlighan, D.M. (2005). Client attachment to therapist, depth of in-session exploration and object relations in brief psychotherapy. *Psychotherapy: Theory, research, practice, training, 42*(1), 85–100.

Maroda, K.J. (2010). *Psychodynamic techniques: Working with emotion in the therapeutic relationship*. New York: The Guilford Press.

McLeod, J. (2003). *Doing counselling research*. London: Sage.

Meszaros, J. (2004). Psychoanalysis is a two-way street. *International Forum Psychoanalysis, 13*, 105–113.

Parish, M. & Eagle, M.N. (2003). Attachment to the therapist. *Psychoanalytic Psychology, 20*(2), 271–286.

Patton, Q.M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Shaver, P.R. & M. Mikulincer (2002). Attachment-related psychodynamics. *Attachment and Human Development, 4*(2), 133–161.

Shilkret, C.J. (2005). Some clinical applications of attachment theory in adult psychotherapy, *Clinical Social Work Journal, 33*(1), 55–68.

Slade, A. (2008). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York: The Guilford Press.

Steven, P.A. & Pelham, G. (2000). A relational approach to therapy. In S. Palmer & R. Woolfe (Eds.), *Integrative and eclectic counselling and psychotherapy*. London: Sage Publications.

Stevenson, C. & Cooper, N. (1997). Qualitative and quantitative research. *The Psychologist, 10*(4), 159–160.

Westen, D. & Gabbard, G.O. (2002). Developments in cognitive neuroscience II: Implications for theories of transference. *Journal of the American Psychoanalytic Association, 50,* 99–134.

Woodhouse, S.S., Schlosser, L.Z., Cook, R.E., Ligiero, P.D. & Gelso, C.J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counselling Psychology, 50*(4), 395–408.

Wosket, V. (1999). *The therapeutic use of self: Counselling practice, research and supervision*. London: Routledge.

Original Research Paper

A preliminary exploration into the prevalence of Early Maladaptive Schemas in a group of people with Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome

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Background: *Research into Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and the impact that Cognitive Behavioural Therapy (CBT) is having on this disabling illness is increasing. However, although schemas have been associated with ME/CFS, research into this relationship does not appear evident.*

Aims: *The aim of this study was to investigate the prevalence of schemas as described by Young, Klosko and Weishaar (2003), namely Early Maladaptive Schemas (EMS) in people with ME/CFS.*

Method: *40 people with ME/CFS and 40 people from a non-clinical population completed Young's Schema Questionnaire (YSQ-S3).*

Results: *Both mean and frequency scores were analysed. The t-test indicated that the schema social isolation was significantly prevalent in the ME/CFS population, however, few people experienced this as an early maladaptive schema. Frequency scores which identified percentages at a 'therapeutically' significant level revealed that the schemas, Unrelenting Standards (URS) and Self-Sacrifice were dominant in both groups. URS was endorsed by 47.5 per cent of the ME/CFS group and by 25 per cent of the non-clinical population. The schema Self-Sacrifice was endorsed by 27.5 per cent of the ME/CFS group and 25 per cent of the non-clinical population.*

Conclusion: *The paper suggests that given the prevalence of the schemas URS and Self-Sacrifice it might be beneficial to assess for these schemas with a view to working with them therapeutically. Potentially the schemas may contribute to the perpetuation of ME/CFS affecting the individual's management and experience of the illness. Additionally, because of the degree of social isolation identified in the ME/CFS group, it is suggested that delivering treatment in groups could go someway to reducing the social isolation experienced by people with this debilitating illness. However, further research in both these areas is necessary.*

Keywords: *Myalgic Encephalomyelitis/Chronic Fatigue Syndrome; Early Maladaptive Schemas; Cognitive Behavioural Therapy; Young Schema Questionnaire.*

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a complex, life-altering illness. Although ME is classified by the World Health Organisation (2004) as a neurological disease with CFS categorisation as an optional term for ME (ICD10:G93.3) and despite extensive research into this debilitating and fluctuating illness, uncertainty surrounds its causation and perpetuating factors (Kerr et al., 2007). Even though biological irregularities are evident (Pinching 2007; Tomada, Joudoi, Matsumoto, Park & Miike, 2005; Kerr et al., 2007; Kennedy, Christian, Hodgetts et al., 2005) no single aetiological agent and no

consistent cellular or biochemical variation has been found (Werbach, 2000). It has been argued that the lack of biological clarity has resulted in ME/CFS being enveloped with controversy. Indeed Richman et al. (2000) contend that the failure of western medicine to validate a viral aetiology for ME/CFS has led to a paradigmatic shift in research perspectives, producing psychiatric and socio-cultural rationalisations for ME/CFS, ultimately delegitimising ME/CFS as a biomedical phenomenon within medical, academic and government institutions and public fields. However, research indicates that higher levels of psycho-pathology are found within the ME/CFS population (Henderson & Tannock, 2004; Afari & Buchwald, 2003; Van Duyse et al., 2002). To be noted though, frequently within the UK, the Fukuda criterion (1994) is used for diagnosis. It is claimed that not only is the terminology used within the criteria vague (Jason et al., 2005) but it purportedly fails to exclude adequately people experiencing fatigue as a symptom of a psychiatric problem, for instance depression or somatisation (Shepherd,1998). Comparisons made by the Fukuda criteria and the Canadian criteria indicate that the latter excluded more psychiatric co-morbidity, selecting more cases of physical dysfunction and neurological symptoms (Carruthers, 2006).

Current guidelines from the National Institute for Health and Clinical Excellence (NICE) recommends Cognitive Behaviour Therapy (CBT) and Graded Exercise Therapy (GET) as treatments for ME/CFS (Clinical Guideline 53, 2007), although the original statement made by NICE pronouncing these treatments as 'treatments of first choice' has been removed after protests from ME support groups (Spencer, 2007). Indeed a survey conducted by the ME support group found that only 7.4 per cent of people with ME/CFS found CBT helpful, 67 per cent reported no change and 26 per cent believed their symptoms had worsened after CBT (Action for ME, 2001). Consistent with this Bazelmans, Prins and Bleijenberg (2006), found that individuals who are engaged in legal procedures related to their illness, and those with psychological or psychiatric co-morbidity predict a less than satisfactory outcome. However, people with ME/CFS are not a homogenous group. The need for sub-grouping has been called for (Jason et. al., 2005). The wide diversity in the clinical course of the illness amongst people with ME/CFS (Jason, Fennell & Taylor, 2003) might possibly explains to some extent the contradiction in research findings, as other research demonstrates the effectiveness and favourable results CBT has had with this illness (Deale et al., 2001; Chadler, Tong & Deary, 2002; Prins et al., 2002; Wittkowski, Toye & Richard, 2004). Whilst none of these studies refute the survey conducted by Action for ME according to NICE CBT and/or graded exercise currently provide the 'clearest research evidence of benefit' for people with people with ME/CFS (NICE CG53, 2007, p.1). For some practitioners, a return to pre–illness levels of functioning is not the aim of treatment, particularly as premorbid activity levels may have been a contributing factor to the illness (Bazelmans, Prins & Bleijenberg, 2006). Importantly, factors that perpetuate and prolong the symptoms are areas that the CBT treatment attends to (Prins & Bleijenberg, 1999). With respect to this, Kinsella (2007) notes that several schemas, akin with those described by Young, Klosko and Weishaar (2003) have been recognised in some patients with CFS. The schemas are subjugation, self-sacrifice, unrelenting standards, emotional inhibition, and failure to achieve (Kinsella, 2007). The schemas are perceived as 'broad pervasive themes or patterns', mostly developed through early life experience, including attachments with significant others, interaction with peers, culture, and the influence of the individual's temperament (Young et al., 2003). They are organised into five domains related to unmet emotional needs and are associated with three broad coping styles: surrender, avoidance and overcompensation, corresponding to freeze, flight, and fight

reactions respectively. Whilst early maladaptive schemas are perceived as having a mainly detrimental affect on perception and behaviour, it is suggested that working therapeutically at schema level, using Schema Therapy with various conditions, is used too frequently and inappropriately by clinicians (James, 2001). Nonetheless, it is plausible that these broad pervasive themes might impede both the treatment, management and the lived experience of people with ME/CFS, as Riso and McBride point out, schemas 'exert a powerful influence over cognition and affect' (2007, p.7). With this in mind the present study investigates the extent that early maladaptive schemas are found within a group of people diagnosed with ME/CFS comparing the results to a non-clinical population.

Method

Participants

Eighty participants took part in the study, 40 people with ME/CFS and 40 people from the general population. All participants were white and British. Participants in each group were matched for age and gender. Each group consisted of six males and 34 female. The age range is given in Table 1, below.

The study utilised convenience sampling. Participants were recruited from ME or ME/CFS support groups and confirmed they had been diagnosed with ME/CFS by a medical practitioner. The non-clinical group was recruited from various places; sport and leisure centres, local businesses and education establishments; parents and teachers from local schools also participated. A range of education qualifications were evident, however in each group the majority of participants had a degree, in the ME/CFS group 16 participants had a first degree and four had a postgraduate degree. In the non-clinical population 14 had a first degree and four a postgraduate degree. Participants in the groups differed in employment. The majority of people in the non-clinical group were either in full- or part-time employment, this was not the case with the ME/CFS group, although some were in part-time employment few were in full-time employment; however, this appears to be a typical characteristic of people with ME/CFS (Afari & Buchwald, 2003). In each group participants were excluded if they were being treated for depression and/or anxiety.

Ethics

The proposal was approved by the University of Derby, according to their procedures. In addition the work was carried out according to ethical guidelines of appropriate professional organisations.

Measures

The short version of the Young Schema Questionnaire (Young, 2003) was distributed to the participants. It was used to assess 18 schemas. This version has the advantage that it can be administered in less time than the longer version and according to Young it appears to have similar psychometric prop-

Table 1: Age and gender distribution of each group.

Age	Number of participants in each group
18–25	One female
26–35	One male, five females
36–45	Two males, 14 females
46–55	Two males, nine females
56–65	One male, five females

erties as the longer version. Factor analysis generally provides support for the EMS on the questionnaires (Glaser et al., 2002; Lee, Taylor & Dunn, 1999), however, research is ongoing. Young's Schema Questionnaire (YSQ-S3) is a self-report inventory with 90 items; five items relate to each schema. The six-point Likert scale ranges from 'completely untrue of me' (1) to 'describes me perfectly' (6). Higher scores on this scale indicate a stronger identification with the item and hence the schema. According to Young a schema that receives two or more items scored at five or over on the YSQ-S3 is potentially meaningful (Young, 2010). The questionnaire can be used as a clinical tool collaboratively with the client to help shed light on the client's narrative and as a research tool.

Further discussion regarding the analysis of the data generated can be found in the following results section.

Results

The purpose of the analysis was to compare the mean scores and the frequency scores of the 18 schemas in each population, in order to develop an understanding of the prevalence of early maladaptive schemas in the ME/CFS group. The frequency scores relate to the percentage that scores reached thresholds of therapeutic significance as proposed by Young (2010). Independent *t*-tests were performed to assess the statistical difference between the mean scores of the non-clinical group and the ME/CFS group. Both mean scores and frequency scores are presented in Table 2. Although the ME/CFS group gave slightly higher ratings on 13 of the schemas than the non-clinical group, independent *t*-test indicated that only the schema Social Isolation was significantly different, t=–3.2, p=<0.001, df=78. The mean difference between the groups was –.47500, representing a medium effect size (r=.35); the 95 per cent confidence limits indicate that if the experiment was repeated the estimated population mean difference would lie between –0.76069 and –1.8931. However, when these results are viewed in relation to the frequency scores which indicate 'therapeutic' significance, it is evident that the schema Social Isolation is not an early maladaptive schema within this group.

Frequency Scores which indicate therapeutic significance (two or more items scored at five or six) revealed that the schemas Unrelenting Standards and Self-Sacrifice received the highest percentages in both groups. The ME/CFS group received 47.5 per cent and 25 per cent respectively. The non-clinical population received 27.5 per cent for the Unrelenting Standards schema and 25 per cent for the Self-Sacrifice schema. Percentages for the other 16 schemas were low in both groups; under 10 per cent as detailed in Table 2.

Discussion

The principal objective of this study was to investigate the prevalence of EMS as theorised by Young et al. (2003) in a group of people experiencing ME/CFS. It forms part of a wider study which explores the relationship between EMS and the experience of people with this illness. Whilst significant statistical difference was observed in the association that the ME/CFS group made with the schema; Social Isolation, this schema was endorsed by few participants as an early maladaptive schema. Rather, the schemas endorsed at a 'therapeutically' significant level were Unrelenting Standards and Self-Sacrifice; this was the case in both groups.

Social isolation pervasive in ME/CFS population

The findings from this study indicate that social isolation was more pervasive in the ME/CFS group than in the non-clinical population, but frequency scores make clear that it was experienced as an early maladaptive schema by very few people. It is, therefore, not a significant early maladaptive schema in this population. However, it does indicate that many participants with ME/CFS identified with characteristics of this schema which pertain to feeling isolated. These findings are

Table 2: Mean scores and frequency scores of the ME/CFS Group and the Non-Clinical Group (NC). ME/CFS: 40 participants. NC: 40 participants.

Schema	Group	Mean	*t*-test for Equality of Means	Test Statistics Sig. (2 tailed)	Frequency percentages indicating therapeutic meaningfulness
Unrelenting Standards	ME/CFS NC	3.1150 2.8650	–.927	.357	47.5 25.0
Self-Sacrifice	ME/CFS NC	3.2500 3.0900	–.663	.502	27.5 25.0
Practical Incompetence/ Dependence	ME/CFS NC	1.7750 1.5350	–1.668	.099	5.0 0.0
Pessimism/ Worry	ME/CFS NC	1.8100 1.7400	–.354	.725	2.5 0.0
Mistrust	ME/CFS NC	1.7300 1.7500	.134	.894	2.5 0.0
Insufficient Self-control/ Self-discipline	ME/CFS NC	1.8350 2.0250	1.226	.224	0.0 7.5
Social isolation	ME/CFS NC	2.0850 1.6100	–.76008	.001	0.0 2.5
Admiration/ Recognition Seeking	ME/CFS NC	2.0950 2.2900	.913	.364	7.5 5.0
Emotional Deprivation	ME/CFS NC	1.5200 1.2750	–.24500	.071	5.0 0.0
Self-Punitive	ME/CFS NC	1.9250 1.9000	–.118	.906	5.0 2.5
Vulnerability to Harm	ME/CFS NC	1.6200 1.5450	–.522	.603	2.5 0.0
Enmeshment	ME/CFS NC	1.4150 1.3750	–.347	.729	2.5 0.0
Failure to Achieve	ME/CFS NC	1.6550 1.6300	–.179	.858	2.5 2.5
Emotional Inhibition	ME/CFS NC	1.9750 2.0650	.452	.653	5.0 2.5
Entitlement/ Superiority	ME/CFS NC	2.0100 2.1550	.802	.425	5.0 2.5
Abandonment	ME/CFS NC	1.6350 1.5200	–.809	.071	5.0 0.0
Subjugation	ME/CFS NC	1.6950 1.7800	.510	.611	2.5 2.5
Defectiveness/ Unlovability	ME/CFS NC	1.4200 1.3600	–.618	.539	2.5 0.0

consistent with previous studies which have highlighted the isolation felt by people with this illness (Guise, Widdicombe & Mickinlay, 2007; Edwards, Thompson & Blair, 2007). Often the unpredictable nature of the illness, together with the physically overwhelming symptoms, renders it problematic for people with ME/CFS to make and keep arranged engagements (Andersen, Premin & Albrecht, 2004, 2007), whilst working outside of the home is also impossible for many people with ME/CFS (Afari & Buchwald, 2003). Moreover, research implies that the nature of the illness and the lack of a biological marker attracts controversy and stigmatisisation (Asbring & Narvanen, 2002) marginalising people with this illness (Ware, 1999), adding to their feelings of being 'different' and 'separate' from others. Given this, it is somewhat surprising that the statistical difference between the groups for this schema was not greater. However, the participants that took part in this study, in the main belonged to ME/CFS support groups, considered to be effective collaborative support networks (Afari & Buchwald, 2003). Indeed, Young et al. (2003), observed that belonging to a subgroup, and a support group meets this classification, enables people to 'share the ways they are different' (2003 p.223), feasibly reducing a sense of isolation through communication of shared experience. With this in mind, one of the benefits of delivering therapeutic treatment in the context of a group, for people with ME/CFS, is that it might provide a respite from the pervasive isolation that some experience.

Frequency scores: EMS endorsed at a 'therapeutic' significant level

Particularly important to counselling psychologists is the extent that early maladaptive schemas are found within the ME/CFS population, largely the findings suggest a range of early maladaptive schemas are experienced by people with this illness but the ones that are most prevalent are Unrelenting Standards and Self-Sacrifice. Young et al. (2003) stipulate that the former schema is only maladaptive if related to some form of dysfunction such as a 'health problem' (p.265) and the latter if taken to an 'unhealthy extreme' (p.248). It is important then that the counselling psychologist explores in therapy the extent that the schema is maladaptive for the client.

Unrelenting Standards (URS) particularly notable in ME/CFS groups

Frequency scores indicate that 47.5 per cent of the ME/CFS population endorsed this schema to a 'therapeutically' significant level; in comparison to 25 per cent of the non-clinical population. Characteristics of this schema include perfectionism, being driven and having internalised high standards connected to hyper-criticalness. Rather than seeking approval from others, Young et al. (2003) postulate that people with this schema behave in such a manner because they feel they 'should'. Importantly this schema fits under the domain 'over vigilance and inhibition' which also identifies characteristics such as suppression of one's feelings and spontaneous responses. The findings concur with literature that suggests that some of the characteristics of the schema and the domain have been observed in people with ME/CFS (Ware, 1999, Kinsella, 2007; Le Bonn, 2007) both as precipitating and perpetuating factors of the illness. Although, research indicates that ambitions, expectations (Duff, 2003) and perfectionism behaviour (Luyten et al., 2006) decline, adapting to the limitations of the illness, the maladaptive coping responses to this schema (Young et al., 2003) might result in behaviours that are not conducive to the well-being of people with ME/CFS. For instance, it is feasible that striving to reach such high standards, viewed as 'surrendering' to the schema, could result in the individual depleting their energy level and hence intensify feelings of stress. This is concerning as links have been made with stress and the immune system within ME/CFS. Antoni and Weiss's (2003) conceptual model of the Interaction of Immune

Dysregulation, Psychological States and CFS Symptoms details the associations and the potential impact of psychological distress on the immune system, which can lead to an exacerbation and/or perpetuation of the symptoms, detrimentally affecting the individual's well-being. A vicious cycle is apparent.

Self-Sacrifice evident in both groups

The schema self-sacrifice lies in the domain of other-directiveness which embodies schemas linked to an over-emphasis on the needs and reactions of others. Typically, this results in the individual putting their own needs after those of others; this can be for various reasons including an avoidance of feeling of guilt or selfishness, to ensure others do not experience distress, and because they think it is the correct way to behave (Young et al., 2003). The findings from this study indicate that only a slightly higher percentage of people related to this schema at a therapeutically significant level in the ME/CFS group than the non-clinical group. Similarly, Fritzsimmons et al.'s (2008) study, which focused on mood and anxiety disorders, also established a high level of endorsement of the Self-Sacrifice schema (54 per cent). Although it might seem inappropriate to compare these studies because of the different subject areas, both studies include a high percentage of women. It draws into question, as pointed out by Fritzsimmons et al., if women have a greater tendency to be self-sacrificing.

Surrendering to the schema; putting other people's needs before their own, might make the individuals endearing to others, and make them feel better about themselves, even if it is only for a short while. However, constantly endeavouring to help others, before meeting their own needs, could increase levels of fatigue and stress. Treatment plans, particularly those that involve pacing, are likely to be jeopardised as 'putting their own health first' could escalate feelings of guilt. Whilst the maladaptive coping strategy of 'avoidance' may result in the individual keeping away from others, in order to avoid their compulsion to meet the needs of others, however, such behaviour could also perpetuate feelings of isolation. Plausibly maladaptive coping strategies could increase distress levels experienced by people with ME/CFS potentially detrimentally affecting the immune system (Antoni & Weiss, 2003).

Limitations

Participants were chiefly from ME or ME/CFS support groups which might not be representative of the population of people with ME/CFS as a whole; not all people with ME/CFS belong to support groups. Additionally some people with ME/CFS are invested in a solely biological explanation and treatment of the illness which might have biased their response to the questionnaire. Hence, determining individual's explanation for the illness, for instance biological or multi-factorial, prior to completing the questionnaire, might have been insightful. Furthermore, the questionnaire assumes that people are aware of what they emotionally feel and can remember how they have felt over the past year; people with ME/CFS sometimes have memory problems, which might have influenced the way they answered the questions on the questionnaire. Furthermore, the study did not take measures of mood or anxiety levels, rather it asked participants to state if they were being treated for depression/anxiety, such measures might prove constructive in future studies. Finally, this was a small scale study that was particularly limited by the number of male participants; however, as stated earlier this reflects the ME/CFS population.

Conclusion

Although this study has several limitations, and is a preliminary investigation, it does seem to indicate that there might be some benefit for counselling psychologists to include the YSQ-S3 as part of the assessment process. Pervasive patterns of behaviour that might aggravate the illness and interfere with the treatment process could be identified and therapeutically worked with.

Although, as the questionnaire is time-consuming, consideration needs to be given as how to implement it without exacerbating the client's fatigue further. Alternatively, based on the prominence of the schemas Unrelenting Standards and the Self-Sacrifice in this study, as part of the treatment process it might be useful to generally address these schemas and the impact their elicited coping responses, might have on the experience of ME/CFS. However, again this calls for further research. It would also be pertinent to explore the self–sacrificing behaviour in women and its relationship to the experience of the illness, as ME/CFS is experienced by a greater percentage of women than men (Shepherd, 1998). Finally the pervasiveness of social isolation found in this study suggests that delivering treatment in a group context, forming a subgroup, might enable people to share their common experiences which in many respects, separates them from society. Although it would be important to research how best to facilitate this to ensure that it is a positive experience.

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References

Action for ME (2001). *The severely affected: A survey of members of Action for ME.* London: Action for ME.

Afari, N. & Buchwald, D. (2003). Chronic Fatigue Syndrome: A review. *American Journal of Psychiatry, 160*, 221–236

Anderson, M., Premin, H. & Albrecht, F. (2004). Illness and disability in Danish Chronic Fatigue Syndrome patients at diagnosis and five-year follow-ups. *Journal of Psychosomatic Research, 56*, 217–229.

Andersen, M., Permin, H. & Albrecht, F. (2007). Nine-year follow-up of Danish Chronic Fatigue Syndrome (CFS) patients: Impact on health, social, vocational, and personal lives. *Journal of Chronic Fatigue Syndrome, 14*(2), 7–23.

Antoni, M. & Weiss, D. (2003). Stress and immunity. In L. Jason, P, Fennal & R. Taylor (Eds.), *Handbook of Chronic Fatigue Syndrome.* New Jersey: John Wiley & Sons.

Asbring, A. (2000). Chronic illness – a disruption in life: Identity-transformation among women with Chronic Fatigue Syndrome and Fibromyalgia. *Journal of Advanced Nursing, 34*(3), 312–319.

Asbring, P. & Narvanen, A. (2002). Women's experience of stigma in relation to Chronic Fatigue Syndrome and Fibromyalgia. *Qualitative Health Research, 12*(2), 148–160.

Bazelmans, E., Prins, J. & Bleijenberg, G. (2006). Cognitive behaviour therapy for relatively active and for passive Chronic Fatigue Syndrome patients. *Cognitive Behaviour Practice, 13*(2), 157–166.

Carruthers, B., (2006). Definitions and aetiology of Myalgic Encephalomyelitis: How the Canadian consensus clinical definition of Myalgic Encephalomyelitis works. *Journal of Clinical Pathology, 60*, 117–119.

Chadler, T., Tong & Deary, V. (2002). Family cognitive behaviour therapy for Chronic Fatigue Syndrome: An uncontrolled study. *Archives of Disease in Childhood, 86*(2), 95.

Deal, A., Husian, K., Chadler, T. & Wessley, S. (2001). Long-term outcome of cognitive behaviour therapy for Chronic Fatigue Syndrome: A five-year follow-up study. *The American Journal of Psychiatry, 158*, 2038–2042.

Duff, K. (2003). Social effects of chronic disorders. In L. Jason, P. Fennell & R. Taylor (Eds.), *Handbook of Chronic Fatigue Syndrome.* New Jersey: John Wiley & Sons Inc.

Edwards, C., Thompson, A. & Blair, A. (2007). An overwhelming illness. Women's experience of living with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis. *Journal of Health Psychology, 12*(2), 203–214.

Fitzsimmons, K., Gallagher, S., Blayone, S., Chan, D., Leaitch, W, Veals, N. & Wilkinson, N. (2008). The Young Schema Questionnaire in group therapy: Client–focused approach. *Social Work in Mental Health, 7*(1–3), 178–185,

Fukuda, K., Straus, S., Hickie, I., Sharpe, M., Dobbins, J. & Komaroff, A. (1994). The Chronic Fatigue Syndrome: A comprehensive approach to its definition and study. *Annals of International Medicine, 1221*, 953–939.

Guise, J., Widdicombe, S. & McKinlay, A. (2007). What is it like to have ME? The discursive construction of ME in computer-mediated communication and face-to-face interaction. *Health, 11*(1), 87–108.

Henderson, M. & Tannock, C. (2004). Objective assessment of personality disorder in Chronic Fatigue Syndrome. *Journal of Psychosomatic Research, 56*(2), 251–254.

James, I. (2001). Schema therapy: The next generation, but should it carry a health warning? *Behavioural and Cognitive Psychotherapy, 29*, 401–407.

Jason, L., Corradi, K., Torres-Harding, S., Taylor, R. & King, C. (2005). Chronic Fatigue Syndrome: The need for subtypes. *Neuropsychology Review, 15*(1), 29–58.

Jason, L., Fennell, P. & Taylor, R. (Eds.) (2003). *Handbook of Chronic Fatigue Syndrome*. New Jersey: John Wiley & Sons.

Jason, L., Witter, E., K. & Torres-Harding, S. (2003). Chronic Fatigue Syndrome, coping, optimism and social support. *Journal of Mental Health, 12*(2), 109–118.

Kennedy, G., Spence, V., McLaren, M., Hill, A., Underwood, C. & Belch, J. (2005). Oxidative stress levels are raised in Chronic Fatigue Syndrome and are associated with clinical symptoms. *Free Radical Biology and Medicine, 39*(5), 584–589.

Kerr, J., Christian, P., Hodgetts, A., Langford, P., Devanur, L., Petty, R., Sinclair, L., Richards, S., Montgomery, J., McDermott, C., Harrison, T., Kellam, P., Nutt, D. & Holgate, S.T. (2007). Current research priorities in Chronic Fatigue Syndrome/Myalgic Encephalomyelitis: Disease mechanisms, a diagnostic test and specific treatments. *Journal of Clinical Pathology, 60*, 113–116.

Kinsella, P., (2002). Review: Behavioural interventions show the most promise for Chronic Fatigue Syndrome. *Evidence Based Nursing, 5*(2), 46

Le Bon, O., Cappeliez, B., Neu, D., Stulens, L., Hoffman, G., Hansenne, M., Lanbrecht, L. Ansseau, M. & Linkowski, P. (2007). Personality profile of patents with Chronic Fatigue Syndrome. *Journal of Chronic Fatigue Syndrome, 14*(1), 55–68.

Luyten. P., Van Houdenhove, B., Cosyens, N. & Van den Broeck, A. (2006). Are patients with Chronic Fatigue Syndrome perfectionistic – or were they? A case control study. *Personality and Individual Differences, 40*(7), 1473–1483.

National Institute for Health & Clinical Excellence (NICE) (2007). *Chronic Fatigue Syndrome/Myalgic Encephalo-myelitis*. Retrieved 25 May 2010, from: http://guidance.nice.org.uk/GG53

Nordahl, H., Holthe, H. & Haugum, J. (2005). Early maladaptive schemas in patients with or without personality disorders: Does schema modification predict symptomatic relief? *Clinical Psychology and Psychotherapy, 12*, 142–149.

Prins, J., Bazelman, E., Van der Werf, S., Van der Meer, J. & Blejenberg, G. (2002). Cognitive behaviour therapy for Chronic Fatigue Syndrome: Predictors of treatment outcome. *International Congress Series, 1241*, 131–135.

Richman, J., Jason, L., Taylor, R. & Jahn, S. (2000). Feminist perspectives on the social construction of Chronic Fatigue Syndrome. *Health Care for Women International, 21*(3), 173–185.

Riso, L. & McBride, C. (2007). Introduction: A return to a focus on cognitive schemas. In L. Riso, P. du Toit, D. Stein & J. Young (Eds.), *Cognitive schemas and core beliefs in psychological problems. A scientist-practitioner's guide*. Washington, DC: American Psychological Association.

Spencer, P. (2007). NICE guidelines – a landmark for ME. I*nteraction, 61*, 2–3.

Tomada, A., Joudoi, E., Matsumoto, T., Park, T. & Miike, T. (2005). Cytokine production and modulation: Comparison of patient with Chronic Fatigue Syndrome and normal controls. *Psychiatric Research, 134*(1), 101–104.

Van Duyse, A., Mariman, A., Poppe, C., Michielsen, W. & Rubens, R. (2002). Chronic Fatigue Syndrome in the psychiatric practice. *Acta Neuropsychiatrica, 14*(3), 127–133.

Ware, N. (1999). Chronic Fatigue Syndrome as an example of the social course of chronic illness. *Culture, Medicine and Psychiatry, 23*(3), 303–331.

Werbach, M. (2000). Chronic Fatigue Syndrome: How far have we come? *Journal of Nutritional & Environmental Medicine, 10*, 181–188

Wittkowski, A., Toye, K. & Richards, H. (2004). A cognitive behaviour therapy group for patients with Chronic Fatigue Syndrome: A preliminary investigation. *Behavioural and Cognitive Psychotherapy, 32*, 107–112.

World Health Organisation (2004). The *ICD–10* statistical classification of diseases and health related problems. *ICD–10* (2nd ed.) Volume 2. Geneva: WHO.

Young, J.E. (2010). *Young Schema Questionnaire: Informal clinical scoring instructions*. Retrieved 30 May 2010, from: http://www.schematherapy.com/id111.htm.

Young, J., Klosko, J. & Weishaar, M. (2003). *Schema therapy: A practitioner's guide*. London. The Guilford Press.

Theoretical Article

Ecopsychology and the person-centred approach: Exploring the relationship

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Content and Focus: *This article explores the relationship between ecopsychology and the person-centred approach to psychotherapy and counselling. The literatures of both topics are reviewed and areas of fit as well as of conflict are identified. This exploration is situated within the context of climate change and the broader damage to the natural world. Specific person-centred concepts are considered with regard to our relationship with the natural world.*

Conclusions: *Considerations for the person-centred approach and counselling psychology practice are discussed. In particular, the article highlights ways in which the self may be relocated within a larger ecological context, the possibility of ecologically situated well-being and incongruence, and the relevance of Rogers' concept of psychological contact to our relationship with the natural world.*

Keywords: *ecopsychology; person-centred approach; environmentalism; the formative tendency; the natural world.*

CAN PERSON-CENTRED THEORY and practice contribute to pro-environmental attitudes and behaviours? This article explores this relationship between ecology, environmentalism and the person-centred approach. This interaction takes us into the realm of ecopsychology (Roszak, Gomes & Kanner, 1995). Ecopsychology is a field of intersection of ecology and psychology, charting the relationship between environmental issues and psychological process and well-being (see, for example, the online journal *Ecopsychology*). It explores theory and empirical findings on the psychological benefits of pro-ecological behaviour and of interacting with nature (Gatersleben, 2008). Ecopsychology also explores ways that psychological knowledge can contribute to ecological sustainability, particularly through helping us understand and change our stance and behaviour towards the physical world. It assumes an emotional bond between people and their natural environment (Brown, 1995). Eco-psychology is a term whose use is growing in published literature (Thompson, 2009) as awareness grows of the need for synthesis and inter-disciplinary dialogue.

The person-centred approach, originally developed by Carl Rogers, has become a well-established and empirically-supported form of counselling and psychotherapy (Elliott, 2001; Elliott, Greenberg & Lietaer, 2004). It is marked out from many other therapies by its belief in a *fundamental tendency toward growth* that exists in each person (Rogers, 1959). The purpose of person-centred therapy is to foster the conditions under which this tendency can express itself. However, the person-centred approach is not limited to counselling and psychotherapy. Carl Rogers and others have applied its principles and practices to issues of politics, peace, conflict resolution, urban diversity, and international diplomacy (Henderson et al., 2007; Proctor et al., 2006).

This article represents a response to calls for greater holism and synthesis between diverse disciplines, particularly in relation to sustainability and the survival of humanity and of our rich ecosystem (Bekoff, 2003). It also seeks to situate people within their ecological context in keeping with counselling psychology's focus on the influence of

multi-faceted contexts upon the well-being and distress of human beings (Strawbridge & Woolfe, 2003). More personally, this exploration arises from the author's interest in relating his identity as a counselling psychologist to his participation in the world outside the therapy room. Such relating has already been explored with respect to psychodynamic and attachment theories (Jordan, 2009; Randall, 2009). Jordan (2009) suggests, for example, that our early experiences of love influence the relationship we develop with nature, and that in the West, our style of attachment to nature is predominantly one of avoidance and ambivalence.

There are clear reasons why counselling psychologists informed by the person-centred approach may wish to reflect on the interplay between their therapeutic work and the ecological context. There has been some application of person-centred ideas to contexts beyond the therapy room (e.g. Proctor et al., 2006). However, there has been to date little exploration of how the approach might contribute towards changes in attitudes and behaviour towards the natural environment. Rather than having to learn an entirely new set of theory and practices, it makes pragmatic sense for therapists to apply person-centred theory and practice to the newer field of ecopsychology, whilst recognising that no single model of psychology is likely to predominate in ecopsychology.

More broadly, counselling psychologists are in the privileged position of talking at depth with people about their lives. The deep respect and empathic understanding inherent within the person-centred approach offers a window into the ways in which a person's relationship with their environment may be affecting their well-being, and vice versa. Recent research (discussed later in the article) also suggests that improved psychological contact with nature may enhance well-being (e.g. Mayer & Frantz, 2004; Schultz et al., 2004). These are some of the reasons why therapists are increasingly interested in this interplay of ideas, particularly at a practical level.

The historical, environmental and psychological context of ecopsychology

Ecopsychology as a discipline has emerged during a particular historical, environmental and psychological context. These contextual factors highlight why therapists should be interested in the relationship between psychology and the environment. Considering such contexts assists us in gaining a comprehensive and nuanced understanding of human beings and their relationships with the world around them.

The publication of *The Limits to Growth* (Meadows et al., 1974) spelled out the increasing consumption of natural resources by humankind and the limits of those resources. Consequently, it argued that economic and population growth cannot continue exponentially. This conclusion elicited strong critical reactions because it challenged a presumption that we could continue indefinitely producing and consuming as much as we wish. The 30-year update confirms the accuracy of the 1974 predictions, demonstrating that as a race, we are still consuming more than the earth can cope with and that the 21st century will see serious environmental, economic and social problems arising from this disparity (Meadows, Randers & Meadows, 2004).

Furthermore, the Intergovernmental Panel on Climate Change has gathered extensive evidence that our climate is changing in significant ways and is very confident that human actions are the cause of these changes (IPCC, 2007). The failure of world leaders to reach a meaningful international agreement at the Climate Change Conference in Copenhagen in 2009 seems symptomatic of our collective inability to fully accept the reality of climate change and to respond accordingly (*The Guardian*, 2009). There appear to be a number of possible reasons for this difficulty, some of which are discussed below, but none of which offer a complete explanation (Kollmuss & Agyeman, 2002).

Decisional bias may influence our responses to these dilemmas. When short-

term assured gain is weighed up against long-term potential cost, we often choose the short-term gain (Bechara, 2001, 2005). Even if the long-term cost is very high and very likely, we can remain deeply embedded in our current patterns, what we might describe as addiction. Macy (1995) sees addiction as one of many pathologies that can be legitimately invoked to describe our collective behaviour towards the wider world.

Peck (1978) suggests that delay of gratification is essential to psychological health and we know it can be learned even by young children (Mischel, Shoda & Rodriguez, 1989). In our current predicament, however, we are asked to delay for uncertain future gratification of the species or ecosystem as a whole. As a culture, our current levels of energy and resource consumption are geared towards immediate gratification. To change such habits requires a societal and ongoing delay of gratification. If the person-centred approach promotes an actualising tendency that drives us to focus mainly on meeting our own needs, then the idea of delaying or denying gratification may seem like externally imposed conditions of worth that conflict with the actualising tendency.

Psychologically it seems to be very difficult for many of us to recognise planet-wide problems and to conceive of appropriate responses, what Albrecht (2010) refers to as 'ecoparalysis'. The inability to meaningfully respond to the climatic and ecological challenges that face us is not always an expression of apathy. The complex nature of the problems and the fact that they are tied to the very foundations of our present economy generate dilemmas not previously encountered in human history, and we may struggle just to comprehend them.

It can also be difficult to imagine a future different to our present, to conceive of a world where resources are limited even in the richest countries, and where the damage done to our biosphere casts a direct and immediate shadow over our daily lives. There is, therefore, a substantial *incongruence* between what we hear about an ecological disaster slowly unfolding, and our inability or unwillingness to change our understanding and behaviours towards our environment (Kollmus & Agyeman, 2002). In response, the person-centred approach proposes a radical commitment to *congruence*, meaning the accurate integration of experience into the self-concept or self-image, or realness, genuineness, and transparency (Rogers, 1959; Cornelius-White, 2007).

Given this background, the central question of this discussion is this: Can person-centred theory and practice contribute to pro-environmental attitudes and behaviours?

The following discussion takes some of the main features of the person-centred approach and discusses these in relation to our relationship with the natural world. This analogy is of course limited and potentially misleading. To assume that we are in the role of helper in relation to the natural world may perpetuate a dualistic split of master/slave or consumer/resource, which is potentially harmful. Despite this danger, I argue that the person-centred model is valuable in its unconditional respect for the *other*, and its belief that the other has within it the resources for maintenance and growth. Areas of potential conflict between the person centred approach and pro-environmental stances are also explored, which relate particularly to the underlying philosophical and culturally embedded assumptions of the person-centred approach.

The actualising tendency

Rogers defines the actualising tendency as 'the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism' (1959, p.195). The actualising tendency promotes movement towards growth, differentiation and autonomy. However, if the actualising tendency is treated as a justification for meeting one's own needs above all else, the person-centred approach might be regarded as rooted in the egocentric and utilitarian ethic that, I argue, is at the root of much of our damaging behaviour towards each other

and our environment. As Mearns and Thorne (2007) point out, the unfortunate effect of Rogers' theory of the actualising tendency is that all restraints on the actualising tendency are seen as negative and restrictive, impeding the natural and healthy process of development of the self. The concept of social mediation is introduced by Mearns and Thorne (2007) to make the theory more consonant with the reality of social mediating forces being both negative and positive.

The concept of dialogue between the actualising tendency and social mediation still retains a strong egocentric point of view, which underpins the self-focussed ways in which we currently relate to our environment. Naess (1973) argues for a 'deep ecology' that rejects this man-in-environment image in favour of a profoundly relational image. It is arguable that changes in attitudes and actions towards nature will require action at collective levels, rather than by autonomous individuals. However, there is much in the person-centred tradition and theory that might be of value to the development of a more nurturing stance in our relationship with our natural world and future life, *if we enlarge the focus from the individual to the biosphere.* Individual psychology can thus give way to relational psychology (Milton, 2009).

The world as organism: The formative tendency

Rogers (1959) always proposed that the person-centred approach is a way of being, rather than a set of techniques. It is a stance, an outlook, a radical belief about the nature of people and as such, cannot be faked. Working in a person-centred way with clients depends on an underlying conviction that the client has within themselves the means of healing, the resources to change. The therapist does not try to change the client. Instead, she seeks to nurture the conditions in which the actualising tendency of the client can work for maintenance and growth.

Carl Rogers believed that the actualising tendency of individual organisms is a microcosm of a broader 'formative' tendency that is evident in the progression from disorder to order, of increasing complexity, and of individual entities joining together in more complex colonies (Rogers, 1978). Rogers sees this tendency at work from the level of cells to that of galaxies. He notes that this notion seems at odds with the second law of thermodynamics, the law of entropy, which states that in a closed system, matter tends towards homogeneity and homeostasis, rather than towards complexity and variety (Dugdale, 1996). For Rogers, this counter-intuitive tendency creates potential for human beings to develop an ever deeper awareness of their place in the universe, and can serve as a basis for a theory of humanistic psychology.

Similarly, Gaia theory proposes that the biosphere (the Earth and its atmosphere) is a self-regulating system which will respond, slowly, to variations in temperature, climate, chemical balances, etc., in order to maintain and nurture life (Lovelock, 1995). Therefore, Gaia theory seems to point towards an actualising or formative tendency within the biosphere. If this is true, our task is not to 'fix' the biosphere but to nurture the conditions under which its own actualising tendency can bring it back to health.

The person-centred belief in the sufficiency of the actualising tendency in human beings also conflicts with the medical model of psychological suffering, in which deficits are identified and direct interventions or treatments are 'prescribed'. In our relationship to the environment, we may see ourselves as the 'doctor', needing to fix the earth with our expertise and power. In the person-centred mode, we may better see ourselves as partners, trying to contribute towards the right conditions that allow the natural adaptive and growth-orientated tendency of the biosphere to heal and maintain itself.

Neville (1999) argues that many person-centred theorists have resisted Rogers' movement outward from the actualising tendency to the concept of the formative tendency,

which Van Belle (1990) describes as 'mystical universalism'. We can see then that the expansion in Rogers' thinking later in his life offers a concept of the self that is more consonant with ecopsychological ideas, albeit one that has not been widely accepted within the person-centred tradition. There is, therefore, a challenge to person-centred practitioners to consider this move from the individual as primary, to the individual as a secondary phenomenon in the context of the biosphere.

Psychological contact with the natural world

Rogers' theory of the development of the self leads naturally to his six conditions of the therapeutic process (Rogers, 1959). As an analogy has been drawn between Rogers' theory of therapy and our understanding of the planet-human relationship, the first of the therapeutic conditions, *psychological contact*, is considered in light of this relationship. In this analogy, I include *empathic understanding* within the domain of psychological contact.

The first of Rogers' six therapeutic conditions states that the therapist and client are in psychological contact with one another (Rogers, 1957). Are we, as individuals or communities, in psychological contact with the natural world? Are we really open to experiencing it or being present to it? Do we mindfully attend to our environment, watching the movement of its seasons and processes, hearing its communication, bracketing our own needs and distractions in order to be fully present?

The theory of Gaia introduced earlier would suggest that our work of psychological contact should be to respect the natural cycles and self-maintaining processes of Gaia, and avoid actions that conflict with those processes. It seems that we are no longer living in tandem with these natural processes of the Earth, and are therefore in poor 'psychological contact' with the Earth, or experiencing limited empathy with it. This section considers the role of psychological contact in our relationship with the natural world.

The individual and the whole

The level at which psychological contact and empathy occur is important within ecopsychology. As has already been suggested, our psychologies are too often located at the level of the individual and grounded in individualistic ways of being and acting (Thatcher & Manktelow, 2007). In this paradigm, the natural world is viewed as 'the 'other', a distant and in the extreme, dangerous place, which needs to be dominated and controlled' (Higley & Milton 2008, p.11). This is a poor relational foundation for psychological contact.

Neville (1999) argues for an alternative viewpoint where human beings are one part of a much larger system, and not a terribly important part at that. This stance encourages us to experience our connection to all parts of the bigger system rather than bolster the individual self as a distinct, well-boundaried, autonomous entity. Oliver (1979) enticingly expresses this connectedness:

> 'Whoever you are, no matter how lonely,
> the world offers itself to your imagination,
> calls to you like the wild geese, harsh and exciting –
> over and over announcing your place
> in the family of things.'
> (Oliver 1979, p.21)

To know 'your place in the family of things' is to experience a moving sense of deep connection with the width and breadth of the world of living and non-living things of 'wonder, beauty and intimacy' (Berry, 2000, p.93) and to move beyond the small concerns of the insecure self, the 'curse of self' (Leary, 2007). Equally though, having a place in the bigger picture means being subject to nature's darker sides, such as the brutality of survival in the food chain. It also means recognising our relative insignificance in light of the vastness and complexity of the world.

Enhancing psychological contact with nature

Given this potential for a relocation of the self, how might this psychological contact and empathy with the natural world be improved and what difference might this make? One method is the Council of All Beings (Seed et al., 2007), a ritual performed in a natural setting, in which participants empathically speak the 'voices' of different elements of nature, enabling the participants to experience and express the despair that is a natural response to our destruction and neglect of nature. It also empowers participants beyond despair to work towards change.

Psychological contact, whilst being useful to our relationship with the environment, can also be good for our own well-being. Research suggests that a person's felt connection to nature may be related to their well-being and ecological behaviour (Mayer & Frantz, 2004; Schultz et al., 2004). Amel, Manning and Scott (2009) found that acting with awareness, an aspect of mindfulness, was significantly positively correlated with sustainable behaviour. Harper (1995) describes 'wilderness practice' which seeks to reconnect people with 'wilderness', using treks through natural environments, attending fully with all five senses to the outside world, leaving behind man-made gadgets and places, and using simple rituals to acknowledge and appreciate all elements of the human and non-human world. Shapiro (1995) uses environmental restoration work to help people learn more about the biology, geology, hydrology, and history of where they live. Learning about the symbiosis and interconnectedness of these phenomena gives people a greater awareness of how they fit into their environment, how they can restore it where it is damaged, and how this interconnectedness becomes apparent within themselves and with other people. Again, such activities happen in communities and often contribute to a deepening of relationships within such communities.

Kaplan (1995) lists some important aspects of having healthy psychological contact with a restorative natural environment. A sense of 'being away' is about distance and difference from the usual urban environment. Through 'soft fascination', we can attend easily to natural phenomena that are enjoyable and easy to comprehend. The 'extent' or scale of the natural environment is related to its therapeutic effects – the greater the scale the greater the effect on well-being. However, where large swathes of greenery are not available, extent can be 'created' through miniaturisation such as that found in Japanese gardens, or creative use of winding paths to give the impression of greater scale. Lastly Kaplan describes the different types of 'compatibility'. There are various roles we can have in relation to natural environments, including the predator role, the locomotion role, the 'taming the wild' role, observation, and survival. Therefore, the ideal natural environment is one that is compatible with the purpose we have for ourselves within that environment.

Spirituality and the natural world

What Kaplan omits to include in the above list is the place of contemplation and spirituality within psychological contact. Many descriptions of spirituality include an element of connecting with and enjoying nature (Taylor, 2001) and some pantheistic religions give the natural world a central role (Harrison, 1999). This opening up to the natural world in collective experience leads naturally, in much ecopsychology literature, to a spiritual dimension of life. For example, Aboriginal spirituality is deeply grounded in land and place (Zapf, 2005). In the Aboriginal worldview, a person's identity 'incorporates the place and their relationship to it' (Zapf, 2005, p.637). This interconnectedness is nurtured by living in a place for many generations, and sensing that the place knows its people, just as the people know their place.

Western epistemology and psychology are often a far cry from this land-based, spiritual knowledge. Cornforth (2008) points out that other disciplines such as education

and social geography are further ahead in this groundedness in land and space than are psychology and counselling. She notes if we moved away from detached individualism, our stories about ourselves could be much more rooted in 'our inter-relationship with the natural world, the places and spaces we occupy … the species with which we daily interact' (Cornforth, 2008, p.151). This breadth and depth of 'rootedness' is richly appealing, though it omits any mention of spiritual rootedness.

It may be that some types of spirituality can help to motivate us towards a self-transcending stance towards our environment. Western spirituality can seem rooted in an individual-centred epistemology that perpetuates the myth of dominance over nature. In the Christian tradition, for example, Genesis 1:28 has often been criticised as the basis for an inherently exploitative relationship with the natural world. More recently, however, the mandate to 'be fruitful and multiply and replenish the Earth and subdue it' has been taken as a command to care well for the Earth. In particular, 'replenishing' the earth clearly points to renewing and recycling, giving back what we take from it (Merchant, 1992).

Rogers' experience and views of mainstream religion have perhaps pushed the wider world of the person-centred approach towards a wariness of spirituality. For example, the dangers of rigid religious dogma inducing unhealthy conditions of worth and highly externalised loci of evaluation are fairly obvious. However, if mature spirituality can encourage ecological restoration, the person-centred approach, like other psychotherapeutic models, may wish to consider the ways in which spirituality might offer a coherent framework for pro-environmental attitudes and behaviours (e.g. McIntosh, 2004; Fox, 1984).

The concept of psychological contact encompasses many of these ideas neatly. To actually be fully present to nature entails spending time in it, being 'softly fascinated' by it, perhaps even doing more of our activities in it. Psychological contact with nature can also go deeper into drawing significance and a sense of belonging from our physical world. And for many, this deep contact with nature is a spiritual experience, ranging from simple awe and wonder to deism and theism.

Implications for practice

The ecopsychological perspective explored thus far has much to say at the theoretical level. For counselling psychologists, the implications for psychotherapeutic practice of such a perspective also deserve attention.

If the self is to be re-located within a larger ecological context, therapists could consider ways in which clients' presenting concerns may relate to their relationships with their environment. In the person-centred approach, incongruence is considered the root cause of all distress (Rogers, 1959). Incongruence is a disparity or dissonance between the self-concept and the lived experience of the person (Warner, 2007). Perhaps, therefore, some human distress is due to the incongruence discussed earlier between our knowledge of our damage to the natural world and our sense of impotence or 'ecoparalysis'. Feelings of depression may be a natural reaction to the recognition, whether conscious or unconscious, that we have seriously harmed our planet, and continue to do so. Anger may also be ecologically situated, towards ourselves for our neglect and our sense of impotence to change, and our anger at each other, governments and corporations for the same reasons. Anxiety is another intelligible ecologically situated reaction as we realise we may be causing irreparable harm to our home and to the survival chances of our species.

In order to explore such ecologically situated distress, Neville (1999) suggests that therapists influenced by the person-centred approach might be able to attend to clients' distress not only or even primarily in their individuality, but as parts of a bigger whole, and in this ecologically situated distress. In this way, the therapist well-versed in deep empathic listening might extend their focus to the voice of 'the pain of the species and

the plight of the world' (1999, p.64). This deep attending may encourage clients to be more fully open and sensitive to their ecologically-situated experience. Just as Cushman (1990) argues for a historically-situated psychology, ecopsychology demands an ecologically situated psychology of well-being and distress.

There are examples of more specific therapeutic approaches and experiences that seek to recognise and work with an ecologically situated sense of self. Conn (1995), for example, describes therapeutic work with clients which includes exploration of the sense of belonging within the broader world, the ways in which interpersonal abuse resonate with the broader abuse of the natural world, or how 'dumping' our emotional garbage into our relationships echoes our dumping of physical rubbish into the very land on which we live. This re-appraisal of the size, significance and true nature of the self is a crucial theme in ecopsychology. Hillman (1995) believes that psychology has taken 'human emotions, relationships, wishes and grievances utterly out of proportion in view of the vast disasters now being suffered by the world' (p.xx). O'Connor (1995) speaks of interrupting 'a client's obsessive, self-absorbed soliloquy with, 'Are you aware that the planet is dying?' (p.154). In each of these ideas and approaches, it is a kind of 'ecological incongruence' that is being acknowledged and challenged, sometimes in quite direct ways.

This challenge can take place not only in individual therapy but in community and outside of traditional therapy structures. It is perhaps fitting that in communities we share the guilt, shame, sadness, despair, and disappointment that we may feel in response to our ongoing damage to our biosphere and to future generations hopes for survival. Carbon Conversations (Randall, 2009) offers groups a space in which to share these feelings before trying to transform them into changes in lifestyle that reduce one's carbon footprint. Likewise, the Transition movement offers opportunities for collective attitude change, collective actions, and sharing of ideas, stories, and encouragement (www.transitionnetwork.org).

Conclusion

In this article, I have argued that psychological therapists have the ability and the responsibility to explore their theories and their practice in relation to the unprecedented ecological context. This consideration is both ethically demanded and therapeutically valuable. Some key elements of the person-centred approach have been explored to enrich and inform our understanding of the natural world and our place within it. I have critiqued the person-centred concept of self and the way in which this can contribute to an egocentric stance towards the world. I have argued that a more ecologically-situated concept of self may be necessary if we are to alter our stance towards the biosphere and future generations of living beings. However, in Rogers' concept of the formative tendency we have seen the potential for an enlargement of focus from the individual to the biosphere that may resonate more closely with the stance and aims of progressive ecopsychology. Additionally, I have suggested ways in which the concept of psychological contact might be fruitfully applied to our relationship with the natural world. For practitioners more generally, this article has attempted a challenge from within, a plea for theoretical and practical synthesis, and a response to what is arguably the most pressing concern that humankind currently faces.

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References

Albrecht, G. (2010). *Ecoparalysis.* Retrieved 6 July 2010, from: http://healthearth.blogspot.com/search/label/Solastalgia

Amel, E.L., Manning, C.M. & Scott, B.A. (2009). Mindfulness and sustainable behaviour: Pondering attention and awareness as means for increasing green behavior. *Ecopsychology, 1*(1), 14–25.

Bechara, A. (2001). Neurobiology of decision-making: Risk and reward. *Seminars in Clinical Neuropsychiatry, 6*(3), 205–216.

Bechara, A. (2005). Decision making, impulse control and loss of willpower to resist drugs: A neurocognitive perspective. *Nature Neuroscience, 8*, 1458–1463.

Bekoff, M. (2003). Minding animals, minding Earth: Science, nature, kinship, and heart. *Human Ecology Forum, 10*(1), 56–76.

Berry, T. (2000). An interview with Thomas Berry. *Wild Earth* (Summer), 93–97.

Bozarth, J.D. (2001). Client-centred unconditional positive regard: A historical perspective. In J.D. Bozarth & P. Wilkins (Eds.), *UPR: Unconditional positive regard* (pp.5–18). Ross-on-Wye: PCCS Books.

Brown, L.R. (1995). Ecopsychology and the environmental revolution: An environmental foreword. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.xiii–xvi). San Francisco: Sierra Club Books.

Conn, S.A. (1995). When the earth hurts, who responds? In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.156–171). San Francisco: Sierra Club Books.

Cornforth, S.C. (2008). Life's span, global warming and ethics: Do counsellors have a part to play in averting a potential catastrophe? *International Journal for the Advancement of Counselling, 30*(3), 145–154.

Cushman, P. (1990). Why the self is empty: Toward a historically-situated psychology. *American Psychologist, 45*, 599–611.

Dugdale, J.S. (1996). *Entropy and its physical meaning* (2nd ed.). London: Taylor & Francis.

Elliott, R. (2001). Research on the effectiveness of humanistic therapies; A meta-analysis. In D. Cain, & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp.57–81). Washington DC: A.P.A.

Elliott, R., Greenberg, L.S. & Lietaer, G. (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp.493–539). New York: Wiley.

Fox, M. (1984). Creation-centred spirituality from Hildegard of Bingen to Julian of Norwich: 300 years of an ecological spirituality in the West. In P. Joranson & K. Butigan (Eds.), *Cry of the environment: Rebuilding the Christian creation tradition* (pp.85–106). Santa Fe: Bear & Company.

Freire, B. (2001). Unconditional positive regard: The distinctive feature of client-centred therapy. In J.D. Bozarth & P. Wilkins (Eds.), *Rogers' therapeutic conditions: Evolution, theory and practice* (pp.145–154). Ross-on-Wye: PCCS Books.

Gaterslaben, B. (2008). Humans and nature: Ten useful findings from environmental psychology research. *Counselling Psychology Review, 23*(2), 24–35.

Harper, S. (1995). The way of wilderness. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.183–200). San Francisco: Sierra Club Books.

Harrison, P. (1999). *The elements of pantheism: Understanding the divinity in nature and the universe.* London: Element.

Henderson, V.L., O'Hara, M., Barfield, G.L. & Rogers, N. (2007). Applications: Beyond the therapeutic context. In M. Cooper, M. O'Hara, P. F. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp.305–324). Basingstoke: Palgrave McMillan.

Higley, N. & Milton, M. (2008). Our connection to the Earth – a neglected relationship in counselling psychology. *Counselling Psychology Review, 23*(2), 10–23.

Hillman, J. (1995). A psyche the size of the Earth: A psychological foreword. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.xvii–xxiii). San Francisco: Sierra Club Books.

IPCC (2007). *The physical science basis: Contribution of Working Group I to the fourth assessment report of the Intergovernmental Panel on Climate Change.* Cambridge: Cambridge University Press.

Jordan, M. (2009). Nature and self: An ambivalent relationship. *Ecopsychology, 1*(1), 26–31.

Kaplan, S. (1995). The restorative benefits of nature: Toward an integrative framework. *Journal of Environmental Psychology, 15*(3), 169–182.

Kollmuss, A. & Agyeman, J. (2002). Mind the gap: Why do people act environmentally and what are the barriers to pro-environmental behaviour? *Environmental Education Research, 8*(3), 239–260.

Leary, M.R. (2007). *The curse of self: Self-awareness, egotism, and the quality of life.* New York: Oxford University Press.

Lovelock, J. (1995). *Gaia: A new look at life on Earth.* Oxford: Oxford University Press.

Macy, J. (1995). Working through environmental despair. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.240–259). San Francisco: Sierra Club Books.

Mayer, F.S. & Frantz, C.M. (2004). The connectedness to nature scale: A measure of individuals' feeling in community with nature. *Journal of Environmental Psychology, 24*(4), 503–515.

McIntosh, A. (2004). *Soil and soul: People versus corporate power.* London: Aurum.

Meadows, D.H., Randers, J. & Meadows, D.L. (2004). *The limits to growth: The 30-year update.* London: Earthscan.

Meadows, D.L., Meadows, D.H., Randers, J. & Behrens, W.W. (1974). *The limits to growth* (2nd ed.). New York: Universe Books.

Mearns, D. & Thorne, B. (2007). *Person-centred counselling in action* (3rd ed.). London: Sage.

Merchant, C. (1992). *Radical ecology: The search for a livable world.* London: Routledge.

Milton, M. (2009). Waking up to nature: Exploring a new direction for psychological practice. *Ecopsychology, 1*(1), 8–13.

Mischel, W., Shoda, Y. & Rodriguez, M.I. (1989). Delay of gratification in children. *Science, 244*(4907), 933–938.

Monbiot, G. (2006). *Heat: How we can stop the planet burning.* London: Penguin.

Naess, A. (1973). The shallow and the deep, long-range ecology movement. A summary. *Inquiry, 16*, 95–100.

Neville, B. (1999). The client-centred ecopsychologist. *The Person-Centred Journal, 6*(1), 59–74.

O'Connor, T. (1995). Therapy for a dying planet. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.149–155). San Francisco: Sierra Club Books.

Oliver, M. (2004). *Wild geese: Selected poems.* Tarset: Bloodaxe.

Peck, M.S. (1978). *The road less travelled: The new psychology of love, traditional values and spiritual growth.* London: Arrow Books.

Proctor, G., Cooper, M., Sanders, P. & Malcolm, B. (2006). *Politicising the person-centred approach: An agenda for social change.* Ross-on-Wye: PCCS Books.

Randall, R. (2009). Loss and climate change: The cost of parallel narratives. *Ecopsychology, 1*(3), 118–129.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.

Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of science. Volume 3. Formulations of the person and the social context* (pp.184–256). New York: McGraw-Hill.

Rogers, C.R. (1978). The formative tendency. *Journal of Humanistic Psychology, 18*(1), 23–26.

Roszak, T., Gomes, M.E. & Kanner, A.D. (1995). *Ecopsychology: Restoring the Earth, healing the mind.* San Francisco: Sierra Club Books.

Schultz, P.W., Shriver, C., Tabonico, J.J. & Khazian, A.M. (2004). Implicit connections with nature. *Journal of Environmental Psychology, 24*, 31–42.

Seed, J., Macy, J., Fleming, P. & Naess, A. (2007). *Thinking like a mountain: Towards a council of all beings.* Gabriola Island: New Catalyst Books.

Shapiro, E. (1995). Restoring habitats, communities, and souls. In T. Roszak, M.E. Gomes & A.D. Kanner (Eds.), *Ecopsychology: Restoring the Earth, healing the mind* (pp.224–239). San Francisco: Sierra Club Books.

Strawbridge, S. & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.3–21). London: Sage.

Swenson, R. (1989). Emergent evolution and the global attractor: The evolutionary epistemology of entropy production maximisation. *Proceedings of the 33rd Annual Meeting of the International Society for the Systems Sciences, 33*(3), 46–53.

Taylor, B. (2001). Earth and nature-based spirituality (part I): From deep ecology to radical environmentalism. *Religion, 31*(2), 175–193.

Thatcher, M. & Manktelow, K. (2007). The cost of individualism. *Counselling Psychology Review, 22*(4), 31–43.

The Guardian (2009). Low targets, goals dropped: Copenhagen ends in failure. *The Guardian*, 19 December.

Thompson, M. (2009). Reviewing ecopsychology research: Exploring five databases and considering the future. *Ecopsychology, 1*(1), 32–37.

Transition Network (2010). *Transition Network.* Retrieved 22 October 2010, from: www.transitionnetwork.org/

Van Belle, H.A. (1990). Rogers' later move towards mysticism: Implications for client-centred therapy. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp.47–58). Leuven, Belgium: Leuven University Press.

Warner, M.S. (2007). Client incongruence and psychopathology. In M. Cooper, M. O'Hara, P.F. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp.154–167). Basingstoke: Palgrave MacMillan.

Zapf, M.K. (2005). The spiritual dimension of person and environment. *International Social Work, 48*(5), 633–642.

Theoretical Article

Depression, cause or consequence of pathological gambling and its implications for treatment

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Background: *Availability and access to gambling, due to new licensing laws, is increasing exponentially. Practicing counselling psychologists need to be prepared to treat what is expected to be an increasing prevalence of pathological gambling (PG), and this cannot be done without the appropriate research base to expand our understanding of the condition.*

Content and Focus: *This paper examines available literature on pathological gambling and depression to investigate how depression and PG interact. Selected published papers on the role of depression in pathological gambling were reviewed. Results are suggestive of depression being more a cause for PG than a consequence.*

Conclusions: *Lack of consensus in the literature was identified and discussed in light of a pathways model of PG for different types of gambler; emotionally vulnerable or behaviourally conditioned. The implications for counselling psychologists are discussed as the evidence provides validation for different treatment pathways, whether the depression is a cause or a consequence of the gambling behaviour.*

Keywords: *pathological gambling; depression; subtypes; pathways; counselling psychology; conditioned behaviour.*

PATHOLOGICAL GAMBLING (PG) is defined by the *DSM-IV* as a persistent and recurrent maladaptive gambling behaviour. The Gambling Commission (1996) estimates about 0.6 per cent of the adult population are pathological gamblers. Research in the area of PG has focused on investigating and evaluating the range of different cognitive, personality and behavioural traits that are observed in the population of pathological gamblers compared with healthy controls. PG diagnosis is often concomitant with a range of psychosocial and psychological difficulties (Thomsen et al., 2009). Most commonly reported are family dysfunctions, poly-substance misuse and affective disorders. As a consequence, high rates of co-morbidity between mood disorders and PG are frequently observed (Kessler et al., 2008). Research into affective disorders associated with PG has indicated a potential relationship, though the exact nature of this connection is still unclear. Research into this link and the gambling field as a whole is still in its infancy. It would benefit from high quality research through randomised control trials and critical reviews of the current literature in order to assess what affective factors play a role in the maintenance of gambling behaviour to a pathological degree. This would then provide significant information, to inform counselling psychology practice, in the assessment and treatment of this population. To date uncertainty exists as to what psychological factors may contribute to the aetiology of PG.

In a national co-morbidity survey in the US, Kessler et al. (2008) found the rate of depression among pathological gamblers to be 55.6 per cent which was significantly higher compared with the rest of the household population sampled ($p<0.05$).

Blaszczynski and Farrell (1998) further showed that if co-morbid depressive symptoms were present it increases the risk of completed suicide. Other studies have shown that the presence of co-morbid depressive symptoms in gamblers are also associated with higher risk of gambling relapse (Hodgins & El-Guebaly, 2004) and increased use of maladaptive coping strategies (Getty et al., 2000). It has been argued that, in order to understand PG, it is essential to understand pathological gamblers' tendency to experience negative affective states such as depression (Thomsen et al., 2009).

The majority of studies report evidence of a link between depression and PG. What is not clear is the aetiology of the interaction when attempting to separate cause from effect. There are two lines of evidence; one suggesting that depression occurs in consequence to PG and one that suggests depression is a cause of gambling engagement to a pathological degree, but neither has been critically evaluated. Investigating how depression and PG interact is of high theoretical and clinical importance so that the most effective treatment interventions can be found. This is especially pertinent when the increased suicide risk associated with co-morbid depression and PG is considered.

Depression is a consequence of PG

Once an individual is involved in gambling classical and operant conditioning can take an effect. The subjective excitement associated with playing and winning, when gambling, acts as positive reinforcement for continued engagement in gambling activity (Griffiths, 1995). There can be positive effects of gambling, but due to gambling odds losing often occurs. Losing creates an internal, uncomfortable, depressive or anxious state which an individual wants to neutralise (Hills et al., 2001). This encourages continued gambling behaviour as a way to escape these negative feelings through negative reinforcement (Blaszczynski & Nower, 2002). Gambling as a habitual behaviour is then established as the individual gambles as a way to alleviate depressive symptoms. This is supported empirically by statistics which indicate three-quarters of pathological gamblers develop symptoms of depression (Blaszczynski & McConaghy, 1988).

According to the *DSM-IV* criteria to meet diagnosis for PG, the gambler must be chronically and progressively unable to resist gambling impulses. The odds of prolonged gambling for a pathological gambler can culminate in losses and the adverse consequences that follow (Korn & Shaffer, 1999). These can include damage/disruption to the gamblers' social, personal and/or work life and increased risk of involvement in illegal acts in an attempt to fund the gambling and recover financial losses (APA, 1994). If it is taken that PG is a primary disorder then PG would emerge in the absence of any other co-morbidity. However, once the individual suffers from PG a series of co-morbidities are seen to develop as a consequence to it.

A commonly reported finding by clinicians is that pathological gamblers universally react with symptoms of depression as financial losses mount (Becona et al., 1996). Losing is a depressing experience which is damaging to individuals' self-esteem but for the majority this depression is only temporary when preceded by unexpected losses. Hills et al. (2001) illustrated in a high powered experiment (N=60 in both the experimental and control groups), that regular gamblers were significantly unhappier when losing compared to occasional gamblers when using a computer based gambling task. However, as it was conducted in a laboratory setting, the conditioning influences associated with the environmental properties of gambling establishments like colour, light and sound would have been absent. This may have biased the results, in favour of depression occurring as a consequence to PG, since the environmental properties associated with gambling can have the capability of creating a psychologically rewarding experience even when the gambler is losing (Griffiths, 1995).

As the addictive element of gambling takes over and gambling becomes more habitual in the gambler's life, abandonment of friends, family and work can occur. Although, Bergh and Kuhlorn (1994) reported that social isolation was considered of minor importance to the gambler, 78 per cent of gambling population reported isolation from family and friends. This regressive behaviour is common in depression and can be a trigger for its onset (Beck & Alford, 2009). The gambler can withdraw from active, independent, responsible activities in favour of dependent activities to avoid responsibility and coping with problems. This argument has been evidenced throughout addictions. Weissman et al. (1976) illustrated that over a third of 106 narcotic addicts were reported as having moderate to severe depression with symptoms associated with a decrease in social functioning and environmental stress. These symptoms are common in gambling addiction and are triggers for the onset of depression (Ferris et al., 1999).

Kim et al.'s (2006) systematic review argues that depressive symptoms evident in gamblers are, in the majority, secondary to PG. However, when the evidence is reviewed for Kim et al.'s (2006) argument (drawn from Becona et al. [1996] and Roy et al.'s [1988] research), the data does not seem to conform to this view and when it does there are methodological biases and/or limitations of low power. The study by Becona et al. (1996) cited to support the hypothesis that depression occurs as a consequence to PG used a Spanish community sample of 1615 adults. The study illustrated that of the 19 pathological gamblers in the sample, four were co-morbid for depression and the depressive symptoms were significantly correlated with the severity of gambling. This could support the contention that depression occurs as a consequence of PG and as the PG worsens so do the depressive symptoms. The conclusion that these results can be generalised to a UK population should be drawn with caution, or best not drawn at all until research indicates they have similar presentations.

Roy et al. (1988) conducted a qualitative interview study using 14 PG in-patient subjects compared with 41 normal controls. It was found that the depressed PG in-patients reported significantly more negative life events associated with gambling, than the non-depressed patients, six months before the depression developed. This adds evidence that depression occurs as a consequence to PG. However, the inpatient sample limits its generalisation. It would seem that evidence in the systematic review by Kim et al.(2006) is not as consistent and convincing suggesting more robust research is needed.

The evidence that suggests depression occurs in consequence to PG include: the financial losses that accumulate serve as a psychosocial stressor which can be a trigger for the onset of depression (Hills et al., 2001): the social isolation that occurs concomitantly with PG (Beck & Alford, 2009) and the reduction in chances for positive reinforcement outside of gambling (Beck & Alford, 2009). It would follow that if depression occurs as a consequence of PG then once PG is treated the depression should resolve. However, research has indicated that some recovered pathological gamblers, when they no longer meet criteria for PG, are still meeting the *DSM-IV* criteria for clinical levels of depression (Shaffer & Korn, 2002). This suggests that depression does not only occur in consequence to PG and that observed depression occurring after the onset of PG may not necessarily be as a result of the PG itself, but may potentially be due to other external factors which are not considered within the research.

Depression is a cause of PG

Evidence has indicated that over 50 per cent of pathological gamblers have accessed or attempted to access treatment for psychological problems prior to being diagnosed with PG (Bergh & Kuhlorn, 1994). McCormick (1994) suggested that a significant number

of pathological gamblers exhibit symptoms similar to that of a depressogenic internal state. This state is then influenced by depressive cognitive styles (McCormick & Taber, 1987), poor coping mechanisms and a greater history of life trauma (Taber et al., 1987). For example, McCormick (1994) found that pathological gamblers used significantly more avoidant coping strategies to deal with their difficulties than substance abusers without a gambling problem. The pathological gamblers' negative mood can be alleviated, or avoided, by the focusing and narrowing of attention that comes when gambling. Gambling then becomes associated with the arousal, stimulation and alleviation of negative affects that occurs whilst playing (Griffiths, 1995).

The relationship between PG and depression can be traced to traditional beliefs about the motivations behind drug addictions (Raylu & Oei, 2002). It is argued that depression can induce hormonal/neurotransmitter changes within the brain. This state makes the brain, in addiction prone individuals, biologically susceptible to seeking illicit drugs to compensate for the underlying chemical imbalances of the dopaminergic and serotonergic systems (Raylu & Oei, 2002). Behavioural addictions such as shopping, sex and gambling can be interpreted as behavioural attempts to 'self medicate' depressive symptoms away by activating the endogenous opioid system (Christenson et al., 1994; McElroy et al., 1995). This process can then become addictive in itself leading a gambler into a cycle of falling into an anhedonic state and through gambling trying to elevate mood which creates an immediate effect that becomes reinforced (Lloyd et al., 2010). Due to the poor outcome odds of prolonged gambling the subject loses and falls into an even deeper anhedonic state and then gambles as a way to get out of it (the sensation-seeking hypothesis). This process develops effects which then become addictive through conditioning processes (Clarke, 2006).

Research has offered support for the sensation-seeking hypothesis by showing that mood and cognitions can significantly account for continuation of gambling despite successive losses (Stewart & Zack, 2008). When investigating co-morbidity of PG and mood disorders, Specker et al. (1996) identified that high-lifetime rates of disorders on Axis I (92 per cent) were found in pathological gamblers compared to the well-matched controls. Studies of this linkage have further suggested that such co-morbidity can potentially increase the risk of an individual developing PG or contribute to the maintenance of PG. Pathological gamblers who are depressed resort to gambling as a means of escaping depressive symptoms and, therefore, choose gambling with its high-risk/high-reward associations to improve mood (Shead & Hodgins, 2009). Evidence has been provided in support of this theory from a range of psychological approaches including neuropsychology (steven & Malenka, 2001), clinical psychology (Clarke, 2006) and psychopharmacology (Grant & Kim, 2002).

One of the primary symptoms of depression is deregulation of mood. Neuroscientific and imaging studies have suggested that brain regions involved in mood regulation lie in close proximity to the areas of the brain responsible for the processing of motivation; craving (Steven & Malenka, 2001). Historically, philosophical debate on emotion and reason argued that a schema for depression was characterised by a loss of interest in activity due to a failure to recognise the potential incentive in that given activity (Fonagy et al., 2004). An alternative schema, commonly found in gamblers, is engaging in behaviour (impulsivity, craving) that seeks an incentive (Kim et al., 2006). These opposite phenomena are the products of shared neural substrates, particularly, the anterior cingulate, ventral striatum, portions of the neocortex and orbital frontal cortex. The neurophysiology of these brain areas suggests that a neurobiological interface occurs between impulsivity (as gambling is

categorised as an impulse disorder by DSM-IV) and mood symptoms (Kim et al., 2006).

Research involving psychopharmacology has also provided evidence in favour of depression being a cause of PG. Robust methodological research looking at the effectiveness of antidepressants when treating pathological gamblers by Grant and Kim (2002) in a double-blind study, found that fluoxetine and psychotherapy produced better improvement of PG and depressive symptoms than psychotherapy alone. This result, after six-months follow-up, appears to indicate that treating PG through psychotherapy alone is insufficient to produce the greatest improvement but treating the underlying depression concurrently with the PG symptoms produces the most significant improvement. Although this provides promising results in favour of depression being a cause of PG, the majority of research on PG and anti-depressants is mixed due to bias in the exclusion criteria (Grant & Kim, 2003; Kim et al., 2001). In the majority of controlled studies investigating the effectiveness of SSRI drugs, all participants with a concurrent mood disorder were excluded and, therefore, the experiments did not test the efficacy of anti-depressants in treating PG subjects who were co-morbid with current mood disorders (Grant & Kim, 2002). Effectively these studies were too exclusive to address the link between depression and PG.

In discussion, evidence for the sensation-seeking hypothesis has been supported through a range of methods, thus adding to its relevance as a theory. But it is difficult to conclude whether sensation-seeking leads to gambling or gambling raises an individual's inclination to be a sensation-seeker. Being a sensation-seeker may predispose an individual to gamble but gambling may also change the personality of the individual. For example, large financial losses, due to excessive gambling, may result in the development of depression which may lead to a decrease in arousal which puts the individual at greater risk of gambling further (Raylu & Oei, 2002). So, the debate still continues.

Perhaps it can be both – evidence for subtypes of PG

The co-morbid link between PG and depression is clearly evident from the literature but to date no longitudinal studies are available to determine which comes first: depression or PG. Evidence is provided for depression being both a cause and a consequence of PG. Yet the underlying limitation in all the research is the assumption that pathological gamblers are one homogenous group (Blaszczynski & Nower, 2002; Kim et al., 2006). Converging research is emerging to suggest that pathological gamblers are a heterogeneous group consisting of distinctly different sub-types (Rugle & Melamed, 1993; Gonzalez-Ibanez et al., 1999).

This evidence additionally illustrates the defining characteristic between two types of pathological gambler; the behaviourally conditioned and the emotionally vulnerable. Both pathways describe similar courses for the development of a pathological gambler with exposure to the same ecological factors of availability and access to gambling. The influence by the same classical and operant conditioning processes then lead to cognitive biases and illusions of control. Habituation to gambling then occurs which is followed by the chasing of losses and a diagnosis of PG.

Blaszczynski and Nower (2002) argue that behaviourally conditioned gamblers meet the *DSM-IV* criteria for PG but lack specific pre-morbid features of psychopathology. It is suggested that high levels of depression may be present in this population but as a consequence to PG. This evidence is echoed by a range of different experimental methods including the cluster analytic study by Gonzalez-Ibanez et al. (1999). This found that this similar presentation of gamblers clustered together. For the community sample studies it would account for the low numbers of gambler where depression is a consequence of PG as it is only one type of gambling subset.

To meet Blaszczynski and Nower's (2002) criteria for the emotionally vulnerable

pathological gambler the same ecological and conditioning processes as the previous subset (behaviourally conditioned) would be experienced. However, they would more commonly present with pre-morbid issues of depression, show evidence of a poor coping history and or negative childhood experiences suggesting that PG is caused by the depression. Individuals within this subset appear to gamble to modulate their affect and/or psychological needs. Understanding this subset of gamblers may explain the results from Grant and Kim's (2002) psychotherapy and pharmacological interventions. Where the majority of studies were conducted on in-patient units where emotionally vulnerable pathological gamblers with co-morbid psychopathology would most likely be present. This may also account for the mixed results in these types of studies due to a potential mix of the two subsets recruited in non in-patient studies.

It appears that the main difference between the emotionally vulnerable gamblers and the behaviourally conditioned type is that any co-morbidity in the case of the emotionally vulnerable subset was present before gambling became a problem, whereas co-morbidities for the behaviourally conditioned gambler occur as a consequence to the gambling problem

Implications for counselling psychology

The theoretical review of the evidence suggests that gambling can be a reaction to financial crises and other negative factors associated with PG for the behaviourally conditioned pathological gamblers. Whereas for the emotionally vulnerable pathological gamblers, gambling can be used to induce dissociation to reduce/escape states of depression (Lee et al., 2007). Either way, the aetiology of depression, to be taken into account at assessment, will play a role in determining appropriate clinical management of PG for each subset. Psychologists should be looking for Blaszczynski and Nower's (2002) characteristics looking for onset, history of depression and the temporal relationship of depression to understand its involvement in PG to ensure the most effective mode of treatment is offered.

Cognitive behavioural therapy (CBT) has been shown to be effective in treating PG, when compared to pharmacological, self-help or cognitive interventions (Toneatto & Ladoucer, 2003). To date, there is a lack of studies evaluating the effectiveness of other models including humanistic and psychodynamic therapies and so current evaluations on the effectiveness of treatment does not represent the full spectrum of potential recovery models (Oakely-Brown et al., 2000). A meta-analysis by Gooding and Tarrier (2009) of minimal treatment interventions of learned behavioural strategies and techniques (such as group CBT over a time-limited structure) has suggested this to be effective for the behaviourally conditioned subset because any co-morbid symptoms of depression should resolve themselves once the PG is addressed and treated (Blaszczynski & Nower, 2002).

For the emotionally vulnerable PG subset, characterised by psychological dysfunctions and being more resistant to change, a more individualised and multi-modal treatment approach is required particularly to manage any risk of suicide (Seguin et al., 2010). Specialised modalities are needed to treat the underlying vulnerabilities and encourage the learning of new coping methods as well as the gambling behaviour (Shaffer & Korn, 2002). CBT in its synergy of looking at thinking patterns and behaviour has shown to be effective in treating this group as, through therapy, depressive symptoms can be lowered which consequently may reduce impulses to escape those symptoms (Toneatto & Ladoucer, 2003). Petry et al., (2006) robustly evaluated the efficacy of individualised treatment finding that CBT interventions improved abstinence rates up to 12-month follow-ups. Other therapy models have yet to be tested (Oakely-Brown et al., 2000).

Blaszczynski and Nower (2002) have presented evidence for two subsets of pathological gamblers looking at depression being either a cause or a consequence of PG but it is yet to be empirically validated. More research is needed to test the validity of this theory in order to assess effectiveness of this model for the treatment of PG and assess its implications for the practice of counselling psychology.

Limitations of the area as a whole and potential areas for future research:

Generally much of the research to date focuses on Caucasian men in a 30 to 50 age range within a clinical population. Future research would benefit from exploring the influences of age, culture, mode of gambling (online compared with bookmakers) and gender in the individual experience of the interaction between depression and PG. Lloyd et al.'s (2010) research suggests that female gamblers tend to use gambling for mood regulation more than male gamblers. Current data is limited to quantitative methods which often lose the individual experience of what is trying to be understood. In order to appreciate how pathological gamblers themselves view or understand the relationship between depression and PG, qualitative interviews may be more appropriate. This is particularly important for counselling psychologists to consider as the client's experience, of any condition or situation, is paramount to the therapeutic relationship aimed for so that therapeutic change can be achieved (Mearns & Cooper, 2005).

Much research is amalgamated from various areas of the world particularly the US, Canada and Australia (Raylu & Oei, 2002). English pathological gamblers may not necessarily have the same presentation and aetiology of development as those from other countries. The gambling approach is very different in England compared to the US. In England, gambling is focused in bookmakers and arcades whereas in the US and Canada engagement in gambling is centred on casinos (Raylu & Oei, 2002). This would suggest that differences may occur in the presentation of each population. The area would thus benefit from further research on England's pathological gamblers and whether treatment approaches should be consistent with other countries or not.

Conclusion

Despite the importance of understanding the aetiology of the relationship between PG and depression due to its associated risk factors research of this co-morbid relationship is still very much in its infancy. This is equally true for the gambling field as a whole where gambling literature is a sparse and significantly under researched area (Raylu & Oei, 2002).

It seems that evidence is supportive of depression as a cause for PG, however, due to sampling biases this may be overestimated. A potential answer to the initial question may well be that depression is both a cause and a consequence which would be an interesting development and suggests a much needed new approach for future research. Availability of and access to gambling, due to new licensing laws, is increasing exponentially (Gambling Commission, 1996). As counselling psychologists we need to be prepared to treat an increasing prevalence of PG, which cannot be done without the appropriate research base to fulfil our understanding of the condition. Being aware of the interplay between depression and PG can help to effectively assess where interventions are most appropriately targeted and resources are adequately assigned.

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References:

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).* Washington, DC; American Psychiatric Association.

Beck, A. & Alford, B. (2009). *Depression causes and treatment* (2nd ed.). Pennsylvania: University of Pennsylvania Press.

Becoña, E., Lorenzo, M.D.C. & Fuentes, M.J. (1996). Pathological gambling and depression. *Psychological Reports, 78*, 635–640.

Blaszczynski, A. & Farrell, E., (1998). A case series of 44 completed gambling-related suicides. *Journal of Gambling Studies, 14*, 93–109.

Blaszczynski, A. & Nower, L. (2002). A pathways model of pathological and problem gambling. *Addiction, 97*, 587–499.

Blaszczynski, A. & McConaghy, N. (1988). SCL-90 assessed psychopathology in pathological gamblers. *Psychological Reports, 62*, 547–552.

Christenson, G.A., Faber, R.J., de Zwaan, M., Raymond, N.C., Specker, S.M., Ekern, M.D., Mackenzie, T.B., Crosby, R.D., Crow, S.J., Eckert, E.D., Mussell, M.P. & Mitchell, J.E. (1994). Compulsive buying: Descriptive characteristics and psychiatric co-morbidity. *Journal of Clinical Psychiatry, 55*, 5–11.

Clarke, D. (2006). Impulsivity as a mediator in the relationship between depression and problem gambling. *Personality and Individual Differences, 40*, 5–15.

Ferris, J., Wynne, H. & Single, E. (1999). *Measuring problem gambling in Canada: final report – Phase 1. Inter-Provincial Taskforce on problem gambling.* Canada: Canadian Centre of Substance Abuse.

Fonagy, P., Gyorgy, G. & Jurist, E. (2004). *Affect regulation, metallisation and the development of self* (2nd ed.). London: Karnac Books.

Getty, H., Watson, J. & Frisch, G. (2000). A comparison of depression and styles of coping in male and female GA members and controls. *Journal of Gambling Studies, 16*, 377–391.

Gonzalez-Ibanez, A., Jimenez, S. & Aymami, M.N. (1999). Evaluacion y tratamiento cognitivo-conductual de jugadores patologicos de maquinas recreativas con premio [Evaluation of the cognitive-behavioural treatment of pathological poker machine gamblers]. *Anuario de Psicologia, 30*, 111–125.

Gooding, P. & Tarrier, N. (2009). A systematic review and meta-analysis of cognitive-behavioural interventions to reduce problem gambling: Hedging our bets? *Behaviour Research and Therapy, 47*, 592–607.

Grant, J.E. & Kim, S.W. (2002). Pharmacotherapy of pathological gambling. *Psychiatry Annuals, 32*, 186–191.

Grant, J.E. & Kim, S.W. (2003). Comorbidity of impulse control disorders in pathological gamblers. *Acta Psychiatrica Scandinavica, 108*, 203–207.

Griffiths, M., (1995). *Adolescent gambling.* London: Routledge.

Hills, A.M., Hill, S., Mamone, N. & Dickerson, M. (2001). Induced mood and persistence at gaming. *Addiction, 96*, 1629–1638.

Hodgins, D. & el-Guebaly, N. (2004). Retrospective and prospective reports of precipitants to relapse in pathological gambling. *Journal of Consulting and Clinical Psychology, 72*, 72–80.

Kessler, R., Hwang, I., La Brie, R., Petukhova, M., Sampson, N. & Winters, K. (2008). *DSM-IV* pathological gambling in the National comorbidity survey replication. *Psychological Medicine, 38*, 1351–1360.

Kim, S., Grant, J.E., Eckert, E.D., Faris, P.L. & Hartman, B.K. (2006). Pathological gambling and mood disorders: Clinical associations and treatment implications. *Journal of Affective Disorders, 92*, 109–116.

Korn, D. & Shaffer H.J. (1999). Gambling and the health of the public: Adopting a public health perspective. *Journal of Gambling Studies, 15*, 289–365.

Lee, H.P., Chae, P.K., Lee, H.S. & Kim, Y.K., (2007). The five-factor gambling motivation model. *Psychiatry Research, 150*, 21–32.

Lloyd, J., Doll, H., Hawton, K., William, D.H., Geddes, J.R., Goodwin, G.M. & Rogers R.D. (2010). How psychological symptoms relate to different motivations for gambling: An online study of internet gamblers. *Biological Psychiatry, 68*, 733–740.

Marks, M.E. & Lesieur, H.R. (1992). A feminist critique of problem gambling research. *British Journal of Addiction, 87*, 549–565.

McCormick, R.A. (1994). The importance of coping skill enhancement in the treatment of the pathological gambler. *Journal of Gambling Studies, 10*, 77–86.

McCormick, R.A. & Taber, J.I. (1987). The pathological gambler: Salient personality variables. In T. Galski (Ed.), *The handbook of pathological gambling* (pp.9–39). Springfield, IL: Charles C. Thomas.

McCormick, R.A., Taber, J.I., Kruedelbach, N. & Russo, A.M. (1987). Personality profiles of hospitalised pathological gamblers: The California Personality Inventory. *Journal of Clinical Psychology, 43*, 521–527.

McElroy, S.L., Keck, P.E & Phillips, K.A. (1995). Kleptomania, compulsive buying, and binge-eating disorder. *Journal of Clinical Psychiatry, 56*, 14–26.

Mearns, D. & Cooper, M. (2005). *Working at relational depth is counselling and psychotherapy.* London: Sage

National Gambling Impact Study Commission Act (1996). PL104-169, 104th Congress.

Oakley-Brown, M.A., Adams, P. & Mobberley, P.M. (2000). Interventions for pathological gambling (Cochrane Review). *The Cochrane Library, 3.*

Petry, N., Ammerman, Y. & Bohl, J. (2006). Cognitive-behavioural therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology, 74*, 555–567.

Raylu, N. & Oei, T. (2002). Pathological gambling: A comprehensive review. *Clinical Psychology Review, 22*, 1009–1061.

Roy, A., Custer, R., Lorenz, V. & Linnoila, M. (1988). Depressed pathological gamblers. *Acta Psychiatrica Scandinavica, 77*, 163–165.

Rugle, L. & Melamed, L. (1993). Neuropsychological assessment of attention problems in pathological gamblers. *Journal of Nervous and Mental Disease, 181*, 107–112.

Seguin, M., Boyer, R., Lesage, A., McGirr, A., Suissa, A., Tousignant, M. & Turecki, G. (2010). Suicide and gambling: Psychopathology and treatment seeking. *Psychology of Addictive Behaviours, 24*, 541–547.

Shaffer, H.J. & Korn, D.A. (2002). Gambling and related mental disorders: A public health analysis. *Annual Review of Public Health, 23*, 171–212.

Shead N.W. & Hodgins D.C. (2009). Affect-regulation expectancies among gamblers. *Journal of Gambling Studies, 25*, 357–375.

Specker, S.M., Carlson, G.A., Edmonson, K.M., Johnson, P.E. & Marcotte, P.E. (1996). Psychopathology in pathological gamblers seeking treatment. *Journal of Gambling Studies, 12*, 67–81.

Steven, H. & Malenka, R. (2001). Addiction and the brain: The neurobiology of compulsion and its persistence. *Nature Reviews Neuroscience, 2*, 695–703.

Stewart, S.H. & Zack, M. (2008). Development and psychometric evaluation of a three-dimensional gambling motives questionnaire. *Addiction, 103*, 1110–1117.

Taber, J.I., McCormick, J.I. & Ramirez, L.R., (1987). The prevalence and impact of major stressors among pathological gamblers. *International Journal of the Addictions, 22*, 71–79.

Thomsen, K., Callesen, M., Linnet, J., Kringlebach, M. & Moller, A. (2009). Severity of gambling is associated with severity of depressive symptoms in pathological gamblers. *Behavioural Pharmacology, 20,* 527–536.

Toneatto, A. & Ladouceur, R. (2003). Treatment of pathological gambling: A critical review of the literature. *Psychology of Addictive Behaviours, 17*, 284–292.

Weissman, M., Slobetz, F., Prusoff, B., Mezritz, M. & Howard, P. (1976). Clinical depression among narcotic addicts maintained on methadone in the community. *American Journal of Psychiatry, 133*, 1434–1438.

Theoretical Article

Existential therapy: A useful approach to trauma?

Lisa Corbett & Martin Milton

Background: *Literature has suggested that the cyclical nature of psychological trauma can lead to enduring long-term effects on individuals and those around them.*
Content and Focus: *This review examines the effects of psychological trauma and its relationship with existential therapy, not to endorse a particular approach in isolation, but to explore a variety of understandings of psychological trauma pertinent to counselling psychology. Despite being relatively unexplored with regards to psychological trauma, favourable empirical evidence is beginning to amass for existential therapy. A review of the contributions (and limitations) of existing approaches to trauma therapy is initially considered before the focus turns to the contribution that existential therapy might make. van Deurzen's existential dimensions (1997) and Jacobsen's existential conceptualisations of crisis are considered in some depth, along with the limitations and empirical challenges of existential therapy.*
Conclusions: *Speculative practical and therapeutic implications are identified and relevant future research is suggested.*

Keywords: *existential therapy; psychological trauma; post-traumatic stress disorder; trauma therapy.*

A TRAUMATIC INCIDENT is a shocking and emotionally overwhelming situation in which an individual experiences or perceives a threat to the physical and/or psychological integrity of self or others, resulting in a reaction of intense fear, helplessness or horror (American Psychiatric Association [APA], 2000; Lodrick, 2007; Rothschild, 2000). It has long been apparent that such experiences can lead to psychological problems, with possibly the first cataloguing of traumatic symptoms documented on Sumerian cuneiform tablets following deaths in battle (Ben Ezra, 2001, cited in Grey, 2007). More recently, acts of terrorism such as the attacks in the US on September 11, 2001, and widespread natural disasters such as the tsunami in south-east Asia in 2004 have been increasingly formulated from the perspective of trauma by professionals and the media (Courtois & Gold, 2009). Indeed, trauma is increasingly being recognised not as a specialised area, but a fundamental aspect of human experience (Gold, 2008).

This paper begins by addressing some responses to traumatic events and the effects of traumatisation documented within the literature, before briefly outlining the key features of post-traumatic stress disorder (PTSD) and compiling some of the current therapeutic options for trauma therapy. Stolorow (2007) made a personal and philosophical reflection on the psychological and emotional impact of trauma, defining it as 'an experience of unbearable affect' in a context in which there is an 'absence of adequate attunement and responsiveness to the [individual's] painful emotional reactions' (p.9-10). Reactions to traumatic events vary considerably, ranging from relatively mild responses, creating minor disruptions in the person's life, to severe and debilitating reactions. It is common for those who are exposed to traumatic events to experience intrusive thoughts and images, accompanied by attempts at avoidance, emotional numbing, and increased arousal (Joseph, 2010).

van der Kolk (1996) wrote that 'traumatised people lead traumatic and traumatising lives' (p.11, cited in Lodrick, 2007, p.10). Themes of repetition are indeed central: the individual may be subjected to intrusive replays of the original trauma (Lodrick, 2007). Trauma re-enactments are common and take the forms of re-victimisation, self-injurious and self-harming behaviours and externalising the trauma by victimising others (van der Kolk & McFarlane, 1996).

Totton (2005) writes that traumatic experiences in childhood can have enduring profound effects on traumatic experiences as an adult, influencing the traumatised person's responses and creating patterns of hyperarousal or dissociation together with a tendency to re-enact traumatic experiences (Perry et al., 1995; Schore, 2000). Wainrib (2006) argues that traumatic events can generate severe psychological reactions that can manifest anytime. For some, the effects last throughout their remaining lifetimes and traumatised individuals have been found to have elevated rates of psychiatric diagnosis including major depression and alcohol or drug dependence (Wainrib, 2006). High co-morbidity rates of trauma and psychosis are also evident in the literature. Bebbington et al. (2004) identified associations between psychotic disorders and early victimisation experiences, Janssen et al. (2004) reported a significant cumulative relationship between trauma and psychosis, while Shevlin et al. (2007) observed a positive relationship between occurrences of childhood trauma and self-reported experiences of hallucinations.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV:* APA, 2000) outlines PTSD as the development of characteristic symptoms of distress or impairment that are present for over one month after exposure to a traumatic event. Banyard (1999) described its cyclical nature, outlining three main clusters of symptoms: re-experiencing phenomena, avoidance/numbing and increased arousal. However, Foa et al. (2008) argues that this diagnostic framework is inherently limiting, and reports a growing consensus for multimodal interventions. It has been argued that PTSD is not a neutral term, but a social construction (Maddux et al., 2004, cited in Joseph, 2010) that may inadvertently pathologise normal and natural reactions to traumatic events. Joseph (2010) also states that the very diagnosis of PTSD and the medicalisation of trauma reactions essentially deny the existential nature of such responses and stifle people's ability to emotionally process their experiences in meaningful and purposive ways.

Approaches to therapy

The National Institute of Clinical Excellence (NICE, 2005) guidelines advocate a course of trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) for PTSD, with research overwhelmingly appearing to demonstrate their efficacy (e.g. Moss, 2009). Hemsley (2010) highlights that within a CBT approach, the principal mechanisms for change are considered to be improvement through emotional processing of the trauma using repeated exposure and amelioration through cognitive restructuring of the event (Resick et al., 2008). However, the current options of intervention are by no means categorical or indeed immobile, and scope for advancement and innovation is highlighted in the literature. For instance, Ryan (2010) argues that advances in the treatment of psychological trauma have emerged in the light of recent developments in neuroscience, while Tarrier (2010) has called attention to the development of positive psychology which may offer further treatment options.

There has also been a move to challenge existing options of intervention within the literature. Pitchford (2009) maintains that contemporary approaches to trauma are flawed, primarily because of the narrow focus on symptom management as opposed to acknowledging the barriers people have to expressing their freedom in choices and will (May, 1999; Paulson & Krippner, 2007).

Hemsley (2010) argued that CBT, for example, assumes that it is the individual's inability to adequately process the traumatic experience that has led to the development of symptoms (Taylor, 2007) which makes little room for inclusion of other modalities and implies that practitioners have knowledge of the client's internal world. Hemsley (2010) developed this reasoning to argue that just using CBT for PTSD reinforces the medical model of intervention without acknowledging that every theoretical model offers a heuristic focus for the level of intervention (Roth & Fonagy, 2005). Hemsley (2010) comments that this undermines professional autonomy within the National Health Service (NHS) and private practice, since insurance companies could demand for interventions consistent with NICE guidelines (Fairfax, 2008). Tarrier (2010), meanwhile, argues for continual innovation, which will come from recognition of variability and heterogeneity and the development of new treatment strategies' (p.140).

Trauma therapy is a complex biological, psychological and social project that unfolds in stages over time and may involve many different modalities to reach a stage of optimal recovery (Herman, 1992). This rationale invites practitioners to acknowledge the idiosynchracies of their clients, and acknowledge a greater range of contributing factors that could be overlooked by a medicalised approach with a primary focus on specific symptoms. With recent developments and emerging alternatives, counselling psychologists are faced with convoluted and perhaps tough decisions to make about which approach corresponds with their therapeutic manner but also best serves the needs of their individual clients.

At this point, we turn from what much of the traditional literature has said and look to the contribution that existential theory and practice can offer the understanding of trauma.

Existential therapy

While existential therapy is ultimately a creative evolving process, Cooper (2003) highlights that it is also a diverse and difficult to define body of psychological theory, practice, and research reflecting an existential influence with the aim of exploring human reality from the perspective of the client. Iacovou (2009) notes that while existential therapy incorporates a broad spectrum of practitioners who administer a variety of approaches – including Existential Analysis, Existential-Humanistic Therapy, Daseinanalysis and Logotherapy – there are some collective themes. For instance, the answers to fundamental philosophical questions that underpin the way the world is perceived and the psychological and interpersonal difficulties encountered shape the theory and practice of existential therapy (Boss, 1979; Cannon, 1991; Cohn, 1984). The therapeutic process is the experiencing of one's existence, and the client's identity is not understood as a fixed matter. Rather than pathologising the client, existential therapy 'does not seek to cure or explain, it merely seeks to explore, describe and clarify in order to try to understand the human predicament' (van Deurzen, 1997, p.3).

Yalom (1980) described existential therapy as a homeless waif that did not belong anywhere, resolving the problem of definition by listing the themes relating to existence (e.g. isolation, freedom). This review follows a similar example, by considering how of existential therapy could be applied to trauma. To do this, van Deurzen's existential dimensions (1997) – a development of Binswanger's (1958) framework – and Jacobsen's (2006) existential conceptualisations of crisis are considered in some depth.

Existential dimensions: A perspective on trauma

van Deurzen (1997) claimed that 'as human beings we are complex bio-socio-psycho-spiritual organisms, joined to the world around us in everything we are and do' (p.94).

Essentially, the author describes a four-dimensional forcefield that we are constantly concerned with: physical, social, psychological and spiritual. The dimensions begin with the relationship between ourselves as a physical body and the natural environment: the biological forces that regulate us within the physical dimension. Secondly, the author describes the social dimension: our social and cultural network through which we relate to others. We are thirdly modulated by the psychological dimension which concerns our personality, character and mental processes, and finally by our relationship to the framework of meaning through which we experience and conceive the world on a spiritual dimension (van Deurzen, 1997). The four dimensions within which existence takes place span polar opposites manifesting as paradoxes, dilemmas, contradictions and conflicts; each with connections and overlaps which prevail when considering their implications as an approach to trauma.

Physical dimension

The client's existence in the physical dimension pertains to the body, health and the natural world. Focusing on this dimension consequently informs the therapist's understanding of the client's world in a physical sense, and the impact of a traumatic event upon it. Throughout life the basic challenge of our physical survival remains a continuously threatened primary concern, since as van Deurzen (1997) claims, we are firstly regulated by physical, biological and natural forces. Similarly, psychological trauma leads to, among other things, a heightened sense of mortality and physical vulnerability (Sadavoy, 1997),

Jacobsen (2006) conceptualised crisis, a term sometimes used interchangeably with trauma (du Plock, 2010), as being associated with three dimensions: loss, adversity and the opening of existence. The individual in crisis loses something, faces adversity, and has the opportunity to define his or her life at a deeper level. Jacobsen's (2006) 'crisis as loss' conceptualisation can involve direct and physical losses of a specific object or person that the client subsequently misses, resulting in grief. Jacobsen (2006) observes that when something is lost, so is a part of oneself that was attached to that person or thing. Bollnow (1966) made a similar connection when discussing bereavement, claiming that '…the bereaved does not inhabit his or her world in the same way as before. Therefore the death of a loved one is loss of existence. The individual shrinks. The death of a loved one is a piece of one's own Death (p.66, cited in Jacobsen, 2006, p.44). This sense of loss, therefore, whether induced by a bereavement or altered circumstances resulting from trauma, can be perceived as both an unfamiliar environment for the individual to inhabit and an intensified impression of one's own mortality.

Just as trauma can elevate our sense of mortality, it potentially induces a range of physical consequences which continue to threaten it: Kendall-Tackett (2009) notes, for instance, that people who have experienced traumatic events have elevated rates of serious and life-threatening illnesses including cardiovascular disease, diabetes, gastrointestinal disorders, and cancer. Tarrier (2010) also highlights emerging evidence that there is an interaction between the psychological and physical injuries that arise from a trauma, in that physical injury can prolong PTSD by constantly triggering memories of the trauma and its consequences (Jenewein et al., 2009; Sharp & Harvey, 2001).

Social dimension

Psychological trauma can be considered through the lens of the social dimension with regards to our habitual and cultural responses to trauma, our instinctive responses to threat, and the social impact of trauma. van Deurzen (1997) writes that we are social creatures, inserted into a cultural network which we assess, categorise and ultimately need to connect with, extending this into a social commentary about the abandonment of our ancestral history. Denham

(2008) described the varied ways people experience, construct and transmit traumatic experiences intergenerationally within American Indian families, revealing that the family's history of trauma and their related narratives appeared to function as a significant carrier of cultural and family identity. Embedded within the trauma narratives were numerous strategies for resilience, or non-pathological adaptive responses and abilities to maintain equilibrium after experiencing adversity (Bonanno, 2004; Conner, et al., 2003; Dion-Stout & Kipling, 2003; Luthar et al., 2000). Similarly, ven der Hart (1983) described the tribal culture Navahos, for whom to be sick is to become fragmented, to be healed is to become whole, and to be whole one must be in harmony with family, friends and nature. An aim of existential therapeutic work is to help a client to become more authentic, more aware of their existence (Cooper, 2003) which would generally include an exploration into a client's social dimension, beliefs, values and experiences,

Psychological trauma no doubt disturbs the social dimension, evidenced in trauma-related literature that describes our instinctive responses to threat. Our struggle for survival requires us to distinguish between those who will protect or attack, and when fearful many people trigger their social engagement system (Porges, 1995). Lodrick (2007) distinguishes 'friend' as the earliest defensive strategy available to us, evident even in the child who smiles – or even laughs – when being scolded. Lodrick (2007) also distinguishes the survival strategies coined by Cannon (1929): 'fight', which involves the threatened individual responding with overt aggression, and 'flight' as a means of putting space between oneself and the threat. Defining a traumatic event is by no means simple and has changed over the years (Ozer & Weiss, 2004), calling into question what kind of experiences are traumatic and for whom. It would seem that our mode of existing within the social dimension affects our response to trauma, or indeed whether we find an event traumatic at all.

Psychological trauma also appears to impact upon us socially. Research (Maercker, 2008a, 2008b; Nietlisbach & Maercker, 2009a, 2009b) has revealed how features of post-traumatic symptomatology and interpersonal factors may provoke an increase of social exclusion which may be an additional emotional burden for trauma victims. PTSD is often accompanied by impairment of psychosocial functioning that is not reflected within the recommendations by NICE (Hemsley, 2010) and McFarlane and van der Kolk (1996) argue that symptoms such as repression, denial and dissociation have a social as well as an individual consciousness.

Psychological dimension

van Deurzen (1997) writes that we are regulated by our personality, character and mental processes; referring to the personal space which we protect and develop in relation to our established physical and social dimensions. While trauma may shatter the world around us, it may also require a prematurely defined 'self' to develop, which will eventually falter and become depleted. The formation of self is described by van Deurzen (1997) as a constant challenge, an ongoing process, but if physical and social well-being has been acquired at some point, a more positive experience can be drawn upon to overcome difficulties. Similarly Jacobsen's (2006) conceptualisation of 'crisis as loss' includes psychological losses of a connection with the mind or soul or existential losses of a relationship with self or other. Though the potential for trauma is consistently prevalent, so is the possibility of generating bonds of emotional attachment within which debilitating emotional pain can be held, constructed as more manageable, and ultimately integrated (Vogel, 1994). Here, the social and psychological dimensions interweave; just as Herman's (1997) commonality and reconnection theory suggests that people affected by trauma need to reconnect and rediscover themselves as well as to connect with those who have

endured similar circumstances. This relational interplay suggests an inter-connection between the existential dimensions and Jacobsen's (2006) crisis conceptualisations in approaching trauma therapeutically, perhaps exemplifying the therapist's requirement to step back and question multiple possibilities.

Jacobsen's (2006) 'crisis as adversity' dimension outlines existential givens, which an individual must learn to accept or face living under false premises. Trauma can enduringly affect one's sense of being-in-the-world by altering our preconceptions: the world is unpredictable and can offer no guarantee of security or consistency (Stolorow, 2007). Such concepts epitomise the subjective conceptualisation of trauma, with therapeutic implications that listening to the subtleties of interpretation and remembrance, nuances of affect and self-experience and idiosyncratic social constructions could provide insight into the client's unique post-traumatic response (Harvey, 1996).

Spiritual dimension

van Deurzen (1997) suggests that we are modulated by our relationship to the overall framework of meaning through which we experience the world and make sense of it on a spiritual dimension. Trauma can indeed provoke an altered philosophy of life that may include spiritual beliefs (Park et al., 1996). When exposed to trauma, the client can experience a level of death awareness that enables them to more clearly and richly experience the joys, meanings, values and life purposes (Frankl, 1969; Yalom, 1980). Jacobsen's (2006) 'crisis as loss' dimension includes loss of meaning and world-view, but his conceptualisation of 'crisis as an opening-of-existence' also resonates here. Trauma presents the therapist with an opportunity to help the client discover a paradoxical respect for life that occurs in response to the proximity of death, identified by Frankl (1969) as 'finality meanings'.

It may be that trauma can result in growth, inasmuch as adversity and distress can push someone to develop. Parkes (1971) characterises traumas as 'psychosocial transitions', explaining that individuals must 'restructure [their] ways of looking at the world and [their] plans for living in it' (p.101). Research suggests that a range of traumas can precipitate positive development, for example, cancer (Cordova et al., 2001; Taylor, 1983); HIV infection (Schwartzberg, 1994); rape (Ashley, 2005; Burt & Katz, 1987; Veronen & Kilpatrick, 1983); incest (Silver et al., 1983); bereavement (Calhoun & Tedeschi, 1989; Lehman et al., 1993; Schwartzberg & Janoff-Bulman, 1991); heart attacks (Affleck et al., 1987) and disasters (McMillen et al., 1997). Jacobsen (2006) describes this concept like a crack in the ground '…the crack allows the individual to look deep into something very significant. In this way, the crisis becomes existential and can become a personal turning point, a new life possibility' (p.46). This is precisely what a traumatic event does, and this analogy has profound therapeutic implications, for it is precisely when the ground opens up before us – when the carpet is swept from under our feet – when we are disturbed, distressed and derascinated - that we potentially have a rare opportunity to work with awareness not previously experienced.

Therapeutic implications

In working therapeutically with a trauma, du Plock (2010) cited Jacobsen's (2006) paper suggesting that it could work almost as a guide: which advocates that the client would need to confront and articulate losses, be afforded the opportunity to sense, acknowledge and express feelings, while confronting the material that was split off during the traumatic event. The therapist ultimately collaborates with the client to induce meaning, implications and possible consequences.

Feelings and moods

van Deurzen-Smith (1988) summarised the most common feelings that emerge after a trauma as a wheel/circular experience. This is similar to researchers from other frameworks (e.g. van der Kolk 1989), who suggest that feelings succeed one another in a cycle. van Deurzen suggests that each has a destructive and a constructive side, and the client may need to experience and understand the varying feelings that surface, become accustomed to them and learn something from them about one's way of life. Boss (1994) discussed moods as ways in which an individual's relationship with the world may manifest. Boss stressed the need for the individual to be able to sense their varying moods and gradually open themselves up to them, so that they are able to meet the world freely and be present to what emerges. This perhaps exemplifies the importance of the therapist's engagement with personal therapy, requiring the therapist to have worked through their own existential concerns, feelings and moods, since they themselves may experience intense feelings and a traumatised client's process of recovery could be extensive.

Reintegration

du Plock (2010) commented that when someone experiences a trauma, their defences are activated and some events are so horrific that the consciousness cannot contain them. Jacobsen (2006) cites Spinelli's (1994) theory of dissociated or divided consciousness, in which certain aspects of a traumatic experience are placed into one of two 'compartments' of consciousness. The more humiliating or anxiety-ridden memories are placed in one compartment, while the more positive memories allocated to the other, and a potential task is for the individual to gradually attempt to recall these details in therapy. An important part of the repair process would also be the confrontation of the client's beliefs and assumptions that could influence the client's stance towards their memories.

Reconstruction

Jacobsen (2006) observed how therapy can generate a more positive interpretation for the trauma survivor, as they re-attribute meaning to the traumatic event. This resembles but goes beyond cognitive restructuring (e.g. Ehlers & Clark, 2000), as the reconstructed meaning and orientation of one's life can be characterised by a more intense and intimate life containing features like reconciliation and acquiescence to one's existence. Jacobsen (2006) provides case examples from an interview to illustrate positive reconstructions of cancer patients, which could have been developed to include Spinelli's (1994) suggestions about the self-construct, which he proposed was maintained and validated by a remembered past that has flexible meaning and significance.

The therapeutic relationship

The pertinence of the social dimension to trauma draws attention to a central preoccupation for existential therapy: the role of the therapeutic alliance. Existential therapy recognises the relational aspect of life and of therapy, therefore helping clients to become aware of their experiences, potentialities, and means of interaction with the therapist (Bugental, 1978; May, 1995; Schneider & May, 1995; Yalom, 1980). The nature of the relationship may differ from more classical kinds of therapy: for instance, the existential therapist functions as a person in a meaningful encounter with another person. This is particularly pertinent to traumatised clients, as case examples concerned with trauma have previously illustrated how the development of the therapeutic relationship has significantly contributed to resolution of thematic issues that defined the therapeutic trauma work (Roth & Batson, 1993), acknowledging that the dynamic process of recovery from a trauma can only occur within the context of a meaningful therapeutic relationship. Roth and Batson (1993) maintain that there is a distinctly humane understanding of the role of the therapist as someone to bear witness to the trauma, to be

a real partner in the re-experiencing of the trauma, and, of course, to provide a safe environment in which to do the trauma work. With relevance to existential work, Lantz (2004) highlights that existential therapists generally believe that effective therapy evolves out of the therapist's willingness to utilise the self to facilitate relationship, action and reflection experiences that help the client work through and struggle with the ultimate issues of human life during the therapeutic process (Frankl, 1969; May, 1983; Mullan & Sangiuliano, 1964; Whitaker, 1976; Yalom, 1980).

Empirical considerations

When reviewing this literature, it is evident that empirical evidence is beginning to amass that recognises the contribution that existential theory and practice can offer our understanding of trauma. Empirical work in this area may have its challenges, however, and it is indeed one of the most under-researched approaches in counselling and psychotherapy (Cooper, 2004). A core epistemological theme within existentialism is concern for the uniqueness and irreducibility of human experience, and traditional scientific methods seem inadequate to the task of understanding the meaningful complexities of human experience (Boss, 1979; May & Yalom, 1995; Norcross, 1987). Epistemologically, existential therapy is impeded this way since 'the basic tenets of existential therapy are such that empirical research methods are often inapplicable or inappropriate' (Yalom, 1980, p.10). While in the world of 'evidence-based-practice' (EBP), therapies are increasingly expected to demonstrate efficacy and efficiency (Rowland & Goss, 2000), existential therapists have expressed reservations about the use of systematic experimental research methods to generate knowledge about the practice and effectiveness of existential therapy and for many such experimental research methods are best replaced with the process of participation (Lantz, 2004). Chalquist (2009) has even suggested that unrestrained empiricism is itself a version of trauma; an intellectualised resistance from experiencing the world on its own terms.

Therapy is fundamentally a complex human endeavour, and easy to measure efficacy studies fail to generate rich qualitative data to truly illustrate the experience. Spinelli (2003) noted that existential-phenomenological research is primarily qualitative-interpretative, which essentially searches for meaning rather than aims to collect facts, and endeavours to understand rather than explain. Spinelli (2003) also highlighted developments in existential-phenomenological research methodologies relevant to counselling psychology research which have focused on hermeneutic single-case efficacy design (Elliot, 2001) and multiple-case depth research (Schneider, 2001). As a further example, Lantz (2004) describes Grounded Theory as a research method for existential therapy: a qualitative, phenomenological and inductive approach that aims to identify data, data themes and emerging theory that is grounded in observation of the study population (Glaser & Strauss, 1967; Lantz, 1987, 2002). The author maintains that this kind of study acquires credibility through the use of prolonged observation, methodological triangulation, data triangulation, peer debriefing and reflection to work towards accurate and dependable observation (Glaser & Strauss, 1967; Greenlee & Lantz, 1993; Lantz, 1987, 2002).

While existential therapy remains relatively under-researched, empirical evidence for cognitive-behavioural approaches is more widespread, though the nature of these studies has been challenged. For instance, the demand for EBP has focused on quantitative studies that address a finite number of parameters and struggle to examine complex interactions (Coote et al., 2004), while limitations such as attrition have been identified to suggest that evidence is frequently overstated or under explained (Foa et al., 2008). The difficulty with EBP seems to be its insistence on a specific form

of 'measurement' with the assumption that if it cannot be measured then it is not 'real' (Hart & Hogan, 2003; Michell, 2003, cited in Nowill, 2010).

van Deurzen (1997) postulates that physical life is based upon a cycle of need: to fill an empty stomach. We also once enjoyed the process of gathering food and eating at the same time: the effort was as important as the goal. However, we have since learnt to postpone gratification, and work is perceived as depleting and exhausting. The natural cycles in which pleasure and effort are commensurate have been replaced with unnatural cycles of entitlement, comfort, instant gratification and whatever else might reinforce such views (van Deurzen, 1997). This depiction reflects an over-simplified prioritising of quick-fix solutions for psychological trauma, while simplifying – if not negating – the core issues. Research has indicated that the long-term benefits of CBT are not quite as clear and certain as sometimes portrayed (e.g. Rowe, 2007; Rufer et al., 2005). Just as van Deurzen (1997) observes that we prefer to outsmart nature and obtain our livelihood with minimal effort, the reality is that we gain relatively little, for the journey is everything, and the 'goal' is indefinable and ever-shifting, according to the individual's perspective and the passage of time. Trauma seemingly affects us all at some point. For some, the real work on personal development after a trauma is on reshaping ourselves, reconnecting with natural cycles within and without, and restoring a sense of meaning to life. This can ultimately be a rewarding effort, the very challenge of our physical existence.

Conclusions: Integration and future research

This review considered the potential for the use of existential therapy for working with psychological trauma. Despite broad philosophical underpinnings and definitions, the issues raised by existential therapy appear to be universally perceived and basic to human experience (Yalom, 1980), suggesting that they could be integrated into almost any approach (van Deurzen, 1997). This paper is not intending to endorse a new prescriptive methodology, but an integration and incorporation of other methods so that the practice of counselling psychology continues to evolve. CBT is recommended within the NICE guidelines, with a concentration on symptoms and diagnostic criteria (Hemsley, 2010), yet this fails to adequately provide a rich understanding of responses to trauma (McHugh & Treisman, 2007) – an issue that an existential therapeutic approach can help correct. People can only heal from trauma if supported as whole beings and provided a safe channel to explore their world and reconnect with themselves (Herman, 1997; Paulson & Krippner, 2007). The responsibility of counselling psychologists, therefore, ultimately lies in understanding their clients' anxieties and experiences rather than coercing them into conforming to a therapeutic model.

Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional psychology (BPS, 2005). Indeed, a commitment to good practice, as outlined by the British Psychological Society (BPS, 2005) and the British Association for Counselling and Psychotherapy (BACP, 2010), is to keep up-to-date with the latest knowledge, implying that counselling psychologists have a continual ethical responsibility to explore how alternative approaches could be used to benefit clients. While empirical evidence is beginning to amass for existential therapy, further projects should be monitored and evaluated to provide support for existing findings and expand data. Perhaps purely empirical methods are inadequate to comprehend the idiosyncratic meanings we assign to trauma, presenting both an obstacle to the acceptance of an existential approach but also a necessity that cannot be overlooked; for to define is to limit and to manualise is to generalise. So it is possible that more is needed; namely, a willingness to experiment and explore other approaches;

to identify ways in which these approaches may be integrated; and to constantly question and debate the accepted methods as reflective and critical practitioners.

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References

Affleck, G., Tennen, H., Croog, S. & Levine, S. (1987). Causal attribution, perceived benefits, and morbidity following a heart attack: An eight-year study. *Journal of Consulting and Clinical Psychology, 55*(1), 29–35.

American Psychiatric Association (APA) (1980). *Diagnostic and statistical manual of mental disorders: Third edition (DSM-III)*. Washington, DC: APA.

American Psychiatric Association (APA) (2000). *Diagnostic and statistical manual of mental disorders: Fourth edition – text revision (DSM-IV-TR)*. Washington, DC: APA.

Ashley, H. (2005). *To what extent can traumatic events be viewed as developmental opportunities? What are the implications of such a position for counselling psychologists working with clients who have experienced trauma?* Cited within a portfolio of academic, therapeutic practice and research work submitted to the University of Surrey in partial fulfilment of the degree of Practitioner Doctorate in Psychotherapeutic and Counselling Psychology (pp.6–18).

Banyard, P. (1999). *Controversies in psychology*. Florence, KY: Routledge.

Bebbington, P.E., Bhugra, D., Brugha, T., Farrell, M., Lewis, G., Meltzer, H. & Jenkins, R. (2004). Psychosis, victimisation and childhood disadvantage: Evidence from the second British National Survey of Psychiatric Morbidity. *British Journal of Psychiatry, 185*, 220–226.

Ben Ezra, M. (2001). Earliest evidence of post-traumatic stress? *British Journal of Psychiatry, 179*(5), 467.

Binswanger, L. (1958). The case of Ellen West. In R. May (Ed.), *Existence* (pp.237–364). New York: Simon & Schuster.

Bollnow, O. (1966). *Krise und neuer Anfang*. Heidelberg: Quelle und Meyer.

Bonanno, G.A. (2004). Loss, trauma, and human resilience: Have we under-estimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20–28.

Boss, M. (1979). *Existential foundations of medicine and psychology* (Trans: S. Conway & A. Cleaves). Northvale, NJ: Aronson.

Boss, M. (1994). *Existential foundations of medicine and psychology*. Northvale, NJ: Aronson.

British Association of Counselling and Psychotherapy (2010). *Ethical Framework*. Retrieved 15 June 2010, from: www.bacp.co.uk/ethical_framework/good_standard.php

British Psychological Society (BPS) (2005). *Professional practice guidelines for counselling psychologists*. Retrieved 16 June 2010, from: www.bps.org.uk/publications/prof-pract/prof-pract_home.cfm.

Bugental, J. (1978). *Psychotherapy and process: The fundaments of an existential-humanistic approach*. Boston, MA: McGraw-Hill.

Burt, M.R. & Katz, B.L. (1987). Dimensions of recovery from rape: focus on growth outcomes. *Journal of Interpersonal Violence, 2*, 57–81.

Calhoun, L.G. & Tedeschi, R.G. (1989). Positive aspects of critical life problems: Recollections of grief. *Omega: Journal of Death and Dying, 20*(4), 265–272.

Cannon, W.B. (1929). *Bodily changes in pain, hunger, fear and rage: An account of recent research into the function of emotional excitement* (2nd ed.). New York, Appleton-Century-Crofts.

Cannon, B. (1991). *Sartre and psychoanalysis: An existentialist challenge to clinical metatheory*. Lawrence, KA: University of Kansas.

Chalquist, C. (2009). A look at the ecotherapy research evidence. *Ecopsychology, 1*(2), 64–74.

Cohn, H.W. (1984). An existential approach to psychotherapy. *British Journal of Medical Psychology, 57*(3), 11–18.

Conner, K.M., Davidson J. & Lee, L. (2003). Spirituality, resilience, and anger in survivors of violent trauma: A community survey. *Journal of Traumatic Stress, 16*(5), 487–494.

Cooper, M. (2003). *Existential therapies*. London: Sage.

Cooper, M. (2004). Viagra for the brain: Psychotherapy research and the challenge to existential therapeutic practice. *Existential Analysis, 15*, 2–14.

Coote, A., Allen, J. & Woodhead, D. (2004). *Finding out what works: Building knowledge about complex, community-based initiatives*. London: King's Fund.

Cordova, M.J., Cunningham, L.C.C., Carlson, C.R. & Andrykowski, M.A. (2001). Post-traumatic growth following breast cancer: A controlled comparison study. *Health Psychology, 20*, 176–185.

Courtois, C.A. & Gold, S.N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1) 3–23.

Denham, A.R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry, 45*(3), 391–414.

Deurzen, E., van (1997). *Everyday mysteries: Existential dimensions of psychotherapy.* London: Routledge.

Deurzen-Smith, E. van (1988). *Existential counselling in practice.* London: Sage.

Dion Stout, M. & Kipling, G. (2003). *Aboriginal people, resilience and the residential school legacy.* Prepared for The Aboriginal Healing Foundation, Ottawa, ON: Anishinabe Printing (Kitigan-Zibi).

Du Plock, S. (2010). *Trauma in the relational world: An existential perspective.* British Psychological Society, Division of Counselling Psychology Conference: Approaching Trauma. 17 April.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Elliot, R. (2001). Hermeneutic single-case efficacy design: An overview. In K.J. Schneider, J.F.T. Bugental & J.F. Pierson (Eds.), *The handbook of humanistic psychology.* London: Sage.

Fairfax, H. (2008). CBT or not CBT: Is that really the question? Re-considering the evidence base – the contribution of process research. *Counselling Psychology Review, 23*(4), 27–35.

Foa, E.B., Keane, T.M. & Friedmad, M.J. (2008). *Effective treatments for post-traumatic stress disorder: Practice guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press.

Frankl, V. (1969). *The will to meaning.* New York: New American Library.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory.* Chicago, OH: Aldine.

Gold, S.N. (2008). About psychological trauma and the APA Division of Trauma Psychology. *Psychological Trauma: Theory, Research, Practice and Policy, 1*, 1–2.

Greenlee, R. & Lantz, J. (1993). Family coping strategies and the rural Appalachian working poor. *Contemporary Family Therapy, 15*, 121–137.

Grey, N. (2007), Post-traumatic stress disorder: Investigation. In S. Lindsay & G. Powell (Eds.), *The handbook of clinical adult psychology* (3rd ed., pp.16–184). London: Routledge.

Hart, N. & Hogan, K. (2003). Second response: Training counselling psychologists: What role for evidence-based practice? *Counselling Psychology Review, 18*(3), 21–27.

Hart, O., ven der (1983). *Rituals in psychotherapy: Transition and continuity.* New York: Irvington Publishers.

Harvey, M.R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1) 3–23.

Hemsley, C. (2010). Why this trauma and why now? The contribution that psychodynamic theory can make to the understanding of post-traumatic stress disorder. *Counselling Psychology Review, 25*(2) 13–20.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror.* New York: Basic Books

Herman, J.L. (1997). *Trauma and recovery* (2nd ed.). New York: Basic Books.

Iacovou, S. (2009). Are well-being, health and happiness appropriate goals for existential therapists? *Existential Analysis, 20*(2).

Jacobsen, B. (2006). The life crisis in a existential perspective: Can trauma and crisis be seen as an aid in personal development? *Existential Analysis, 17*(1), 39–54.

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., de Graaf, R. & van Os, J. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatr Scand, 109*, 38–45.

Jenewein, J., Wittmann, L., Moergeli, H., Creutzig, J. & Schnyder, U. (2009). Mutual influence of posttraumatic stress disorder symptoms and chronic pain among injured accident survivors: A longitudinal study. *Journal of Traumatic Stress, 22*, 540–548.

Joseph, S. (2010). Working with psychological trauma. *Healthcare Counselling & Psychotherapy Journal, 10*(2).

Kendall-Tackett, K. (2009). Psychological trauma and physical health: A psychoneuroimmunology approach to etiology of negative health effects and possible interventions. *Psychological Trauma: Theory, Research, Practice and Policy, 1*(1), 35–48.

Kolk, B., van der (1989). The compulsion to repeat the trauma: Re-enactment, revictimisation and masochism. *Psychiatric Clinics of North America, 12*(2), 389–411.

Kolk, B., van der (1996). The complexity of adaptation to trauma: self-regulation, stimulus, discrimination, and characterological development. In B. van der Kolk, A. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York: Guilford Press.

Kolk, B., van der & McFarlane, A. (1996). The black hole of trauma. In B. van der Kolk, A. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York: Guilford Press.

Lantz, J. (1987). Guilt and restitution: A ghetto healer's approach. *Voices, 23*, 42–45.

Lantz, J. (2002). Family development and the martial arts: A phenomenological study. *Contemporary Family Therapy, 24*, 265–280.

Lantz, J. (2004). Research and evaluation issues in existential psychotherapy. *Journal of Contemporary Psychotherapy, 34*(4), 331–340.

Lehman, D.R., Davis, C.G., Delongis, A., Wortman, C.B., Bluck, S., Mandel, D. & Ellard, J.H. (1993). Positive and negative changes following bereavement and their relations to adjustment. *Journal of Social and Clinical Psychology, 12*, 90–112.

Lodrick, Z. (2007). Psychological trauma – what every trauma worker should know. *The British Journal of Psychotherapy Integration, 4*(2).

Luthar, S.S., Cicchetti, D. & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work authors. *Child Development, 71*(3), 543–562.

Maddux, J.E., Snyder, C.R. & Lopez, S.J., (2004). Toward a positive clinical psychology: Deconstructing the illness ideology and constructing an ideology of human strengths and potential. In P.A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp.320–334). Hoboken, NJ: Wiley.

Maercker, A. (2008a). *A social facilitation model of post-traumatic stress disorder.* University of Zurich: Unpublished manuscript.

Maercker, A. (2008b). *Towards a new social facilitation model of PTSD.* Paper 39. Berlin: International Congress of Psychology.

May, R. (1983). *The discovery of being.* New York: Norton.

May, R. (1995). *Discovery of being.* New York: Peter Smith.

May, R. (1999). *Freedom and destiny.* New York: Peter Smith.

May, R. & Yalom, I.D. (1995). Existential psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (5th ed., pp.262–292). Itasca, IL: Peacock.

McFarlane, A.C. & van der Kolk, B.A. (1996). Trauma and its challenge to society. In B. van der Kolk, A. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York: Guilford Press.

McHugh, P.R. & Treisman, G. (2007). PTSD: A problematic category. *Journal of Anxiety Disorders, 21*(2), 211–222.

McMillen, C., Smith, E.M. & Fisher, R.H. (1997). Perceived benefit and mental health after three types of disaster. *Journal of Consulting and Clinical Psychology, 65*, 733–739.

Michell, J. (2003). The qualitative imperative. Positivism, naïve realism and the place of qualitative methods in psychology. *Theory and Psychology, 13*, 5–31.

Moss, E. (2009). The place of psychodynamic psychotherapy in the integrated treatment of post-traumatic stress disorder and trauma recovery. *Psychotherapy Theory, Research, Practice, Training, 46*(2), 171–179.

Mullan, H. & Sangiuliano, I. (1964). *The therapist's contribution to the treatment process.* Springfield, IL: Charles C. Thomas.

National Institute for Health and Clinical Excellence (2005). *Post-traumatic stress disorder.* Retrieved 4 April 2010, from: www.nice.org.uk/Guidance/CG26

Nietlisbach, G. & Maercker, A. (2009a). Effects of social exclusion in trauma survivors with post-traumatic stress disorder. *Psychological Trauma: Theory, Research, Practice and Policy, 1*(4), 323–331.

Nietlisbach, G. & Maercker, A. (2009b). Social cognition and interpersonal impairments in trauma survivors with PTSD. *Journal of Aggression, Maltreatment & Trauma, 18*, 382–402.

Norcross, J.C. (1987). A rational and empirical analysis of existential psychotherapy. *Journal of Humanistic Psychology, 27*, 41–68.

Nowill, J. (2010). A critical review of the controversy surrounding eye movement desensitisation and reprocessing. *Counselling Psychology Review, 25*(1), 63–71.

Ozer, E.J. & Weiss, D.S. (2004). Who develops post-traumatic stress disorder? *Current Directions in Psychological Science, 13*(4), 169–172.

Park, C.L, Cohen, L.H, Murch, R. (1996). Assessment and prediction of stress-related growth. *Journal of Personality, 64*(1), 71–105.

Parkes, C.M. (1971). Psychosocial transitions: A field for study. *Social Science and Medicine, 5*, 101–115.

Paulson, D. & Krippner, S. (2007). *Haunted by combat: Understanding PTSD in war veterans including women, reservists, and those coming back from Iraq.* Westport, CT: Praeger.

Perry, B.D., Pollard, R., Blakley, T.L., Baker, W.L., Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: How 'states' become 'traits'. *Infant Mental Health Journal, 16*(4), 271–291.

Pitchford, D.B. (2009). The existentialism of Rollo May: An influence on trauma treatment. *Journal of Humanistic Psychology, 49*, 441.

Porges, S. (1995). Orienting in a defensive world: Mammilian modifications of our evolutionary heritage. A polyvagal theory. *Psychophysiology, 32*, 301–318.

Resick, P.A., Galovski, T.E., Uhlmansiek, M.O., Scher, C.D., Clum, G.A. & Young-Xu, Y. (2008). A randomised clinical trial to dismantle components of cognitive processing therapy for post-traumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76*(2), 243–258.

Roth, S. & Batson, R. (1993). The creative balance: The therapeutic relationship and thematic issues in trauma resolution. *Journal of Traumatic Stress, 6*(2) 159–177.

Roth, A. & Fonagy, P. (2005). *What works for whom?* London & New York: The Guilford Press.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: Norton.

Rowe, D. (2007). *Making up the mind.* Oxford: Blackwell Publishing.

Rowland, N. & Goss, S. (2000). *Evidence-based counselling and psychological therapies: Research and applications.* London: Routledge.

Rufer, M. Grothusen, A., Mas, R., Peter, H. & Hand, I. (2005). Temporal stability of symptom dimensions in adult patients with obsessive-compulsive disorder. *Journal of Affective Disorders, 88*(1) 99–102.

Ryan, J. (2010). New developments in trauma therapy. *Therapy Today, 21*(5)

Sadavoy, J.(1997). Survivors: A review of the late-life effects of prior psychological trauma. *American Journal of Geriatric Psychology, 5*, 4.

Schneider, K.J. & May, R. (1995). *The psychology of existence: An integrative, clinical perspective.* New York: McGraw-Hill.

Schneider, K.J. (2001). Multiple-case depth research: Bringing experience-near closer. In K.J. Schneider, J.F.T. Bugental & J.F. Pierson (Eds.), *The handbook of humanistic psychology.* London: Sage.

Schore, A.N. (2000). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1–2), 201–269.

Schwartzberg, S.S. (1994). Vitality and growth in HIV-infected gay men. *Social Science and Medicine, 38*, 593–602.

Schwartzberg, S.S. & Janoff-Bulman, R. (1991). Grief and the search for meaning: Exploring the assumptive world of bereaved college students. *Journal of Social and Clinical Psychology, 10*, 270–288.

Shevlin, M., Dorahy, M. & Adamson, G. (2007). Childhood traumas and hallucinations: An analysis of the National Comorbidity Survey. *Journal of Psychiatric Research, 41*, 222–228.

Silver, R.L., Boon, C. & Stones, M. (1983). Searching for a meaning in misfortune: Making sense of incest. *Journal of Social Issues, 39*, 81–102.

Sharp, T.J. & Harvey, A.G. (2001). Chronic pain and post-traumatic stress disorder: Mutual maintenance? *Clinical Psychology Review, 21*, 857–877.

Spinelli, E. (1994). *Demystifying therapy.* London: Constable.

Spinelli, E. (2003). The Existential-Phenomenological Paradigm. In R. Woolfe, W. Dyden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed.). London: Sage.

Stolorow, R.D. (2007). *Trauma and human existence: Autobiographical, psychoanalytic and philosophical reflections.* New York & London: The Analytic Press.

Tarrier, N. (2010). The cognitive and behavioural treatment of PTSD, what is known and what is known to be unknown: How not to fall into the practice gap. *Clinical Psychology: Science and Practice, 17*(2), 134–143.

Taylor, S.E. (1983). Adjustment to threatening events: A theory of cognitive adaption. *American Psychologist, 38*, 1161–1173.

Taylor, S. (2007). *Clinician's guide to PTSD: A cognitive behavioural approach.* London & New York: The Guilford Press.

Totton, N. (2005). Can psychotherapy help make a better future? *Psychotherapy and Politics International, 3*(2) 83–95.

Veronen, L.J. & Kilpatrick, D.G. (1983). Rape: A precursor of change. In E.J. Callahan & K.A. McClusky (Eds.), *Lifespan developmental psychology: Non-normative events.* San Diego, CA: Academic Press.

Vogel, L. (1994). *The fragile 'we': Ethical implications of Heidegger's being and time.* Evanston, IL: MIT.

Wainrib, B.R. (2006). *Healing crisis and trauma with body, mind, and spirit.* New York: Springer Publishing Company.

Whitaker, C. (1976). The hindrance of theory in clinical work. In P. Guerin (Ed.), *Family therapy: Theory and practice* (pp.154–164). New York.

Yalom, I.D. (1980). *Existential psychotherapy.* New York: Basic Books.

Book Reviews: Is there a value to book reviews, or are they promotional hype?

Caroline Knott

THERE IS A SECTION of the online Counselling Psychologist Forum (www.bps.org.uk/dcop) that has been assigned to **'Book Reviews'** and **'Book Recommendations'**. You may wonder what the difference is, and how it affects you in your training and practice. Below I provide brief descriptions of these types of contribution before outlining some of the benefits opportunities that may be available to DCoP members.

Book Reviews pertain to newly-published books that purport to bring something new to an area of research, theory or practice. Following a book launch it is the publisher's aim to continue to promote a book to elicit good reviews which in turn should increase sales. To be included on the reading list for a professional training course is ideal, but this can take time. To have a book reviewed by a credible professional can be achieved quickly, and if the review is published in a professional forum such as *Counselling Psychology Review* and *The Psychologist* the readership makes it an exceptional promotional medium.

Book Recommendations should be based on use in clinical practice or when undertaking research projects. I personally feel that there are a number of books that clinicians use or have used that could be recommended. These should be tried and trusted, and albeit published less recently, still be relevant for today.

I hope the Book Review section will become more interactive and DCoP members feel encouraged to contribute. This might be by reviewing newly-published books or recommending books or articles which they feel are relevant for the work of counselling psychologists. I do, however, understand that book reviews are subjective and as such I hope other clinicians will contribute to this page with their own opinions even if they are contrary to those of the reviewer.

Books available for review

I have discussed the role of the Forum and the Book Review section with Heather Allan, Manager: Publicity and Promotions PCCS Books Ltd. (PCCS Books is an independent publisher of counselling, psychotherapy and positive, radical, critical psychology)

She has kindly sent me a list of books that are available for review.

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If you are a counselling psychologist or a trainee counselling psychologist and you would like to review one of the books mentioned, please e-mail Heather and inform her of your area of interest, and the title of the book you are interested in reviewing. If you are chosen to undertake a review, please submit a copy of this to the Forum for our interest and also a copy to Heather for her use.

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Dr Caroline Knott
E-mail: DCoPNews@bps.org

Book Review

Person-Centred and Experiential Therapies Work: A Review of the Research on Counselling, Psychotherapy and Related Practices
Mick Cooper, Jeanne Watson & Dagmar Holldampf (Eds.)
PCCS Books, 2010.

Reviewed by Isabel Gibbard

This book is a response to the widely held perception that there is a lack of evidence for the effectiveness of Person-Centred and Experiential (PCE) therapies. Its first aim is to present a comprehensive and systematic review of the research evidence. This book certainly provides a wealth of current information. The first three chapters concentrate on the quantitative evidence. As a person-centred counsellor in the NHS I am expected to comply with the NICE guidelines, to offer counselling only to people who decline the recommended treatments, and only after informing them of the uncertainty of its effectiveness (NICE, 2009). I was, therefore, most interested in Elliott and Friere's presentation of the results of their meta-analysis of the quantitative evidence for the effectiveness of PCE therapies. Although their conclusion is very positive, that PCE therapies are effective, this chapter was disappointing in that they only present a brief summary of their preliminary findings. In the next chapter, Holldampf et al. provide a more detailed review of the quantitative evidence for the effectiveness of PCE therapies with children and young people. The PCE philosophy has applications outside therapy and Cornelius White et al. present evidence of its effectiveness in education, parenting and management.

The next chapters concentrate on the qualitative evidence. Timulak and Creaner present the findings of a meta-analysis of qualitative outcome studies. Bohart and Tallman present evidence that it is not the therapy that is effective, but the client who is effective in making the therapy work for them. In the next chapter Watson et al. provide evidence for the role that both the quality of the therapeutic relationship and the depth of the client's experiencing play in the outcome of therapy and review the kind of change processes which occur during therapy. In the next two chapters, Watson and Watson, and Freire and Grafanaki review the measures which are used to evaluate PCE therapies. Finally, Wilkins describes how it is possible to do research in a person-centred way.

The editors intend this book to empower PCE therapists to present the facts about their effectiveness, and to that end the authors have tried to make their chapters as accessible as possible to a wide-ranging, non-specialist audience. However, some authors have been more successful than others and this book is not an easy read. The editors acknowledge that some of the writing will be unfamiliar to people new to research, and suggest that such readers read the book alongside an introductory research text. In addition some of the experiential writing is dense and technical, and will be unfamiliar to person-centred practitioners.

The second aim of the book is to summarise the current situation so that the PCE community can develop a coherent programme of research for the future. In their final chapter the editors highlight the threat posed to the PCE approaches by the evidence-based agenda and they identify key priorities and an urgent need for research in all the areas covered by the book. In view of the hierarchy of evidence employed by regulatory bodies, they identify Randomised Controlled Trials as the first priority.

However, much of the PCE research challenges the evidence based agenda. The qualitative meta analysis of Timulak and Creaner demonstrates that, from the client's point of view, the outcomes of successful therapy are complex, sometimes surprising, and include aspects other than the kind of symptom reduction which is measured in Randomised Controlled Trials. The evidence provided by Bohart and Tallman that it is the client that 'works' not the therapy, challenges the rationale behind all effectiveness research.

There is a conflict between the therapeutic and philosophical beliefs held by many PCE researchers and the current emphasis on quantitative evidence. The PCE approaches resist the categorisation of patients according to disorder and the measurement of successful therapy in terms of symptom reduction. Despite this, experiential researchers have been involved in such research for some time where as those from the person-centred wing have been reluctant to become involved. This book shows how current person-centred research is concentrating on developing measures of the relationship in order to test to Rogers' original theory, and, according to Wilkins, it is only qualitative research which meets the criteria of researching in a person-centred way. This book demonstrates how the person-centred and experiential approaches can make uncomfortable bedfellows. It is complex and contradictory, and whether a shared understanding can be reached and coherent programme of research developed for the future remains to be seen.

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