DOCTORAL THESIS PORTFOLIO

AN EXPLORATION OF ADULT MALE EXPERIENCES OF HAVING IRRITABLE BOWEL SYNDROME (IBS): A QUALITATIVE STUDY

BY NIGEL CAMPBELL

PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY

LONDON METROPOLITAN UNIVERSITY

IN COLLABORATION WITH ST GEORGE'S HEALTHCARE NHS TRUST

2015

ACKNOWLEDGEMENTS

I would like to thank several people who helped me to conceptualise and carry out this empirical research project. I am grateful to my supervisory team comprising of Dr Elaine Kasket, Dr Philip Hayton for their academic guidance and motivational support from the beginning of this project through to submission. I am also indebted to Professor Dominic Palmer-Brown and Professor Christopher Branford-White who acted as academic sponsors for my empirical project on behalf on London Metropolitan University.

I am grateful to my study collaborator Dr Andrew Poullis, Consultant Gastroenterologist at St George's Hospital for facilitating access and recruitment of study participants and for his consistent support over the course of this research project. Suitable participants were sourced through the dedicated efforts of the hospital dietician team for which I remain appreciative.

I offer a special thanks to the brave men who came forward and agreed to take part in this study. Their transparent and much valued accounts of having Irritable Bowel Syndrome (IBS) contributed to the rich study findings and the implications that were proposed.

TABLE OF CONTENTS

INTRODUCTION TO PORTFOLIO

This doctoral thesis portfolio includes coursework elements from Year 3 modules for the Professional Doctorate in Counselling Psychology. The portfolio contains:

A. Process Report, Applied Therapeutic Practice
B. Theoretical Essay, Counselling Couples and Groups
C. Reflective Essay, Cognitive Behaviour Therapy - Level 3
D. Empirical Research Project, Doctoral Research and Thesis Preparation

All pieces of coursework presented in this portfolio were completed with adherence to the core values and ethos of Counselling Psychology underlying clinical practice and research. The individual pieces of coursework addressed specific learning outcomes inherent to their modules of origin and formed part of course training requirements.

A. Process Report, Applied Therapeutic Practice

The process report was an illustration of my ability to conceptualise and deliver psychological treatments as a Counselling Psychologist with a client presenting with a specialist clinical presentation. The process report also demonstrated my capacity to work clinically with this client using multi-theoretical perspectives gained from pluralistic training. This report reflected on working therapeutically within the context of multi-disciplinary team and the ramifications this entailed.

B. Theoretical Essay, Counselling Couples and Groups

The theoretical essay aimed to contrast and compare therapeutic interventions when working with couples experiencing difficulties from a cognitive behavioural therapy and object relations perspective. This essay outlined the theories and philosophies underlying the two approaches along

with the pertinent features that demonstrated how they could work in practice with couples presenting for therapy. This essay also critically reflected on the understanding of and personal ability to work with issues of diversity within couples work.

C. Reflective Essay, Cognitive Behaviour Therapy - Level 3

The reflective essay exhibited how my professional training as a Counselling Psychologist has continually challenged and developed my theoretical thinking and clinical practice. This essay illustrated how I have developed my own personal philosophy of practice stemming from learning and experience applying different models of practice and subsequently reflecting on their impact. This essay considered the implications of receiving a pluralistic training in several models of psychological approach. I reflected on how this can lead to integrating relevant aspects from different therapeutic approaches under a malleable theoretical framework to aid flexibility in formulating complex client presentations and efforts to individualise treatment.

D. Empirical Research Project, Doctoral Research and Thesis Preparation

The empirical research project demonstrated my ability as a Counselling Psychology researcher to design, conduct, analyse and discuss a research project in my chosen subject area. The empirical project explored adult men's experiences of having Irritable Bowel Syndrome (IBS). The study was conducted using a qualitative approach and aimed to access the salient similarities and differences in experiences and perceptions among a small sample of adult male IBS sufferers. The study findings were discussed against existing IBS literature. The theoretical and practical implications that emerged from the findings were explored with relevance for Counselling Psychologists working with this client group in the future.

SECTION A:

PROCESS REPORT,
APPLIED THERAPEUTIC PRACTICE

1.0 INTRODUCTION

1.1 Overview

This process report is an illustration of the work I conducted with a client named Maria (pseudonym). I have selected this particular case as it demonstrates my ability to conceptualise and work with Maria's specialist clinical presentation of vomit phobia (hemetophobia) linked with attachment issues from a multi-theoretical perspective, within a multi-disciplinary team. I worked with Maria in an NHS psychological therapies service for complex client presentations where I am expected to use a cognitive behaviour therapy (CBT) approach for treatment (twenty sessions). CBT is an approved treatment option for specific phobias such as hemetophobia (NICE, 2011). I have adopted a flexible CBT framework incorporating relevant psychological theories to best individualise conceptualisation and treatment of client needs fitting with a Counselling Psychology ethos.

1.2 Referral information

My line manager originally assessed Maria for our service and then referred her to me as deemed suitable for my level of training. The referral stipulated that Maria had a long history of anxiety related issues (past agoraphobia and panic attacks) which was likely connected with attachment issues. Maria was specifically being referred for treatment of her vomit phobia. The referral stated Maria had suffered from vomit phobia for almost thirty years. Maria had moderate measures of depression and anxiety.

1.3 Client information

Maria is in her mid-thirties, Mexican but has been living in the UK for eight years. She is married with four children (aged two to eight years). She has endured much marital discord over her eight years of marriage including past physical abuse. She is university educated and works as a translator. Maria has a 'bad tempered' sister (one year older) who she has always had a

'difficult' relationship with. Maria describes both her parents as kind and loving. However, her mother could also be emotionally and physically unavailable. Her mother died of a brain tumour in 2006. Her father and sister live in Mexico. There are no other reported mental illnesses in the family history. Four years previously Maria had CBT for agoraphobia which was successful. She is not currently taking any medication. She has previously taken Sertraline prescribed by her GP to help manage anxiety (for agoraphobia).

2.0 ASSESSMENT

The initial interview was based on the CBT assessment procedure outlined by Kirk (1989) and the specific CBT assessment for vomit phobia by Veale (2009).

2.1 Client's perspective of issues

Maria believes she has suffered from vomit phobia since she was six years old as a consequence of observing a female classmate vomit at school. Maria recalls that vomit phobia persisted into adulthood and got significantly worse as a result of the marital discord she has endured throughout marriage. She has received no formal diagnosis of vomit phobia. Maria wants to rid herself of vomit phobia which she believes makes her unhappy, compromises her personal freedom and prevents her from being a good mother.

2.2 Onset and development

Vomit phobia precipitated aged six after anxiously observing a girl vomiting at school. Further incidents of vomiting/ fearing vomiting occurred which were distressing (particularly the nausea and worry) leading the phobia to develop. Maria has vivid mental images (memories) of vomiting. Her father often held her head/ hand when she vomited. Physical contact provided an 'anchor', comfort so she did not 'feel alone'. She stated her parents often helped her manage her problems. She reported a more ambivalent relationship with her

mother. She initially described her as loving but later stated she could be emotionally and physically unavailable at times.

Her vomit phobia ameliorated during high school. Her father worked at the school, she had plenty of friends and she was excelling academically. She developed agoraphobia with panic attacks after leaving high school (eventually helped with CBT). She moved to the UK in 2004 to marry her husband (they met on the internet). She believes her 'dictatorial' husband has caused much marital discord leading to an exacerbation of her vomit phobia. Maria works from home (her 'safe place') and does not go out often. She has few friends. An assessment of her interconnecting vomit phobia factors (Veale, 2009) are listed in Table 1.

Table 1. Factors associated with vomit phobia.

Factors associated with vomit phobia	Evidence provided
Safety seeking behaviours	Seeks company when going outside, carries water in fear of choking.
Worry and self-reassurance	Worries about contracting illness, mentally plans how she will cope.
Experiential avoidance	Distraction via writing in diary, mobile telephone games, chatting to people.
Self-focused attention	Stomach, mouth, throat sensations after eating, nausea.
Hyper-vigilance	When alone, hearing of sick people, noticing vomit in the street, noticing bodily symptoms.
Avoidance of vomit cues	Avoids going out and seeing vomit, lifts or boats, sick people.

Maria was very motivated to discuss and work on her vomit phobia (our primary goal). Skills to manage vomit phobia we agreed could ultimately

increase personal freedom (e.g. go out more) and facilitate being a better mother (e.g. help children more when vomiting). Maria presented with good psychological mindedness and fairly good emotional awareness. Our therapeutic relationship is good. I asked Maria to consider providing consent for this process report. After time away to consider she willingly consented.

3.0 FORMULATION

In an effort to conceptualise Maria's problem with vomit phobia it was useful to adopt a multi-theoretical approach. Using a pluralistic approach I formulated that the deeper 'nub' of Maria's distress was one of being 'vulnerable and in need of help', which helps explain her historically shifting anxiety (shifting between agoraphobia and vomit phobia).

Maria's primary caregiver in childhood was her mother who was not consistently emotionally or physically available. In attachment theory, the emotional responsiveness of the attachment figure helps manage the infant's anxieties until they are able to do this autonomously (Lemma, 2003). These early experiences of perceived abandonment may have led Maria to develop an insecure attachment style in childhood, carried into adulthood (Bowlby, 1988). Hence, Maria can be clingy in her attempts to secure attachment and as a consequence of her lack of autonomy managing her emotions (Gravell, 2010).

When sick Maria felt 'less alone' when her father was present. Also, her vomit phobia exacerbates when she is home alone. She eradicates self-awareness of anxiety relating to existential isolation and vulnerability through merging with another (Yalom, 1980). For example, she moved country and converted religion to merge with her husband. Karpman's drama triangle (1968) helps clarify Maria's common systemic role of victim in relation to the roles of persecutor and rescuer. For example, her powerful feelings of vulnerability (when discussing her rejecting husband) are communicated to me in the transference relationship (Carr, 2006). I sense she is trying to elicit my assistance as rescuer from her husband the persecutor.

From a CBT perspective being ‘vulnerable and in need of help’ reflects her core beliefs ‘I’m weak’ and ‘I’m stupid’ emerging from early experiences and her assumption ‘I have no one to rely on’ (reflecting a lack of autonomy). Her beliefs help to generate negative automatic thoughts that function to confirm her negative beliefs.

The precipitation of vomit phobia from a CBT perspective suggests that past memories of vomiting can become fused with the present which fits well with Maria’s predisposition for developing phobia due to insecure attachment. Observing the vomiting girl void of parental help may have triggered Maria’s unconscious fears of abandonment (Lemma, 2003). Indeed, Bowlby (1973) suggests that phobias are the product of anxious attachment, conditioning and learnt avoidant behaviours.

Using a flexible CBT framework we can posit that as a result of perceived attachment, systemic or existential vulnerability Maria then maintains her phobia from a CBT perspective (Veale, 2009) via a complex interplay of factors by (a) engaging with triggering symptoms of nausea, thoughts, images which can be misinterpreted as forthcoming vomiting, (b) appraised as potentially awful, (c) leading to further anxiety and attendance to nausea and gastrointestinal symptoms trapping Maria in a vicious cycle of vomit phobia perpetuation (see Figure 1).

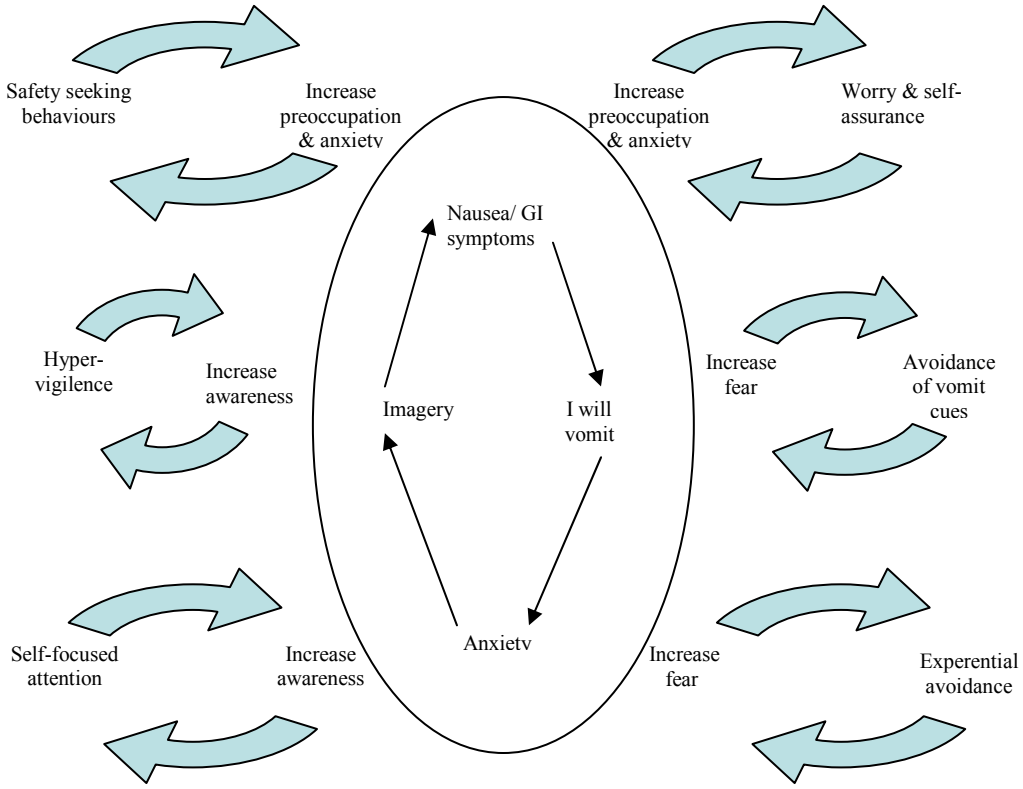

Figure 1. Maintenance of vomit phobia (Veale, 2009).

Maria verbally expressed her understanding of an earlier, more basic formulation incorporating insecure attachment theory within a CBT framework.

4.0 TRANSCRIPT AND COMMENTARY

The following transcript was taken from session four. In previous sessions we had focused on assessment, collaboratively establishing a preliminary formulation, goal setting and began socialisation to the CBT-based treatment plan. Maria was keen to challenge her phobia and engage in tasks. Our therapeutic relationship was developing well although I realised this partly related to her tendency to seek attachment for containment purposes. In this session I wanted to explore her cognitive appraisal/ worry aspects of early experiences relating to vomiting and developing Hemetophobia. I also continued socialisation to treatment theory and began exploring her worry beliefs and thought control. Earlier in the session we reviewed disconfirmatory

evidence (regarding fear of vomiting) gained from a homework behavioural experiment. The transcript begins (thirteen minutes five seconds) after we had explored an early memory observing a girl vomit at primary school.

(sound of a loud voices talking in the room next door)

Client1: But there were so many things. I, I also remember.

Therapist1: Hmm.

Client2: When I was probably… (counting in Spanish) twelve years old.

Therapist2: Hmm, hmm.

Client3: I was…erm…..I was always quite nervous in the classroom. Thinking..oh. It's like, I don't know why I got idea that have to go to the toilet.

Therapist3: Yeah.

Client4: Very often.

Therapist4: Right.

I am offering minimal encouragers for her to continue exploring her past anxiety-provoking experience.

Client5: So it was like a bother to have to tell the teacher every time. Can I go to the toilet? Can I go to the toilet?

Therapist5: Hmm.

Maria was freely describing her experience but perhaps an intervention to ask why this was a 'bother' for her could have clarified the connection with her 'nervous' feelings.

Client6: So. I got my mum to, to speak to the teacher.

Therapist6: Yeah.

Client7: So she say okay. Just relax, don't worry. Anytime you want to go to the toilet don't need to ask me.

Therapist7: Hmm. Hmm

Here Maria is recruiting her mother to 'rescue' her from a recurring anxiety-provoking situation. As if asking permission from her teacher to use the toilet is 'persecutory' for Maria who is in the role of the 'victim'. This is an example of a systemic drama triangle that often emerges for Maria as an interpersonal means for managing anxiety (Karpman, 1968).

Client8: Just go.

Therapist8: Okay.

Client9: So...and that. Yeah, I don't about? That was…because I saw somebody wetting themselves.

Therapist9: Yeah.

I am impressed she is able to arrive at these conclusions via her own processing. I continue to offer encouragement to say more without interrupting her progress.

Client10: So that is like. I don't know about that one. And now when I think about it.

Therapist10: Hmm.

Client11: It's…you know it's not just about the problem…. different things that I see and, and for any reason….

Therapist11: Yeah.

Client12: I think it is going to happen to me.

Therapist12: Yeah, it's kind of fear of catastrophe.

Client13: Yeah.

I try to summarise what has been a recurring theme from past sessions stating her cognitive appraisal of such anxiety-provoking situations is potential catastrophe.

Therapist13: It's a….(cut-off).

Client14: So that happened to one, one boy. And I do remember as well to try and avoid that…that boy. And then I just felt….not disgusted. But I don't know…something just…..made me try to avoid it.

Therapist14: Hmm.

Possibly I should have made an intervention to explore why she chose to 'avoid it' to increase her awareness of how her behaviour is linked to her anxiety.

Client15: And, and I do remember, I, I went with him even in secondary school (sound of water pipes outside window). And I always have that.

Therapist15: Hmm.

Client16: In my mind. It's like it never goes away.

Therapist16: Hmm. Hmm.

Client17: And I remember to be very anxious just when I go into the toilet. Just thinking it may happen to me.

Therapist17: Right.

Client18: Oh (cut-off).

Therapist18: What happens.. if it had happened to you? What would that mean?

Client19: I don't know?

Therapist19: Hmm?

Client20: Embarrassment.

My question was able to identify embarrassment as her feared outcome.

Therapist20: Hmm. What happens? What would happen if you were that girl who was sick in the classroom? How would you feel?

(pipe noise outside becomes louder)

Client21: I suppose the same. Embarrassed.

I was trying to elicit the emotion associated with embarrassment (in previous sessions she highlighted this was 'shame'). I should have drawn her attention to the notion that embarrassment was the cognitive appraisal, not the emotion. Possibly I should have mentioned that this embarrassment would likely confirm her negative core belief 'I'm stupid' which we had previously been identified linked with losing control.

Therapist21: Hmm. Would ah (breathing out sound) ….do you think that embarrassment would stay there for ever? …or would it become more?

The sound of the pipes is distracting and slightly frustrating. Consequently my question about the consequences of embarrassment lacks a smooth delivery.

Client22: No, probably not.

Therapist22: Hmm…. So it's thee ah…It sounds like it's the fear of that potentially happening…..Is..nearly worse than if it actually did happen to you?

Client23: I think so.

Therapist23: Hmm… (sound of voices next door increases) Yeah, I think you are right cause (I focus my attention on her vomit distress hierarchy constructed as homework.) Because this is the fear of it …potentially happening and this is the fear of it's actually happening. And it is actually worse…...in thee erm.. observational role.

I am trying to reinforce her homework finding that she measures the fear of vomiting as more distressing than past experiences of actually vomiting.

Client24: I know.

Therapist24: So to speak. So…well it makes sense that it seems to be the worry and the fear.. associated …with vomiting.

(voices talking next door become louder again)

Client25: Yeah.

Therapist25: That's actually worse than the reality. So…and that goes back to the whole erm ..thing we are trying to do. Is to..embrace the problem as one of

trying too hard to…do all the things to prevent being sick ..and worrying about that (vomiting). Rather than actually being sick itself.

I use this opportunity to reinforce previous socialisation efforts that vomit phobia is a problem of worry and trying to use techniques to prevent vomiting (Veale, 2009).

So…okay good. Good examples …….pause …….So….worry. Can you remember what you were worrying about for instance when you were on the way to (place name)? (I refer back to data recorded in her behavioural experiment sheet) in those first ..or sorry you felt quite anxious those first 10-15 minutes? What were you thinking about? Can you remember? What sort of thoughts?

I am interested to know more about her thinking at the beginning of the experiment when her worrying was most notable and to help reinforce the relationship between worry and anxiety.

Client26: I…(sighs)….Just I actually worry …that I will get worried. ..Just seeing this…you know this preoccupation ..that you know. Just thinking….what I'm going to do when I start feeling. You know, my heart has start racing and I have really sweaty hands. So whatever..

Maria's sighing indicates to me that discussing worry is anxiety-provoking for her. Perhaps I should I have checked this out with her. Previously she had stated that talking about vomiting generated anxiety for her. I am struck by her awareness of the concept 'worry about worry'.

Therapist26: Good.

Although Maria had not identified the thought content as yet I try to remain patient. My comment 'good' relates to her appraisal of worry as a 'preoccupation' and how she links this with her physical symptoms.

Client27: What I'm already thinking about what I'm going to do when that happens.

Therapist27: Right (cut-off).

Client28: So just the think or the thought of it. It just start building up anxiety.

Therapist28: Yeah.

Client29: It's like erm…erm…how you say it? You don't wish something but at the same time what you're doing..

Therapist29: Hmm.

Client30: Is, is leading… to that… which you are trying to avoid, avoid. I don't want to feel that way. That so anxious.

Therapist30: Hmm..

Client31: When I'm at (place name).

Therapist31: Hmm.

Client32: But at the same time. All the thinking and thinking and thinking and preoccupation. Is just..

Therapist32: Hmm?

Client33: Making me feel..

Therapist33: Yeah.

Client34: You know? Nervous….

Therapist34: Hmm, hmm.

Client35: And anxious.

Therapist35: You're right.

I am encouraging and confirming Maria's realisation that her incessant worry is fuelling her anxiety. Talking about worry increases her anxiety along with her pace of speaking. I get the impression that expressing her distress is a plea for me to help her (in her vulnerability). I am trying to contain her emotions without overly reacting to them (Gravell, 2010).

Client36: so…(cut-off).

Therapist36: Worry about worry.

Client37: Yeah exactly.

Therapist37: As for you…..have you heard that concept ..from before.

Client38: Yeah (laughing a little).

Maria seems amused that I noticed her use of 'counsellor language' in relation to conceptualising worry. I suspect her laughter might also have the function of relieving her anxiety.

Therapist38: It's erm…yeah, but is does happen. So..erm what sort of things were you worrying about? Can you remember any of the content of the thoughts?

Client39: Just erm…the, the distance between home which is my safe place.

Therapist39: Right (unintelligible word).

This intervention helps to identify her thought content. Also, I am aware that staying at home is an avoidant behaviour of hers which seems to be a residual problem from her previous agoraphobia.

Client40: And, and the…the shopping centre.

Therapist40: Right.

Client41: When oh, when I'm, when I'm there…I will really feel…I'm twenty, thirty minutes away.

Therapist41: Hmm.

(noise from the pipes outside)

Client42: From home.

Therapist42: Yeah?

Client43: …..which is. Do you know what, I, I, I'm on my way.

Therapist43: Hmm.

Client44: I don't know. Planning some ways or thinking go back cause. It's always..I'm, I'm not feeling the control. I'm just going to go back.

Therapist44: Right .

Again I am thinking how this urge to escape relates to agoraphobia. However, I don't want to shift the emphasis away from her dialogue relating avoidant behaviour to hemetophobia.

Client45: And I'm close. So…it's alright.

Therapist45: Yeah.

Client46: Maybe ten minutes. Still..

Therapist46: Hmm.

Client47: Not too bad. But..you know? As the time passes by.

Therapist47: Hmm, hmm.

Client48: It's not really how. It's not going to get ..that easy to just …go back home..

Therapist48: Hmm.

Client49: If I needed to.

Therapist49: So it's due (cut-off)

Client50: So that makes you, you know.. tense and just start worrying a lot…and then more and more.

Therapist50: Hmm. And that. Because that avoidance behaviour is so ingrained and goes so far back. That, that's why it's still so powerful. Because you have been reinforcing it all these years. And you use.. the avoidance role.. to kind of the return home to manage the anxiety but it is maintaining the problem. It's maintaining the anxiety. And ultimately the worry.

Client51: I know.

This intervention lacked articulacy but I am trying to summarise the extent of her habitual avoidance and the impact this has maintaining her anxiety/ worry currently and throughout her life. In retrospect, possibly her long-term dysfunctional attempts to manage her anxiety through avoidance has been

reinforcing a sense of vulnerability/ helplessness. Sharing this may have increased her awareness.

Therapist51: The worry about worry……So, that's why these experiments are…trying to go against that. So it's like….even though you predict that it's going to be uncomfortable you're forcing yourself…

Client52: Yes.

Therapist52: Into a…a difficult situation for you. But erm…okay. So……anything else about the shopping centre that you were thinking about…which was worrying…or a particular concern?

Client53: Always the choking….as always.

Therapist53: The choking yeah.

Client54: Just thinking that I may have something and it just…(the voices next door get louder) goes to the wrong place and I will just start coughing and then..the coughing will lead me to feeling sick probably and just maybe… if I'm not going to be sick at least ….thinking….that it, it may be a possibility.

Therapist54: Right.

The hypervigilence of danger symptoms (coughing) can lead to self-focused attention (trying to identify gastrointestinal symptoms/ nausea) and then worry about vomiting. I think both Maria and I have an agreed awareness of this mechanism but I believe I should have explicitly reflected on this thinking to emphasize the interlinking factors maintaining the problem.

Client55: That's..you know? Fall into just….

Therapist55: Hmm.

Client56: Feeling really, really, really anxious.

Therapist56: Yeah…yeah. Okay, so it's…It's a common one. I think you have hit on something quite important with the idea about a…..following……it's like a…..you know?.....Vomit, fear of vomiting. It, it emerges from.. you know…past experiences of what they call 'ghosts of the past' (Veale, 2009). So, which have become fused in the present….And such as these things here.

Client57: Yeah.

I realise that Maria bringing up coughing provides a good opportunity to offer some psycho-education about the development of vomit phobia. However, I am having difficulty extracting the relevant information from memory and then verbalising this in a coherent manner. This partly relates to some insecurity about delivering this new material to a client.

Therapist57: So….erm…. and because you have had experiences ..of say feeling sick, as a child. That erm..these are very, very dis, distressing things for a child to go through. When we're sick. And it's like they.. think they are going to choke when they are being sick. Or they think they could potentially die. Because they are going to be sick.

Client58: Yeah.

Therapist58: Erm. Okay, when we get into adulthood we may think…alright if I am sick I'm probably not going to choke to death. I'm probably going to start coughing, you'll struggle to breath. ….But it's not that rational in our mind because we have old associations that put doubt in our mind from memories. From like say….vomiting as a child. So that's what kind of makes the fear of vomiting..you know…so.. strong.

Client59: Ahem.

Therapist59: Does that make sense?

Client60: Yeah.

I initially believe I did a reasonable job socialising Maria to this theory. However, Maria's response is brief and like me she may be distracted by the noise from next door. Hence, I check whether this makes sense.

Therapist60: So it is...

Client61: And I think it's, it's not just. In my case it's not just linked..with that erm…. like those examples.

Therapist61: Yes.

Client62: Associating with… how I have felt before. Just thinking that I will be sick. Even if, if there is nothing…no, no evidence that tells me there should be.

Therapist62: Yeah.

I am encouraged that Maria is reaching a stage of awareness where she is beginning to identify that there is no firm evidence of impending vomit. I note this is a shift from earlier in treatment.

Client63: But like the other day. Yeah, my tummy probably was rumbling or whatever…but..you know, it's just …that discomfort made me feel like that but now.

Therapist63: Hmm.

Client64: That's another ghost I suppose.. from last week.

Therapist64: Yeah.

Client65: That I'm carrying…over.

Therapist65: Yeah, yeah. So it's like you're (cut-off).

I feel reassured that Maria understands my 'ghosts' analogy. However, in my enthusiasm I mis-time my next intervention and get cut-off. I wanted to emphasise the fear of vomiting is likely being reinforced by the assimilation of all this new threat related information.

Client66: No, I wasn't sick but I was feeling terrible. Just thinking I was going to be sick.

Therapist66: Hmm, hmm.

Client67: So it gets…you know it's just horrible that you just carry, carry, carry, carry and every time happens something new.

Therapist67: Hmm, hmm.

Client68: It stays with you.

Therapist68: It's fighting to stay there. That kind of fear of vomiting. That's why we need to keep working at it…..to kind of desensitise you to the fear. And that's what these experiments are trying to do. And are successful to (pointing at behavioural experiment sheet) come down from seventy (percent) to twenty (percent). It's desensitising you to the fear.

Maria's verbalisation conveys a sense of vulnerability at how trapped she is in her vicious cycle. My intervention aims to instil hope through pointing out the purpose of these behavioural experiments is to desensitize her to her fear. I highlight that she is already making progress finding disconfirmatory evidence about vomit-related fears and by pointing this out I hope is empowering for

her, helping to shift her away from a perspective of being 'vulnerable and in need of help'.

Client69: Yeah.

Therapist69: So…..cool! So……..pause……hmm……pause……..…what do you think? What do you think the advantages and disadvantages are of…of worrying? What would you say the disadvantages are?

I decide this is a good point to deviate from this topic for now. On shifting emphasis back to the agenda I experience a wave of tiredness and my mind temporarily goes blank. I suspect this is because working with vomit phobia is new to me and thus requires my close concentration with can be draining. Possibly if I had better attended to my counter-transference here I would have realised my sense of feeling slightly 'drained' could have indicated what Maria might have been feeling too. In retrospect, I realise that I (and most likely Maria) needed time to process the previous work. More reflection may have capitalised on/ reinforced learning. Eventually I compose myself to begin exploring worry beliefs (Wells, 1997), although this seems rushed.

(sound of the pipes outside)

Client70: That it can go erm .….to the extreme. And then just….(unintelligible) like basically.

Therapist70: To go to extreme (writing down). Yeah.

Client71: You know it's out of proportion. It's just…it's not good at all.

Therapist71: Hmm…….okay…what if it a…what happens if it's taking over your life then?

Client72: I don't know..it just prevents you from doing things.

I am trying to write and talk which is something I find difficult to do at the same time. Consequently, I am not fully engaging with Maria and my next intervention about the 'life impact' of worrying seems out of place. The purpose of this intervention was to help create a dissonance between where her life is now (engaging with vomit-related worry) and how this is preventing her from achieving her value-directed goals (Hayes et al, 1999; Veale, 2009).

Therapist72: Hmm.

Client73: It prevents you from doing things.

Therapist73: Yeah, yeah. So …it's..(I am writing down notes) doing things.....

5.0 ENDINGS

I believe that my goal of exploring her early experiences leading to developing vomit phobia was reasonable successful at emphasizing the central role of worry in establishing the problem. Guided discovery facilitated an increased awareness of her avoidant behaviour in early childhood developing and ultimately maintaining her anxiety. My goal to examine her worry beliefs (Wells, 1997) was also reasonably helpful in setting up future challenging of the dissonance between holding both positive and negative worry beliefs in the following session. Thought control experiments helped demonstrate that effort to suppress thinking is counterproductive. Our therapeutic relationship was developing and we were collaborating well at the end of the session to set up the next exposure experiment (homework) in a hierarchy of feared situations.

6.0 EVALUATION

I believe our therapeutic progress in this session was reasonably good. I missed some easy opportunities to reinforce Maria's awareness by highlighting links between thoughts and affect. However, I am aware

imperfections were likely as vomit phobia theory/ treatment was new to me and it was mentally taxing keeping all the relevant information in mind.

Whereas attachment and CBT aspects were in the preliminary formulation, existential and systemic elements were assimilated in the process of gradual re-formulation (Cooper & McLeod, 2011; Perkins, 2008). My growing awareness of interpersonal influencing factors emerged in later sessions ultimately contributing to the development of the multi-theoretical formulation. From a Counselling Psychology perspective this process helped gain a progressively clearer perception of Maria's central issue of being 'vulnerable and in need of help' to provide a more accurate guide for her treatment needs. In later sessions I would adapt worry interventions (Wells, 1997) to have an increasingly specific focus on vomit-related worries which generated further evidence about her lack of autonomy managing her emotions linked to interpersonal support. For example, Maria expressed an urge to hold my hand as her anxiety increased in an exercise to push vomit-related worry. In later sessions stronger efforts were made to promote empowerment/ increase her sense of autonomy, directly challenging her 'nub' issue. Eliciting feedback from Maria helped identify her success with exposure experiments, finding disconfirmatory evidence about fears (as measured by comparable reductions in predicted and actual experienced anxiety). Her growing awareness of her efficacy to desensitize herself to vomit-related fears was feeding empowerment.

7.0 REFLECTIONS ON LEARNING

As a consequence of writing this report I have realised that it took several weeks of progressive re-formulation to arrive at the current multi-theoretical conceptualisation of Maria's 'nub' issue. I believe that with further practice and supervision my confidence conceptualising client cases will become quicker and more assured.

This was a new placement for me where Maria was my first client. I was initially unsure how accepting the placement would be of a multi-theoretical

approach to formulation as I understood I would be delivering CBT-based interventions. Brief consults and 'covering supervision' with members of the CBT team emphasised I adopt a more rigid CBT formulation. This appeared dismissive of fully addressing the attachment/ systemic issues and seemed reductionist in adequately addressing the nub of Maria's problem. However, my supervisor (who I enjoy a strong relationship with) very much supported my efforts at multi-theoretical conceptualisation. Thus, I was receiving mixed messages within the multi-disciplinary team which was confusing and which I later found out related to interpersonal/ professional orientation tensions between staff due to recent merging of CBT and psychotherapy teams. I later discovered that pluralistic formulation is encouraged even if practicing a specialist (CBT) approach (Cooper & McLeod, 2011). I realise in future I will likely have to defend and reinforce my identity as a practitioner of Counselling Psychology to best realise my ideals for client treatment within the parameters accepted by specific settings.

8.0 REFERENCES

Bowlby, J. (1973). *Separation.* London: Penguin.

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

Carr, A. (2006). *Family therapy: Concepts, process and practice* (2nd Ed.). Chichester, West Sussex: John Wiley & Sons.

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

Gravell, L. (2010). The counselling psychologist as therapeutic container. *Counselling psychology review, 25*(2), 28-33.

Hayes, S. C., Strosahl, K. D. & Wilson, K. (1999). *Acceptance and commitment therapy*. New York: Guilford Press.

Karpman, S. (1968). Fairy tales and script drama analysis. *Transaction analysis bulletin, 26*(7), 39-44.

Kirk, J. (1989). Cognitive-behavioural assessment. In K. Hawton, P. M. Salkovskis, J. Kirk, D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: A practical guide* (pp. 13-51). New York: Oxford University Press.

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy.* Chichester, West Sussex: John Wiley & Sons.

National Institute for Health and Clinical Excellence (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* London: National Institute for Health and Clinical Excellence. Retrieved

May 20, 2012, from http://www.nice.org.uk/nicemedia/live/13314/52601/52601.pdf.

Perkins, J. B. (2008). *A case formulation approach to cognitive behaviour therapy.* New York: Guilford Press.

Veale, D. (2009). Cognitive behaviour therapy for a specific phobia of vomiting. *The cognitive behaviour therapist,* 2, 272-288.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide.* Chichester, West Sussex: John Wiley & Sons.

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

SECTION B:

THEORETICAL ESSAY,
COUNSELLING COUPLES AND GROUPS

A CONTRAST AND COMPARISON OF THE PROCESS AND CONTENT INTERVENTIONS FOR WORKING WITH COUPLES FROM A COGNITIVE BEHAVIOURAL THERAPY AND AN OBJECT RELATIONS PERSPECTIVE

1.0 OVERVIEW

In the course of this essay I will contrast and compare the theory and practice of counselling couples from the perspective of cognitive behavioural therapy (CBT) and object relations couple therapy (ORCT). I will highlight the salient theories and philosophies underlying each approach then outline the pertinent features that define the separate approaches and how they work in practice. Throughout this essay efforts will be made to reflect on relevant aspects of these approaches relevant to a Counselling Psychology ethos.

2.0 INFLUENCES ON THE DEVELOPMENT OF CBT FOR COUPLES

There are several important theories and philosophies that have contributed to the development of CBT for couples work. *Structural functionalism* conceptualises society as an overarching concept made up of constituent parts that are collectively orientated towards achieving a state of equilibrium (Parsons, 1951). Within a wider social system the couple is considered a sub-system, whereby the actions and behaviours of the couple work to stabilise the dyad. Stuart (1969) developed a model of behavioural marital treatment that emphasised increasing the regularity and variety of positive behaviours that a couple demonstrates to each other to boost relationship satisfaction. Stuart incorporated reinforcing principles from operant conditioning, whereby individuals were rewarded for their positive efforts towards their partners.

Cognitive therapy (Beck, Rush, Shaw & Emery, 1979) gradually blended with behavioural approaches which together helped to establish the prominence of CBT for treating couples. Family life cycle implications have contributed to our understanding that the couple will face stages of development (e.g. arrival of children) which the couple has to adequately negotiate otherwise relationship problems can emerge (Carter & McGoldrick, 1999). More recently, systemic theory has gained greater emphasis at addressing the impact of environment stresses that can act on the couple which require consideration alongside interpersonal stresses (Epstein & Baucom, 2002).

In CBT the individual aspects of the couple are of relevance as they will perceive relationship behaviours in different ways, relating to both specific events and wider behaviour (Epstein & Baucom, 2002). It is assumed that behaviour patterns will reoccur due to the maintaining influence of the couple. CBT is interested in how the couple presently processes information and communicates and how this relates to meeting individual and relationship needs (Epstein & Baucom, 2002).

2.1 Assessment

It is important to assess cognitive, behavioural and emotional factors that maintain the couple's relationship (Baucom, Epstein, LaTaillade & Kirby, 2008). These factors are interconnected and therefore changes relating to one domain will have the capacity impact and bring about change in another domain. Baucom, Epstein, LaTaillade and Kirby (2008) propose that assessment aims to define the difficulty the couple are experiencing in their relationship, and the dyadic, individual and environmental factors for formulation purposes. Patterns of interaction in the dyad and how these patterns have developed are of relevance. The assessor relies on observing couple interaction, clinical interview and self-report measures. Baucom, Epstein, LaTaillade and Kirby (2008) suggest first conducting a conjoint session ascertaining how the couple met, their developmental history, and any significant events of relevant to for the relationship and commence socialisation to CBT.

One individual session with each partner will follow exploring personal histories, family of origin, mental health issues and risks factors (Epstein & Baucom, 2002). Individual pathology will be explored which may negatively impact on the relationship and may need to be addressed first or this could compromise the effectiveness of couples work (Epstein & Baucom, 2002). Information gathered during these sessions remains confidential unless the individual discloses this information to their partner.

2.2 CBT in practice

The therapist listens to individual accounts of the couple in turn, reflecting and providing feedback on their shared dyadic concerns whilst maintaining a neutral stance (Epstein & Baucom, 2002). Principle behavioural, cognitive and emotional interventions will be discussed in turn.

2.2.1 Behavioural interventions

Baucom, Epstein, LaTaillade and Kirby (2008) suggest enhancing positive behaviours between partners and reducing negative ones will positively influence their thoughts and feelings of the couple in relation to each other and improve relationship satisfaction. These positive behaviours fall into expressive or instrumental categories. Expressive behaviours are emotionally-orientated towards showing affection/ love. Instrumental behaviours are practical in focus (e.g. preparing dinner) emphasising commitment. Different couples will appreciate different types of instrumental and expressive behaviours (Epstein & Baucom, 2002) which caters to Counselling Psychology engagement with subjectivity.

Negative behaviours are often criticisms between partners or accusations of blame (Baucom & Epstein, 1990). Negative behaviours directed towards a partner are considered to bring about negative responses, a pattern called negative reciprocity (Epstein & Baucom, 2002). Likewise, positive reciprocity results from mutual efforts to exchange positive behaviours. This relates to the concept of quid pro quo, whereby if one partner contributes something positive to the relationship their partner will likely respond in a similar positive vain (Dattilio, 2010). Homework assignments (common in CBT) can involve the gradual introduction of more positive behaviours between partners.

Dattilio (2010) presents strategic guidelines for identifying the needs of the listener and the speaker to address maladaptive patterns of communication. The speaker is encouraged to speak with a measured tone of voice, maintaining eye contact, watching for responsive indicators (e.g. body

language) from the listener. Questions are expected to be meaningful, not cross-examining, taking care not to over speak whilst also providing space for the listener to appraise what has been said. Likewise, the listener is expected to be attentive, maintaining eye contact without interrupting the speaker. The listener is expected to reflect on what they have heard (and clarify if need be) and then summarise to promote a shared sense of understanding with the speaker. This skills technique brings greater awareness to the reciprocal process of adaptive communication.

Sometimes it may be necessary to regulate recurrent over speaking of one partner to address power issues, which Counselling Psychologists aim to do empowerment rather than control. This can often happen with male clients who are socialised to be dominant as a consequence of gender role pressures (Payne, 2010).

2.2.2 Cognitive interventions

Baucom, Epstein, LaTaillade and Kirby (2008) emphasize that interventions for several types of cognition are necessary when the processing of information is occurring in a 'distorted manner' (p. 52).

Cognitive attributions designate specific meanings to a partner's behaviours (Epstein & Baucom, 2002). For example, Jack might cook Sarah a breakfast as a caring gesture (a hypothetical couple). However, Socratic questioning may reveal that Sarah attribute's Jack gesture to guilt for shouting at her yesterday. Evidence of *selective attention* can be relevant if one partner is focusing on specific negative aspects. The therapist can use guided discovery to consider the other positive aspects which may encapsulate a balanced view. CBT therapists will try to elicit the *expectations* the couple hold. This has relevance for the couple who are set in their ways and the therapist needs to comprehend their expectations about change (Dattilio, 2010).

The broader relationship beliefs that couples have are often *assumptions* and *standards* (Epstein & Baucom, 2002). Assumptions can often be accessed

using the downward arrow technique aimed at grasping the meaning behind cognitions (Dattilio, 1993). For example, Sarah holds the assumption that Jack's reluctance to have children indicates a lack of commitment to their relationship. A therapist would need to bracket any personal assumptions about societal approval for consummating relationships with children. Indeed, therapists should consider that their clients may often have different sexualities, religious and cultural values, diverse lifestyle choices and beliefs that relate very little to their own. Therapists should be careful not to let their personal biases, or stereotypical thinking emerge which could potentially create ruptures in treatment across orientations of therapeutic approach (Payne, 2010).

Sometimes partners will have very different standards about how they and their partners should conduct themselves in their relationship (Epstein & Baucom, 2002). For example, how much time a couple spends together/ apart may require negotiating a revision of shared standards. A Counselling Psychologist would be interested in identifying any cultural standards that might emerge (e.g. the wife is expected to stay at home and the husband goes to work). The therapist will need to address this diversity in standards, to bring awareness to the differing perspectives and hopefully agree a revised consensus on standards.

Ultimately, cognitive restructuring is a viable technique for modifying cognitions (or assumptions/ beliefs) by evaluating available evidence to promote balanced thinking (Beck, 1995). The Counselling Psychologist should endeavour to appreciate the subjective value of cognitions/ beliefs (and their potential diversity) for both partners.

2.2.3 Emotion interventions

Sometimes one or both partners show tendencies to restrict emotional expression which can lead to dissatisfaction in the relationship (Baucom, Epstein, LaTaillade & Kirby, 2008). Restricted emotional expression can stem 'the norm' of the family of origin or cultural norms. Sometimes cognitive

interventions are relevant (e.g. challenging assumptions about acceptable expression of anger). Sometimes behavioural factors are relevant (e.g. an individual considers a partner's high emotional expression as inappropriate).

Greenberg and Safran (1987) distinguish between expression of primary and secondary emotions. They propose that an individual has frightening primary emotions stemming from personal needs (e.g. Sarah's anxiety that Jack cannot commit to her). However, the individual settles for the expression of less frightening secondary emotions (e.g. Sarah's anger). Baucom, Epstein, LaTaillade and Kirby (2008) propose a series of interventions that can be used for emotional issues. The therapist can use questioning or interpretations to access an individuals primary emotions. The therapist can normalise the expression of emotions in a safe therapeutic environment where partners are encouraged to respond to their partner's expressions in a caring manner. Therapists can encourage labelling of different emotions to heighten awareness/ identify any deficits in understanding. Use of metaphors or imagery can also prove useful.

One or both partners can experience problems with over-expression of emotion (Baucom, Epstein, LaTaillade & Kirby, 2008). Sometimes the behaviour of one partner can trigger the emotional reaction (e.g. Sarah's criticism eliciting Jack's anger). Baucom, Epstein, LaTaillade and Kirby (2008) propose that couples can either be encouraged to schedule times to discuss emotionally loaded issues which functions to restrict the regularity of expression to more appropriate times and contexts. Or the couple can try using alternative sources for sharing emotions (e.g. using friends), taking the pressure off the couple.

3.0 INFLUENCES ON THE DEVELOPMENT OF OBJECT RELATIONS COUPLE THERAPY (ORCT)

In contrast to CBT, object relations couple therapy (ORCT) originates primarily from psychoanalytic object relations theory. Scharff and Scharff (2008) propose that ORCT addresses thoughts, feelings, behaviours, interactions at

the level of mind and body between partners and their environment. These are similar concerns to CBT, although here they are conceptualised and approached in a different way.

Object relations theory proposes that a human's behaviour is a consequence of early experiences relating to significant caregivers (Bobes & Rothman, 1998). Fairbairn (1952; 1963) considers infants to be born with full awareness, a 'whole self' and strive to obtain relatedness through behaviour. Scharff and Scharff (2008) summarise that the infant can become frustrated by the mother when needs are not immediately met which can be interpreted as rejection. This rejection creates pain for the infant who consequently introjects (takes in) the mother figure as a rejecting object. However, the infant wants to maintain the notion that the mother is good so it splits off the concept of the rejecting mother and represses this concept in their unconscious mind. What follows is the rejected object is then further split into *exciting* and *rejecting* parts (which are respectively associated with feelings of *longing* and *rage*). The infant then splits off and represses (along with negative feelings) the part of the self which identifies with the mother as rejecting.

Fairbairn (1952; 1963) considers that object relations exist internally for an individual comprised of the two unconscious systems (exciting and rejecting) connected with the object. Fairbairn suggests that the rejecting object relationship then represses the exciting object relationship. Dicks (1967) proposed that the individual is attracted to his partner in a conscious sense (e.g. sexually, compatibility, shared values) but also at an unconscious level which together highlights the couples compatibility.

The individual identifies 'lost parts of the self' through union with a partner which is exciting as these aspects can now be expressed through the partner (Scharff & Scharff, 2008, p. 169). Repressed aspects of the personality effectively re-emerge seeking understanding from the partner (Scharff & Scharff, 1991). In ORCT the work is primarily orientated on the unconscious dynamics between the couple, how this relates to their past relationships (Scharff & Scharff, 2008). Thus, internalised objects can create difficulties

when the individual confuses these aspects with current romantic partners (Bobes & Rothman, 1998).

3.1 Assessment

In ORCT the therapist assessment can involve twice as many conjoint and individual sessions to arrive at a formulation (Scharff & Scharff, 2008). The couple's relationship is the sole focus of the difficulty rather than the multi-factorial focus as in CBT. Scharff and Scharff (2008) propose assessment sets the frame for how therapy will work/ be managed. As in CBT the therapist maintains a neutral stance. A safe psychological space is established to explore the couple's relationship, so they can be listened to, express their feelings freely all so the therapist can provide interpretations (Scharff & Scharff, 2008). In ORCT the interest is in comprehending conscious and unconscious communication. The therapist tries to identify strong emotions (linked to the unconscious), noting core anxieties and defences (Scharff & Scharff, 2008).

3.2 ORCT in practice

Sessions are unstructured and non-directive (contrasting with directive, structured CBT). The therapist addresses the conscious concerns of the couple, observing body language, whilst listening out for themes in the dialogue, hoping to hone in on occasions when strong affect is expressed which helps identify objects in the unconscious (Scharff & Scharff, 2008).

Projective identification is the process by which an individual projects objects onto another person (Lemma, 2003). Introjective identification is the process by which an individual takes in projected objects and then identifies with them, consequently behaving as if these aspects were their own (Lemma, 2003; Bobes & Rothman, 1998). Both processes occur unconsciously within the transference relationship (Lemma, 2003). Transference (a Freudian concept) can be conceived as a present day enactment of a past object relationship, which has been internalised in the individual (Lemma, 2003).

Countertransference is another Freudian concept that the therapist uses which is ‘the therapist’s experience of the patient and the feelings aroused whilst with the patient’ (Lemma, 2003, p. 68). The transference relationship between the couple is considered to be maintaining their difficulty relating which contrasts with the CBT perspective that it is the collective influence of cognitive, behavioural, emotional and environmental factors of the dyad that maintains the difficulty.

By examining the transference relationship a therapist is able to deliver interpretations to the couple bringing awareness to how they relate. This approach contrasts greatly with the conscious focus of CBT with its predominantly present tense focus. Interventions for both approaches occur in the here and now. A common goal in ORCT is to liberate the couple from the impact of projective and introjective identifications (Scharff & Scharff, 2008).

For example, Jack as a child often felt criticised by his father when he failed to meet his father’s high standards and often belittled Jack’s musical aspirations. With his partner Sarah he increasingly found her to be domineering and condemns his musical hobbies. He perceived a lack of acceptance and criticism from Sarah, re-enacting a pattern of relating from childhood associated with similar emotional pain. Jack projects the internalised aspects of the critical father onto Sarah. Jack feels Sarah does not understand him. More recently Jack has opted to withdraw from Sarah when she becomes critical which is a less upsetting option for him compared with arguing.

Sarah on the other hand perceived her mother as rejecting and emotionally unavailable. Sarah introjected the rejecting mother object. Sarah then projects these aspects of the mother onto Jack who unconsciously accepts them. She gets increasingly anxious when he is not with her, is constantly texting him and is becoming increasingly resentful about competing with his musical interests. Thus, the relationship becomes dysfunctional as Jack takes on the role of the rejecting mother accentuated by his withdrawal behaviour. Jack and Sarah’s relationship is indicative of the simultaneous process of projective

and introjective identification that bonds them at an unconscious level but is also fuelling their discord (Scharff & Scharff, 2008).

The Counselling Psychologist will be encouraged to exercise reflexivity to accurately interpret to the transference relationship which considers the communication between partners and with the therapist. Also, the complex nature of the transference relationship (with three participants) highlights a Counselling Psychologist's need to appreciate and comprehend intersubjectivity. With intersubjectivity, the perceptions, emotions and interactive factors belonging to all participants are interconnected from a phenomenological perspective (Kasket, 2013). Indeed, the central focus of relationships in ORCT fits well with the Counselling Psychology dedication to base treatment in the therapeutic relationship, perhaps more comprehensively than in a CBT approach.

The therapist is also keen to identify from their interactions their recurring use of defences, protecting core anxieties (Scharff & Scharff, 2008). Projection, introjection and splitting are all primitive defences (Lemma, 2003). For example, a defence Jack uses is to withdraw from Sarah, protect against the pain of sustained criticism. The therapist needs to be actively involved at an unconscious level, interpreting their countertransference, often a 'feeling of discomfort' in response to a common pattern of relating originating from the couple (Scharff & Scharff, 2008, p .174). For example, I (as therapist) felt pressured to attend to Sarah's needs and acknowledge her. This attention grabbing behaviour could indicate defence of a core anxiety (e.g. fear of abandonment).

By sharing interpretations with the couple this brings understanding, provides a sense of being psychologically held and enhances their working alliance (Scharff & Scharff, 2008). Efforts are made to make the unconscious conscious which permits the couple to make choices based on their new found awareness (Bobes & Rothman, 1998). This marries well with a Counselling Psychology emphasis to develop 'insight and increased capacity for choice' (Strawbridge & Woolfe, 2003). Hopefully the couple develop the

ability to ‘modify each other’s projections, to distinguish them from aspects of the self, then take back their projections’ (Scharff & Scharff, 2008, p. 186). The couple are able to recognise each other in a clearer more accepting light, potentially leading to a more loving relationship (Scharff & Scharff, 2008). Reaching this stage of therapeutic enlightenment reflects the ability of partners to gain more *autonomy* over how they choose to relate to each other and which promotes *empowerment* (both valued goals in Counselling Psychology).

4.0 REFLECTIONS ON LEARNING

Comparing these two approaches has proved beneficial for developing a pluralistic understanding of couples counselling. This relates to a recent emphasis in Counselling Psychology to embrace pluralistic practice to best meet the needs of our clients (Cooper & McLeod, 2011). There is the possibility that even if I choose to work with couples explicitly using CBT there is the potential to still refer to the transference relationship implicitly to guide and enrich my understanding of the couple in treatment.

Fonaghy and Target (1996) state that through *reflective functioning* an individual is better able to comprehend the behaviour of another as stemming from their internal perspectives which ultimately benefits communication between them and shared empathy. Perhaps through enhancing reflective functioning principles in couples, either in CBT or ORCT couples are able to realise adaptive change. This could be the mechanism of change common to both approaches. Indeed, facilitating empathy between partners and also conveyed by a therapist is a core Counselling Psychology quality which adheres to underlying humanistic values (Strawbridge & Woolfe, 2003, p. 8) and can hold emphasis in the practice of both CBT and ORCT.

5.0 REFERENCES

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Baucom, D. H. & Epstein, N. (1990). *Cognitive behavioural marital therapy.* New York: Brunner/ Mazel.

Baucom, D. H., Epstein, N. B., Taillade, J. J. & Kirby, J. S. (2008). Cognitive behavioural couples therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 31-72) (4th ed.). New York: Guilford Press.

Bobes, T. & Rothman, B. (1998). *The crowded bed.* New York: W. W. Norton & Co.

Carter, B. & McGoldrick, M. (Eds.). (1999). *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed.). Boston: Allyn & Bacon.

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

Dattilio, F. M. (2009). *Cognitive behavioural therapy with couples and families: A comprehensive guide for clinicians.* New York: Guilford Press.

Dicks, H. V. (1967). *Marital tensions: Clinical studies towards a psychoanalytic theory of interaction.* London: Routledge & Kegan Paul.

Epstein, N. & Baucom D. (2002). *Enhanced cognitive behavioural therapy for couples: A contextual approach.* Washington DC: American Psychological Association.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality.* London: Routledge & Kegan Paul.

Fairbairn, W. R. D. (1963). Synopsis of an object relations theory of the personality. *International Journal of Psychoanalysis, 44*, 224-224.

Fonaghy, P. & Target, M. (1996). Playing with reality 1: theory of mind and a normal development of psychic reality*. International Journal of Psychoanalysis, 77*, 217-233.

Greenberg, L. S. & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the processes of change.* New York: Guilford Press.

Kasket, E. (2013). The counselling psychologist researcher. In G. Davey (Ed.), *Applied Psychology*, Student Companion Site. Chichester, West Sussex: BPS Blackwell. Retrieved January 5, 2013, from http://bcs.wiley.com/hebcs/Books?action=mininav&bcsId=6483&itemId=1444331213&assetId=297219&resourceId =29364&newwindow=true

Lemma, A. (2003*). Introduction to the practice of psychoanalytic psychotherapy.* Chichester, West Sussex, UK: John Wiley & Sons.

Parsons, T. (1951). *The social system.* London: Routledge.

Payne, M. (2010). *Couple counselling: A practical guide.* London: Sage Publications Ltd.

Scharff, J. S. & Scharff, D. E. (1991). *Object relations couple therapy.* New York: Jason Aronson Inc.

Scharff, J. S. & Scharff, D. E. (2008). Object relations couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 167-195) (4th ed.). New York: Guilford Press.

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

Stuart, R. B. (1969). Operant interpersonal treatment for marital discord. *Journal of Consulting and Clinical Psychology, 33*, 675-682.

SECTION C:

REFLECTIVE ESSAY,
COGNITIVE BEHAVIOURAL THERAPY - LEVEL 3

THE IMPACT OF LEARNING AND EXPERIENCE ON DEVELOPING A PERSONAL PHILOSOPHY OF PRACTICE AS A COUNSELLING PSYCHOLOGIST

1.0 INTRODUCTION

Throughout my professional training as a Counselling Psychologist my orientation towards theoretical thinking and practice has gone through continual challenge and development. My own personal philosophy of practice has been influenced by my pluralistic university training and efforts to gain a deeper understanding of the humanistic elements that underlie the Counselling Psychology ethos. My philosophy of practice has also been shaped by experience of applying models and specific skills in practice and reflecting on upon their impact. Additionally, my reading, clinical supervision and experiences of personal therapy have all contributed to my development. My theoretical orientation to Counselling Psychology rests upon a cognitive behaviour therapy (CBT) framework that I use to guide conceptualisation and structure treatment. I simultaneously endorse being reflective to facilitate the integration of new information for formulation purposes and flexibility in responding to often complex client needs.

In this essay I shall discuss how I have integrated humanistic elements into a flexible CBT approach and highlight the importance of gaining a pluralistic comprehension of the therapeutic relationship. I will elaborate on my need to develop increasingly individualised treatment protocols in practice as a consequence of regular confrontation with complex client presentations. I will discuss how I have dealt with new learning, the possibilities and ramifications of integration and how this has impacted upon addressing and finding solutions for treating complexity. Finally, I will highlight my thinking on possible future developments of practice and maintaining integrity as a Counselling Psychologist.

2.0 ADOPTING A FLEXIBLE CBT FRAMEWORK FOR THE PURPOSES OF INTEGRATION

I have adopted CBT as the core theoretical framework for conceptualising my client work as a Counselling Psychologist. It is the primary approach taught on training course and I have become comfortable using this model in my

practice with clients with general presentations and those with substance misuse related problems. The majority of my clients have complex, co-morbid presentations. CBT along with other specifically behavioural or cognitive therapies has proved to be an 'empirically supported treatment' for a wide range of psychological issues (Cooper, 2008, p. 32). CBT also has a proven high treatment success rate with substance misuse clients (Raistrick, Heather & Godfrey, 2006; NICE, 2011). Therefore, there is a great deal of efficacy for using CBT as the core theoretical framework in my practice as a Counselling Psychologist.

In developing my personal philosophy of practice I rely on the security of a CBT framework to guide treatment but I make enduring efforts to incorporate humanistic thinking to compliment my practice. Beck, Rush, Shaw & Emery (1979) point out that humanistic core conditions of empathy, congruence and unconditional positive regard (Rogers, 1957) are important although not fully sufficient on their own to bring about therapeutic change in clients. Indeed, Sander and Wills (2005) support this argument stating that integration of the core conditions is 'necessary' and that integration of techniques from other approaches into cognitive therapy is becoming 'the norm' (p. 228).

With my experience delivering CBT I have noticed on some occasions that working with client emotions has seemed like an emotional labelling process that ultimately is aimed towards accessing the related cognitions and beliefs. The danger of therapeutic models being applied in an overly mechanistic manner is that their 'holistic' impact is compromised (Connor, 2000, p. 294). Sander and Wills (2005) have warned us that the impact of cognitive therapy is very much compromised unless emotional experiences are adequately connected with. Thus, I have felt an increasing need to encourage clients to explore and stay with accessed emotions, to process them more comprehensively as a means of catharsis. This realisation comes particularly from working with my male clients, some of whom struggle for awareness of their emotions. This lack of affect awareness in men often associated with a preference for more rational processing has been identified as a condition called alexithymia (Levant & Pollack, 1998). Additionally, I have learned from

the more humanistic orientated trainees in my placement supervision group about techniques for increasing emotional awareness by exploring bodily sensations. Schneider and May (1995b) in their existential-humanistic approach use such a technique. First of all the client is asked to scan for bodily sensations, then asked what they associate with these sensations, which may be feelings, images or thoughts. This approach I believe helps raise emotional awareness early in treatment and brings the cognitive model (Beck, 1967) to life for clients prior to engaging in challenging cognitions. These are examples I use to ease the directive focus of CBT, when necessary, to achieve a sense of grounding in humanistic principles.

3.0 DEVELOPING A MORE PLURALISTIC UNDERSTANDING OF THE THERAPEUTIC RELATIONSHIP

Cognitive therapy in previous years has been criticised for either undervaluing or indeed ignoring use of the therapeutic relationship to bring about client change (Sanders & Wills, 2005). In my approach as a Counselling Psychologist I make strong efforts to nurture the therapeutic relationship by striving for development of a positive alliance early on through adherence to the core conditions (Greenberg, 2009; Rogers, 1957). Research has shown that paying sufficient attention to developing the therapeutic alliance and building trust in the early sessions can lead to better therapy treatment outcomes (Hovarth & Bedi, 2002). Cooper (2008) in his summary of research findings on the efficacy of using the therapeutic relationship advocates establishing a firm therapeutic alliance prior to implementing more challenging inventions in treatment.

Greenberg (2009) elaborates that it is the therapeutic relationship that supports a clients emotional processing through providing opportunity for exploring affect in a non-critical, safe environment. I try to utilise these principles by enduring to be fully present for the client and encourage shared emotional experience. To be fully present I believe it is necessary to use the ‘self’ as an ‘instrument’ (Yalom, 2001, p. 40). I agree with Yalom that an important development in the ability to empathize, develop intimacy with a

client and facilitate emotional processing comes from the experience of being in personal therapy. It is important to have had experience processing of my own issues and it brings perspective to the experience of being a client.

As a consequence of my Counselling Psychology training I have developed a conceptual and practical understanding of psychodynamic psychotherapy. Primarily, I utilise aspects of psychodynamic thinking implicitly to gain a deeper understanding of process issues by studying the transference relationship. Comprehending the transference relationship often brings understanding of powerful emotional reactions expressed by the client. I have had clients who endured critical male figures in childhood who subsequently developed negative core beliefs as a consequence of sustained criticism. Thus, I was keen to monitor my own CBT based interventions for perceived criticism which could trigger re-enactment of a pattern of relating by the client from the past, recreated in the present day with me as if I am the critical figure from the past (Hinshelwood, 1991). I believe reflecting on the transference relationship implicitly is essential to my practice even though it is CBT orientated. Otherwise heightened emotional reactions from a client at times may seem incomprehensible and coming out of nowhere. The necessity to remain reflective also applies to countertransference issues, as client responses can trigger my own personal issues and emotions which if not recognised and dealt by the therapist could potentially damage the therapeutic relationship and ultimately the client's progress. Indeed, successful attendance to countertransference has empirically been found to influence better treatment outcomes (Goldfried et al., 1997).

To summarise, my use of transference concepts is used implicitly to facilitate increased comprehension of the complexity of the therapeutic relationship which relates to the client's presenting issues. I use transference concepts implicitly so as not to apply psychodynamic theory on top of CBT theory which would create a clash of theoretical frameworks. The humanistic and existential-humanistic concepts and techniques I have integrated within my CBT approach I have done so explicitly. I have integrated these elements from different approaches through the process of assimilation (Hollanders,

2003). Thus, the integrated skills and concepts are introduced to fit with my established framework whilst maintaining the credibility of my CBT approach.

4.0 THE INFLUENCE OF LEARNING ON CLIENT CONCEPTUALISATION AND CLINICAL PRACTICE WHEN ADDRESSING COMPLEXITY

My pluralist Counselling Psychology training has introduced me to psychodynamic psychotherapy, CBT and the various third wave CBT approaches. The advantages of pluralistic training are that I have learned to appreciate the value and 'truth' in more than one therapeutic approach (Hollanders, 2003, p. 280). This helps to conceptualize complex client presentations from alternative perspectives to enhance understanding. However, the assimilation of all this knowledge has created a tension of sorts, whereby I have to evaluate not only the options for what is my preferred modality of practice but what ethically and professionally speaking is best for specific clients. Again, this requires me to be reflective both as psychological assessor and practitioner to resolve this dilemma and make the best choice to facilitate the client's needs.

One means of resolving this tension comes through integration of new information within the existing framework. The function of integration has been to embellish and improve upon the range of skills, interventions offered by traditional CBT in efforts to increase the effectiveness of treatment through offering greater individualization. By establishing a more sophisticated and diverse tool kit of skills I can then creatively reflect upon which intervention best suits a client by addressing the complexity of presentation within the confines of a flexible CBT framework.

Previously I have discussed how I have integrated skills and techniques in to my framework from approaches not directly affiliated with CBT. However, CBT is now absorbing techniques from third wave CBT approaches. This is of no surprise as CBT is not a pure approach itself, originally emerging from a combination of separate (yet compatible) cognitive and behaviour therapies. A recent CBT treatment protocol for problem drinking includes recyclical thinking

techniques (focusing on rumination, worry) for managing negative emotion (Spada, 2010). These skills have undoubted emerged from metacognitive theory (Wells, 2009) which have been adapted and incorporated within a CBT framework and treatment plan. Indeed, I have utilised Spada's techniques in client work when I have deemed it appropriate and found them to be very useful. However, I incorporated these skills after I had been trained in metacognition theory so I had a firm conceptual understanding prior to integration. On another occasion, I believe I have inadvertently identified a client's 'social isolation trap' which is a component of the psychotherapy file for cognitive analytic therapy (Ryle, 1995, p.48). By graphically identifying the chain of self-perpetuating behaviours that consequentially confirmed my client's isolation belief this provided a valuable realisation for both the client and myself. Therefore, I can appreciate the value of potentially integrating this technique in a more deliberate sense in the future after taking it to supervision.

I believe that the gradual integration of new elements and skills is necessary for CBT to survive in the world of perpetual therapeutic advancement. I do not believe that it is useful to deliver traditional CBT in a rigid fashion and enjoy treatment success for a client population with differing and often complex presenting issues. Sander & Wills (2005) remind us that protocols for using cognitive models are often devised for the treatment of single psychological issues presented in isolation. However, it has been my experience that presenting difficulties are often part of a co-morbid assembly. With such complex client presentations arising in my placements I am forced to conceptualise increasingly individualised treatment plans, which is encouraged under the Counselling Psychology ethos and ultimately impacts upon my emerging identity as a practitioner. This is embellished with the integration of useful new techniques that I can reflect upon and creatively select the most appropriate interventions to advance treatment on an individual basis. Thus, individualisation is possible by utilising both 'flexibility' and 'coherence of approach' (Horton, 2000, p. 325).

However, I am careful not to integrate in an eclectic manner, adopting skills and ideas from approaches and incorporating them with abandon. I am not an eclectic practitioner. Sanders and Wills (2005) remind us that it is dangerous to believe that using techniques eclectically from specific approaches have the same impact and efficacy as if they were from used within their parental theoretical approach. I believe my pluralistic training and being able to appreciate multiple theoretical perspectives helps to keep this at the forefront of my mind. I realise there is no firm evidence base for my own integrated approach to CBT to validate its use. However, I advocate Cooper (2008) stating that a lack of evidence does not necessarily mean an approach is 'ineffective', only that it has yet to be adequately researched (p. 46). Therefore, at every opportunity I aim to respect the CBT framework and I will not integrate new techniques or concepts that I believe compromise the grounding framework which again requires reflection. Therefore, I consider it essential to discuss the possibilities of integration in supervision prior to being introduced in practice.

I have found that on some occasions clients either do not progress, or prove unsuited to CBT despite enduring efforts to individualise treatment to meet their specific requirements. This is partly influenced by placement pressure to adopt CBT as the default approach. Ultimately, I have to consider the limitations of CBT and the possibilities of alternative treatment options and/ or referring the client on. I have had experience of a complex client with substance misuse issues not fully believing the reasoning behind challenging thoughts and beliefs. He had relapsed sharply into depression during CBT treatment. By reflecting on the client's progress and the difficulties occurring I was able to identify alternative treatment options. Eventually, the treatment that brought about sustained improvement in his depressive symptoms was mindfulness-based cognitive therapy (MBCT) (Crane, 2009). Having had more than three bouts of depression and with his marked tendency for experiential avoidance he very much met the treatment criteria for MBCT (NICE, 2009). He also held a firm interest in Buddhism which relates strongly to mindfulness. Therefore, through reflection MBCT proved to be the best fit for this client's treatment. Although, the different theories behind CBT and MBCT meant that I

had to stop and change the modality of approach rather try to integrate approaches.

Previously, using CBT I treated a client with a complex presentation involving alcohol misuse linked to depression and anger following multiple family bereavements. His depression and anger symptoms only marginally improved over 18 sessions and suffered three lapses back into alcohol misuse in this time. He showed evidence of much rigidity in his thinking and a general resistance towards change. On reflection, I believe this client may have benefited more from referral for acceptance and commitment therapy (Hayes, Strosahl & Wilson, 1999), known as ACT. The central focus of ACT is to encourage development of psychological flexibility which seemed very lacking with this client as he seemed much wrapped up in his own mind. He had a tendency towards rumination which along with alcohol misuse are both forms of experiential avoidance which can be targeted with ACT through acceptance interventions.

Mindfulness interventions could aim to encourage him fully experience the pain of his emotions, not struggle with trying to avoid them. Cognitive defusion techniques for his persistent thoughts relating to perceived selfishness and wrongful expression of anger would try to shift his perception of such private events and change the function of such cognitions rather challenge the content as is the case in CBT. Also, he had very strong family values making him suited to ACT with its committed focus on pursuing value linked goals. Emphasizing the permanence of his values may have better helped him come to terms with his frequent alcohol lapses. Indeed recent research has found that ACT helps reduce perceived stigma for those suffering substance misuse issues (Luoma, Kohlenberg, Hayes, Bunting & Rye, 2008). In my experience those occasions when it is necessary to consider changing the treatment modality are rare, which gives credence to the general applicability and efficacy of CBT.

5.0 POSSIBILITIES FOR FUTURE DEVELOPMENT AND MAINTAINING INTEGRITY AS A COUNSELLING PSYCHOLOGIST

My integration of techniques and concepts from third wave CBT and other approaches has happened slowly over time, and in parallel with my reading, professional training and practice. This is fitting with the suggestion that integration of elements from other approaches is 'gradually and progressively assimilated' (Horton, 2000, p. 324). Attachment theory (Bowlby, 1988) has been integrated implicitly to help enrich my CBT conceptualisation of early development experiences and ramifications for later life. I am currently considering integrating interventions for value directed goals from ACT (Hayes, Strosahl & Wilson, 1999), which I believe is related in some ways to establishing existential meaningfulness in life (Yalom, 1980). This could be interpreted as an example of overlapping concepts between models (Horton, 2000) which pluralistic thinking helps to recognise. Indeed, the integration of existential elements is becoming more apparent now with third wave CBT approaches (Van Deurzen & Adams, 2011). However, I am considering further training in ACT which would provide the opportunity for me to develop (with adequate supervision) as a specialist ACT practitioner. This is partly due to my personal and professional appreciation of mindfulness techniques which I consider ACT to incorporate in a powerful and sophisticated way.

I agree that with experience as a practitioner I will strive to develop a more personalised means of practice over time (Horton, 2000). With regular reflection on my practice I feel there is scope for further integration of techniques within my CBT approach as news skills and findings emerge on the horizon. In this respect it helps to maintain 'a spirit of open enquiry' (Connor, 2000, p. 293). Skovholt and Ronnestad (1995) claim that with accumulated experience as a practitioner a therapist will more and more utilise practical learning to navigate the course of treatment, with less strict adherence to theoretical constructs. I agree with this devised progression in the general sense although I am currently unwilling to compromise the security of the CBT framework as this may in turn compromise my integrity as a Counselling Psychologist. In therapy it has been said 'integrity implies

wholeness, honesty, transparency and congruence' (Connor, 2000, p. 303). Integrity may influence making sound clinical choices, such as integrating new skills that fit with my orientating framework, individualizing treatment, or accurate assessment of specific treatment needs such as referring to a specialist.

I feel I have a professional duty to keep up to date with emerging empirical evidence for the general and specific disorders I treat and with the approach that I use. I consider that many of the third wave CBT approaches are relatively new and a good deal more empirical evidence is needed to support their efficacy as treatment options. In that respect they fall behind CBT as an empirically validated approach. However, Cooper (2008) points out that empirical evidence for CBT often excludes research participants that have co-morbid issues which compromises generalisability. Therefore, as most of my clients have complex co-morbid presentations it seems unwise for me to fully validate the existing evidence base for CBT but instead remain curious about relevant emerging evidence that might set my mind at ease.

Therefore, in tune with the Counselling Psychology ethos I aim to develop my scientific understanding of practice in tandem with greater fluency and sophistication of delivering therapy from an artistic perspective. I believe there will always be a tension that exists between these scientific and artistic components which will be mediated and resolved by my efforts to remain a reflective practitioner. I believe my philosophy of practice will develop over the years with the aim of gaining a progressively clearer understanding of what my personal identity is as a Counselling Psychologist.

6.0 REFERENCES

Beck, A. T. (1967). *Depression: clinical, experimental and theoretical aspects.* New York: Harper and Row.

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

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

Connor, M. (2000). Integration and eclecticism in counselling training. In S. Palmer & R. Woolfe (Eds.), *Integrative and eclectic counselling and psychotherapy* (pp. 291-304). London: Sage.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly.* London: Sage.

Crane, R. (2009). *Mindfulness-based cognitive therapy*. East Sussex: Routledge.

Goldfried, M. R., Castonguay, L. G., Hayes, A. M., Drozd, J. F. & Shapiro, D. A. (1997). A comparative analysis of the therapeutic focus in cognitive-behavioural and psychodynamic-interpersonal sessions. *Journal of consulting and clinical psychology, 65* (5), 740-748.

Greenberg, L. S. (2009). Emotion in the therapeutic relationship in emotion-focused therapy. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioural psychotherapies* (pp. 43-62). East Sussex: Routledge.

Hayes, S. C., Strosahl, K. D. & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change.* New York: Guilford Press.

Hinshelwood, R. D. (1991). Psychodynamic formulation in assessment for psychotherapy. *British journal of psychotherapy, 8*, 166-174.

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

Horton, I. (2000). Principles and practice of a personal integration. In S. Palmer & R. Woolfe (Eds.), *Integrative and eclectic counselling and psychotherapy* (pp. 315-328). London: Sage.

Hovarth, A. O. & Bedi, R. P. (2002). The alliance. In J. C. Norcross (ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford University Press.

Levant, R. F. & Pollack, W. S. (1998). Desperately seeking language: Understanding, assessing, and treating normative male alexithymia. In R. F. Levant & W. S. Pollack (Eds.), *New psychotherapy for men* (pp. 35-56). Hoboken, NJ: John Wiley & Sons Ltd.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K. & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development and pilot outcomes, *Addiction research and theory, 16* (2), 149-165.

NICE (2009). *Depression: The treatment and management of depression in adults.* London: NICE.

NICE (2011). *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.* London: NICE.

Raistrick, D., Heather, H. & Godfrey, C. (2006). *Review of the effectiveness of treatment for alcohol problems.* London: National treatment agency for substance misuse, Department of Heath.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21* (2), 95-103.

Ryle, A. (1995). *Cognitive analytic therapy: Developments in theory and practice.* Chichester: John Wiley & Sons Ltd

Sanders, D. & Wills (2005). *Cognitive therapy: An introduction* (2nd ed.), London: Sage.

Schneider, K. J. & May, R. (1995b). Guidelines for an existential integrative approach. In K. J. Schneider & R. May (Eds.), *The psychology of existence: An integrative clinical perspective*. New York: McGraw-Hill.

Spada, M. (2010). *Cognitive behavioural therapy for problem drinking.* East Sussex: Routledge.

Skovholt, T. M. & Ronnestad, M. H. (1995). *The evolving professional self: Stages and themes in therapist and counselor development.* West Sussex: John Wiley & Sons.

Van Duerzen, E. & Adams, M. (2011). *Skills in existential counselling and psychotherapy.* London: Sage.

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

Yalom, I. D. (2001). *The gift of therapy: Reflections on being a therapist.* London: Piatkus Books.

Wells, A (2009). *Metacognitive therapy for anxiety and depression.* New York: The Guilford Press.

SECTION D:

EMPIRICAL RESEARCH PROJECT, DOCTORAL RESEARCH AND THESIS PREPARATION

AN EXPLORATION OF ADULT MALE EXPERIENCES OF HAVING IRRITABLE BOWEL SYNDROME (IBS): A QUALITATIVE STUDY

1.0 ABSTRACT

Irritable Bowel Syndrome (IBS) is a common functional bowel disorder thought to effect between 10-20% of the UK population. IBS places much demand on the NHS to fund and treat. It is twice as common for IBS to be found in women compared to men. IBS gender findings are limited. Little is known about how IBS is experienced by men. A qualitative approach examined in-depth subjective accounts of six men who had IBS via semi-structured interviews. Interviews were analysed using Interpretative Phenomenological Analysis (IPA). Findings were interpreted against existing IBS research and literature and using a biopsychosocial framework.

Participants experienced IBS as psychologically debilitating which often restricted activities, threatened relational identities and was isolating. Enduring experience of IBS seemed to compromise sense of self, constructs of masculinity and could foster despondency and helplessness with IBS. IBS symptoms frequently seemed unpredictable and illogical to cope with. Participants often conveyed ambivalence about seeking help for IBS. Many participants struggled to get their needs recognised and met in treatment with health professionals. Men had difficulties comprehending the ambiguities of IBS and need to accept and adapt to IBS. Disclosing IBS to others presented risk for incurring poor understanding, stigma and shame.

Counselling psychologists could adapt therapeutic styles to build containing, collaborative relationships that better engage men in treatment. Therapeutic interventions could be adapted to better empower men and more adequately respond to their needs with IBS. Subjective differences in IBS presentation and experience implied need to individualise therapeutic treatments. Counselling Psychologists could help men accept the given aspects of IBS and nurture awareness of management responsibilities and abilities to influence IBS. Therapeutic efforts could challenge any stigma or shame about having IBS. Counselling Psychologists could facilitate efforts to maintain a valued sense of self and promote psychological well-being rather than specifically seeking a cure.

2.0 PERSONAL REFLEXIVE STATEMENT

Counselling psychology is interested in the phenomenological study of subjective human experiences and understandings. My research project adopts Interpretative Phenomenological Analysis (IPA) which is a type of phenomenological enquiry. I will be openly examining the subjective qualities of lived experiences, perceptions and meaning-making of males with IBS.

An important assumption with IPA is that the researcher can never relate directly to a research participant's experiences and subjective meanings (Willig, 2008). The researcher will always be interpreting the participant's experiences from the researcher's own perspective. Therefore, as a researcher my own personal influence when deciphering participants' experiences needs to be reflexively embraced. I need to remain open-minded and reflexive as I am actively involved in designing, analysing and discussing findings in the course of conducting research. As a researcher I will have my own assumptions and biases which may differ from that of my research participants. Therefore, it is important that I bracket my presuppositions throughout this study, particularly as the participant sample share similar demographics to me. There is risk of being lulled into the comfortable notion that I share experiences with the participant sample. I might have certain investments in what they say because the findings could have potential implications for me.

I have had IBS for ten years. My experience with IBS has brought to light several assumptions and biases I have formed about the condition which are worth noting. My experience is that IBS is frustrating and can lead to feelings of discomfort and fatigue. I perceive that IBS is preventing me living a full and normal life. I believe IBS has in the past restricted engagement with social activities. Sometimes symptoms seem uncontrollable and my ability to self-regulate and manage symptoms seems compromised. When my IBS symptoms are bad this can result in feelings of unhappiness. I believe IBS might result from a dysfunctional brain-gut connection which influences how I perceive IBS symptoms. IBS might be influenced by how I think and I have a

tendency to worry about my symptoms currently and concerning the future. I believe it is possible to get rid of IBS but I have not achieved this yet. Also, I do believe that a sufferer can manage their symptoms to achieve degrees of symptom relief.

My experience is that most health professionals struggled to fully appreciate the debilitating impact IBS has had on me (both physically and psychologically). I never received much empathy from my GP/ gastroenterologist before or after receiving my IBS diagnosis and I believe they lacked confidence outlining a treatment plan. My experience is that most friends and family do not seem to understand IBS and have struggled to find ways to offer support. I have felt at times that I have to endure my condition alone.

My mother has been a long-term IBS sufferer and I suspect I may have been genetically predisposed to develop the condition. I believe I developed IBS over a period of years during a time of difficulties at work and related interpersonal problems. I have sought out different methods of therapeutic help for IBS. Psychoanalytic, existential and integrative counselling have failed to provide significant relief. However, I found hypnotherapy to provide short-term relief.

I need to reflect on my reality with IBS and the ramifications this has for carrying out this study. In conducting a review of the literature I will need to bracket my personal assumptions and biases for the purposes of maintaining a neutral attitude towards the literature but also remain reflexive in recording my perceptions and responses to the literature. Taking a critically reflective stance I will be interested in research that has close relevance to my own study for the purposes of contextualisation. I aim to identify important aspects existing research has failed to address and promote a rationale for my study's exploratory emphasis for what we do not yet know.

I must be careful to ensure that my interview schedule consists of open questions, non-leading and free from bias. During interviews I must be aware

of potential counter-transference and that participant answers about their experiences may relate to my own experiences and may trigger particular reactions from me. I need to be able to hear their accounts of experience without my expectations framing what I expect or want to hear. My assumptions and biases could potentially direct the focus or prompting of questioning or my body language could communicate reactions to the client.

I will read my personal reflexive statement prior to each interview to remind me of my presuppositions which will hopefully protect against personal bias influencing the interview process. I will also record my thoughts and feelings after each interview in a journal which endorses reflexive engagement with the research process (Lee, 2009). Further presuppositions could emerge once the interview process has commenced which will require bracketing in subsequent interviews.

Analysis involves a double hermeneutic in how I consider how participants are thinking about their experiences. It is important within IPA to acknowledge researcher subjectivity and personal presuppositions because reflexive engagement with the data forms an inevitable part of the findings. Hence, more so than other sections of this research study the analysis will be a combined product of participant and analyst influences (Smith, Flowers & Larkin, 2009). A reflexive stance will follow in the discussion of the findings. To encourage reflexivity I will endeavour to record my perceptions and ideas about the research in a journal throughout the course of the study.

3.0 INTRODUCTION

3.1 Overview

Irritable Bowel Syndrome (IBS) is a chronic functional gastrointestinal disorder characterised by abdominal pain and altered bowel habit (Blanchard, 2001; Camilleri & Choi, 1997). IBS is the most common form of functional gastrointestinal disorder (Chang, 2004). IBS can be a relapsing and enduring condition (Spiller et al., 2007). IBS is thought to affect between 10-22% of the UK general population (Hellier, Sanderson, Morris, Elias & De Caestecker, 2006). However, approximately 50% of individuals in the UK who experience IBS symptoms do not seek medical attention and may remain undiagnosed (Spiller et al., 2007). IBS has been found to be socially restrictive and to compromise sex life, sleep, diet, and quality of life; it can result in sick days from work (Luscombe, 2000).

Physical symptoms of IBS range from abdominal bloating and pain to abnormalities in gut motility (Toner, Segal, Emmott & Myran, 2000). In contrast, individuals without IBS will experience normal, measured contractions of the gut so that food moves through the gut in a regular fashion free of discomfort. For individuals with IBS who have diarrhoea-predominant symptoms there is most likely enhanced motility (hypermotility) or too many gut contractions, moving food through the gut more urgently than normal (Lackner, 2005). The opposite may be true for those with constipation-predominant symptoms who experience too few contractions of the gut (hypomotility) and gut movements are slower than normal.

The majority of individuals with IBS that do seek professional help will be treated in primary care settings (National Institute for Health and Care Excellence [NICE], 2008). NICE is an independent body providing evidence-based guidelines for health professionals and others to ensure quality of patient healthcare and social care services. National Health Service (NHS) primary care treatment for IBS is believed to cost in excess of £200 million annually (Akehurst et al., 2002). The non-patient prevalence of IBS is twice as

high in women compared with men, with the gender ratio widening in healthcare settings (Blanchard, Keefer, Galovski, Taylor & Turner, 2001; Toner, Segal, Emmott & Myran, 2000). There is little research about how IBS specifically affects men.

IBS is a poorly understood condition with no known cause or definite cure (Blanchard, 2005). However, genetic predisposition, childhood learning, critical events and individual beliefs are all considered to influence development of IBS (Crane & Martin, 2003). IBS may occur following physical illness or injury (Neal, Hebden & Spiller, 1997; Spence & Moss-Morris, 2007) and has been associated with past physical and/ or sexual abuse (Drossman, 1995; Talley, Fett, Zinsmeister & Melton, 1994). Dancey, Taghavi and Fox (1998) found evidence that stress can result in worsening GI symptoms for individuals with IBS during the following week. Later Blanchard et al. (2008) suggested stress does not explicitly cause change in GI symptoms but rather the relationship is more reciprocal.

Of the population of IBS patients in NHS primary care, 15-20% have a co-existing psychological diagnosis (NICE, 2008). Anxiety is commonly co-morbid with IBS (Blanchard, 2001; Lydiard, 1992). It has been debated whether IBS is causal, consequential or co-occurs with psychological problems (Toner, Segal, Emmott & Myran, 2000). Sykes, Blanchard, Lackner, Keefer and Krasner (2003) found evidence that anxiety issues occurred in individuals prior to developing IBS and suggested enduring IBS can increase vulnerability to suffering depression. However, Muscatello et al. (2010) found evidence that emotional symptoms (in depression, anger, anxiety) are integral to IBS but not causal. IBS patients may also be referred to NHS secondary care (usually gastroenterology units) when ‘red flag’ symptoms (e.g., rectal bleeding, anaemia) arise that potentially belong to other conditions and require investigation.

People with IBS can also access help and information through charities such as ‘CORE’ and the ‘IBS Network’. Online information and advice is available through the website ‘IBS-relief.co.uk’. Internet forums for posing questions/

accessing support from other people with IBS are available at ‘medhelp.org’ and through the ‘IBS Facebook group’.

Existing research has shown hypnotherapy, psychodynamic psychotherapy, cognitive and behavioural therapies all have some success treating IBS (Blanchard, 2005; NICE, 2008). However, while there have been developments in the pathophysiological understanding of IBS more progress is needed to realise convincing treatment solutions (Horwitz & Fisher, 2001). Our understanding of IBS is still in infancy and there is more to learn about this complex condition.

The majority of psychological research into IBS stems from health and clinical psychology disciplines. There is currently little practical involvement of Counselling Psychologists working with individuals who have IBS. However, Counselling Psychologists do have experience of working with clients with chronic conditions such as Human Immunodeficiency Virus [HIV] (Bor, 1993; Harris & Larsen, 2008), Chronic Fatigue Syndrome (Dayes, 2011; Stalmeisters, 2012) and Chronic Pain (Hession, 2010). Similar to treating these chronic conditions, Counselling Psychologists could help individuals with IBS to better accept life with IBS and not solely focus on achieving a cure (Hessian, 2010; Papadopolous & Bor, 1995). Counselling Psychologists could help IBS clients to discover the meaning their condition holds for them, improve management of IBS and collaboratively work towards empowering individuals with IBS and enhancing their sense of well-being (Cooper, 2009; Hession, 2010).

Counselling Psychologists can work independently, or as part of multi-disciplinary teams as is often the case in NHS primary care (Corney, 2003; Hessian, 2010; Papadopoulos & Bor, 1995). Counselling Psychologists could work this way with IBS clients in primary care and perhaps also in consultation with other health professional disciplines to enhance communication and client care in secondary care settings. Counselling Psychologists could also work in consultation with IBS charities and online organisations (previously mentioned) and perhaps enhance awareness about treating IBS through

liaison with providers of general psychological therapy services (e.g. Mind) where IBS clients could be referred/ or self-refer.

The literature review will initially focus on defining IBS and the importance of the biopsychosocial model as a framework for comprehending the condition. This will be followed with a discussion of relevant IBS research from a cognitive-behavioural and psychosocial focus which has helped further enhance how we conceptualise IBS and reveals the diversity of the condition. A review of three primary psychological therapy approaches used in treating IBS and their general protocols and efficacy will follow. This will help expose how well current understandings about IBS translate to effective therapeutic approaches.

The literature review will then consider patient perceptions of treatment issues and experiences associated with IBS. This is valuable for developing deeper individual understandings of psychological IBS treatments, how they relate to treatment effectiveness and the implications for Counselling Psychologists. As the literature review becomes more specific it will highlight the usefulness of relevant gender-related research. This will help identify the lack of knowledge we have about men with IBS and their vulnerability in therapeutic environments. Finally, a discussion of the contextual ramifications of the reviewed studies for the improved practice of Counselling Psychologists will be provided along with a clear rationale for conducting this study.

3.2 Understanding IBS and individuals with IBS

3.2.1 Diagnosis

IBS diagnosis is based on exclusion once other organic bowel conditions have been medically ruled out (Blanchard, 2001). Various systems have evolved over the past 35 years to diagnose IBS; Manning (Manning, Thompson, Heaton & Morris, 1978), Rome I (Thompson et al., 1992); Rome II (Drossman,

Corazziari, Talley, Thompson & Whitehead, 2000); Rome III (Drossman, 2006). Rome II criteria are most commonly used in practice and research.

Rome II criteria for diagnosis considers that over the preceding twelve months an individual is required to have had twelve weeks (not necessarily consecutive) of abdominal pain or discomfort accompanied by at least two of the following criteria: (a) relief achieved after defecation; (b) onset associated with alteration in stool frequency and or/ consistency (such as diarrhoea or constipation); (c) onset associated with alteration in form or appearance of stool (ranging from watery to compacted). Supportive symptoms for IBS are: (1) fewer than three bowel movements per week; (2) more than three bowel movements per day; (3) hard or lumpy stools; (4) loose or watery stools; (5) straining during bowel movement; (6) urgent bowel movement; (7) feeling of incomplete evacuation; (8) passage of mucus (during bowel movement); (9) abdominal fullness, bloating, or swelling.

The diagnosis process is further complicated by symptom overlap between IBS and other functional gastrointestinal disorders (Alpers, 2008). IBS is often co-morbid with psychological issues (Blanchard, 2001). IBS sufferers can also report non-colonic co-morbidities (e.g., headaches, back pain) which fall outside Rome diagnostic criteria (Riedl et al., 2008). However, NICE guidelines (2008) acknowledge non-colonic symptoms can function to support IBS diagnosis. IBS diagnostic systems currently do not address psychological aspects often associated with IBS.

3.2.2 Biopsychosocial understanding of IBS

IBS as a form of functional bowel disorder can be understood from the perspective of an empirically supported biopsychosocial model (Drossman, 1996). A biopsychosocial model conceptualises human illness as a combined product of biological, psychological and social factors rather than solely biological as in a biomedical model (Engel, 1977). The gastrointestinal (GI) symptoms that arise in IBS can be comprehended using biopsychosocial understanding (Lackner, 2005). It is the complex interplay of biopsychosocial

factors, rather than the influence of isolated factors that contributes to the development and subsequent maintenance of IBS (Toner, Segal, Emmott & Myran, 2000). Thus, IBS is conceptualised as a functional disorder, but not a form of organic disease (Drossman et al., 1999). This is important as an organic cause for IBS has not been identified.

IBS symptoms emerge due to disruptive movements of the GI tract which it is believed derives from dysregulations in the interaction between the enteric nervous system (ENS) and the central nervous system (CNS) (Lackner, 2005; Toner, Segal, Emmott & Myran, 2000). The ENS and the CNS are 'neural structures' that together comprise the 'brain-gut axis' that work together to control the function of the gut (Lackner, 2005, p. 126).

For people with IBS the normal gut function is regularly disrupted due to poor interaction between the ENS and CNS (Lackner, 2005). The CNS perceives movements in the GI tract as painful at times for people with IBS due to visceral hypersensitivity (Drossman, 1996). Drossman defines visceral hypersensitivity as 'the exaggerated experience of pain in response to mildly painful or even normal visceral stimuli' (p. 5). Gut motility and visceral sensitivity are reflex behaviours governed by the ENS (Lackner, 2005). Also, people with IBS are considered to have lower thresholds for GI pain perception compared with people who do not have IBS (Toner, Segal, Emmott & Myran, 2000). See Musial et al. (2008) for an extensive psychophysiological explanation of visceral pain in IBS.

From a biopsychosocial understanding the multiple influencing factors are believed to contribute to the diversity of symptoms that can emerge with IBS (Toner, Segal, Emmott & Myran, 2000). Disruptions in gut motility occur mainly in the small and large intestine. However, there are no defined dysregulatory patterns of gut motility in IBS, which adds to complexity. People with IBS can have either predominantly diarrhoea- or constipation-related symptoms or indeed have a combination of both. It is this variation of IBS symptoms that has led to classification of sub-types of IBS: diarrhoea-

predominant, constipation-predominant, or alternating (Thompson et al., 1999).

3.2.3 Cognitive and coping aspects of IBS

The emergence of the biopsychosocial model as a means for conceptualising IBS has precipitated much cognitive and behaviour orientated research. By reviewing this research we are better able to recognise how biopsychosocial understanding of IBS has advanced along with development of coping skills for managing this complex condition.

Research on cognitive factors, beliefs and attitudes associated with IBS have produced varying findings. Lackner et al. (2005) carried out a cross-sectional study (n=281) examining the relationship between dysfunctional attitudes that individuals held about IBS and the emotional component of pain. Measures were taken for pain, dysfunctional attitudes and psychopathology and findings correlated. Findings revealed that a significant quantity of IBS participants held attitudes and beliefs that indicated a tendency for negative thinking that likely precipitated IBS symptoms in response to stressful situations. These dysfunctional attitudes were said to have an interpersonal emphasis incorporated within social appraisal beliefs (need for approval, perfectionism). These beliefs were found to predict the emotional unpleasantness of pain. However, this study is limited in that it used correlational data and thus cannot explicitly infer a causal relationship between dysfunctional attitudes and GI pain. The researchers proposed that modifying beliefs may bring reduction in IBS symptoms, particularly pain. Engaging with values and beliefs is approved Counselling Psychology practice (Division of Counselling Psychology, 2005) and in this context may bring about physiological and psychological relief for individuals with IBS from a cognitive-behavioural therapy perspective.

In terms of coping, individuals with IBS tend to have less capacity to manage GI difficulties and exhibit more psychological distress compared to non-IBS sufferers (Drossman et al., 1988). Individuals with IBS often exhibit dysfunctional coping methods when trying to manage their condition

(Salkovskis, 1989). Salkovskis, basing his views upon clinical experience, highlighted that people with IBS often tried to avoid perceived consequences and embarrassment following thoughts of feared loss of control of their bowels (fear of catastrophe). Individuals with IBS then attribute successfully preventing disaster to their efforts of avoidance which helps maintain IBS in the long-term. Indeed, individuals with IBS were found to have elevated levels of experiential avoidance for physical sensations, thoughts and emotions (Drews & Hazlett-Stevens, 2008).

Worry and catastrophising are cognitive concepts relevant to IBS. Worry is defined as a succession of negative thoughts linked with affect directed towards the goal of problem solving (Borkovec et al., 1983). Catastrophising is defined as tendency to attribute the worst possible outcome to a situation and exaggerating the likelihood of this happening (Wells, 1997). Lackner and Quigley (2004) carried out a study (n=186) that examined whether pain catastrophising mediates the relationship between worry and pain suffering in IBS patients. Questionnaires were used to measure pain perception, anxiety, pain catastrophising, somatic complaints and GI symptom severity. Mediation analyses discovered that IBS patients who worry frequently also engage in more catastrophising which in turn intensifies the suffering aspect of pain. They proposed that worry emerges following the activation of threat-related beliefs. However, the researchers admit their participant sample contained many individuals with severe IBS for whom catastrophising tendencies may be more understandable and perhaps is not representative of the wider population.

Keefer et al. (2005) also examined the concept of worry with an additional focus on intolerance of uncertainty for individuals with IBS in a randomised controlled trial (RCT). Forty-six participants were categorised by the three IBS sub-types (diarrhoea-predominant, constipation-predominant, or alternating). Participants completed the Penn State Worry Questionnaire (Meyer et al., 1990), Intolerance of Uncertainty questionnaire (Freeston et al., 1994), and the State Trait Anxiety Inventory (Spielberger et al., 1983) and participants also kept symptom diaries.

Findings revealed that participants with IBS exhibited significantly higher intolerance of uncertainty compared with the control group. Worry was found to predict severity of GI symptoms. The researchers suggested that worry facilitates possible precipitation and perpetuation of IBS. These findings alongside those of Lackner and Quigley (2004) extend our knowledge particularly of the cognitive mechanisms and individual biases that function to nurture IBS symptoms and influence coping. From a Counselling Psychology perspective this helps expose diversity of IBS which has relevance for developing individualised treatment plans. However, this was only a preliminary study and further supportive research is needed. Also, the researchers used correlation analysis which prevented identification of direct causal relationships between factors.

3.2.4 Psychosocial research on IBS

Some research has focused more attention on exploring the psychosocial aspects of IBS. Interpersonal difficulties have been associated with pain catastrophising (Lacker & Gurtman, 2004). In an enlightening study Lackner and Gurtman (2005) conducted an analysis of patterns of interpersonal problems for people with and without IBS (n=233). They used self-report questionnaires, including: (i) an inventory of interpersonal problems and; (ii) a brief symptom inventory.

Findings showed that more interpersonal problems existed for individuals with IBS compared with a healthy control group. IBS participants exhibited significant tendency to be unassertive and socially inhibited (anxious, easily embarrassed). Those participants with more severe IBS experienced more interpersonal difficulty in their lives. Also, individuals with diarrhoea-predominant IBS were found to be more affiliating and eager to please others. The general submissive profile of individuals with IBS it was speculated derived from either shortcomings in assertion skills or an impaired ability to action these skills. Again, findings are limited through using correlational data which prevents confirmation of direct causal relationships. These personality profile findings may prove useful for Counselling Psychologists to incorporate

when assessing people with IBS to focus interventions on a more specific and subjective basis.

Toner, Segal, Emmott and Myran (2000) suggest individuals with IBS perceive the general populace to hold negative attitudes about IBS, and offer poor understanding and empathy which contributes to stigma. Stigma and potentially trivialising IBS as a mere functional condition, or being 'medically unexplained' is believed to inhibit help seeking behaviours to manage IBS (Looper & Kirmayer, 2004, p. 372).

Perceived stigma for individuals with IBS has been defined as 'the shame someone feels when they have certain attributes or conditions which they perceive to be shameful or unacceptable' (Dancey & Rutter, 2005, p. 124). Dancey and Rutter suggested that people with IBS fear the negative discriminatory attitudes of others. Individuals with IBS over time may then internalise stigma and attribute similar negative attitudes towards themselves and feel ashamed for having IBS. Internalised stigma and perceptions of shame are believed to contribute to compromised engagement in social activities and quality of life. Internalised stigma has been found to contribute to depression and anxiety (Taft, Riehl, Dowjotas & Keefer, 2014).

Dancey, Hutton-Young, Moye and Devins (2002) in a quantitative study (n=117) examined the perceptions of stigma, illness intrusiveness and quality of life (QOL) in men and women with IBS. IBS symptoms, perceived stigma, illness intrusiveness and quality of life were measured by self-report questionnaires and data was correlated. This study emphasised the social consequences of enduring IBS in relation to the concept of illness intrusiveness. Illness intrusiveness can be defined as the degree to which illness/ or treatment thereof compromises engagement with valued activities/ interests and impinges on good psychological health (Devins et al., 1993). Results showed that IBS symptom severity, perceived stigma and illness intrusiveness report similar magnitudes regardless of gender.

QOL was found to decrease more drastically for men in the presence of IBS compared with women. Men recognised higher levels of personal stigma associated with poor QOL. Illness intrusiveness proved to be a more mediating factor for men in the relationship between symptom severity and QOL. It was suggested that men might possess fewer skills to cope with lifestyle disruption or experience more distress associated with the personal disruptions and feelings of stigma of suffering from an 'unacceptable illness' (p. 393). It was suggested QOL in men might be defined to a greater extent by their value placed on personal freedom. Women were found to suffer more from physical IBS symptoms and it was suggested symptom relief could be sought through using medications. Thus, psychological therapies could focus more specifically on addressing male vulnerabilities to IBS stigma/ associated shame and lifestyle disruption.

Dancey, Hutton-Young, Moye and Devins (2002) suggested education programmes could provide male IBS sufferers with information on how IBS can be experienced by men and help counter feelings of bowel disorder stigma. The researchers suggested both men and women should be encouraged to engage in social activities and interests to maintain good QOL. This study identified important gender differences in how males and females are experiencing and coping with IBS. Perhaps further psychosocially-orientated research can improve gender-related knowledge and elucidate how IBS manifests in social contexts, and ultimately gender differences may inform psychological treatment of IBS.

The reviewed research has expanded our biopsychosocial understanding of IBS particularly highlighting the complexity of multi-factor interplay and exposed the diversity of IBS symptoms and coping behaviours. Ultimately, these findings have ramifications for Counselling Psychologists working with individuals with IBS and efforts to individualise therapeutic treatment.

3.3 Interventions for IBS

Efforts have been made to define IBS, to understand the condition and how it manifests. However, considering contemporary knowledge, how is IBS treated and how effective is treatment? NICE guidelines (2008) for treating adults with IBS propose that psychological interventions for IBS should follow if symptoms persist and have not responded well to pharmacological interventions after 12 months. Guidelines recommend that pharmacological interventions should only be introduced after efforts by health professionals to reduce IBS symptoms by dietary (e.g., identifying food intolerances, reducing coffee/ alcohol, modifying fibre intake) and lifestyle interventions (e.g., increasing physical activity) have not brought relief. Medications can range from antispasmodics (for gastrointestinal spasms), antidepressants (for analgesic effect), to laxatives (for constipation). However, it has been argued that medications are aimed more at alleviation of IBS symptoms rather than a cure (Lacy & Lee, 2005) and are not effective for everyone with IBS (Brandt et al., 2002).

If IBS persists despite medical help then treatment efforts shift towards inventions to address any psychological issues which may be contributing to IBS. The psychological therapies that NICE guidelines (2008) support are cognitive-behavioural therapy (CBT), hypnotherapy, and brief psychodynamic therapy. What follows is a brief critical review of the literature pertaining to these three IBS treatments, outlining the salient aspects of each approach.

3.3.1 Cognitive and behavioural therapies

Cognitive-behavioural therapy (CBT) is one of several approaches falling under the umbrella term cognitive and behavioural therapies. Blanchard (2001) succinctly describes the general focus of the cognitive and behavioural approaches to treating IBS as attempts to alter thoughts and/ or behaviours about IBS in collaboration with the client. Toner, Segal, Emmott and Myran (2000) summarise their CBT treatment protocol as having three main objectives: (1) to encourage the re-conceptualisation of a client's view of IBS,

shifting the perception from one of helplessness to that of hopefulness and resourcefulness; (2) to develop awareness of the relationships between thoughts, feelings, behaviours, surrounding environments and IBS symptoms; and (3) to encourage the development of more adaptive means of coping with IBS with the aim of encouraging quality of life.

Early studies provided efficacious findings for using CBT with IBS (Bennett & Wilkinson, 1985; Neff & Blanchard, 1987). However, it was Greene and Blanchard (1994) who achieved some of the strongest results (n=20). They took a simple approach to study design comparing the impact of, more specifically, cognitive therapy for IBS (over ten sessions) with a symptom-monitoring control group. Women constituted 75% of the sample. Therapy focused on raising awareness of the connections between cognitions, GI symptoms and stressful situations. Treatment then progressed to developing more adaptive responses to perceived threat and ultimately modification of problematic beliefs.

This study produced impressive results, with 80% of participants in the cognitive therapy group improving their IBS symptoms (measured by Composite Primary Symptom Reduction scores) compared to 10% in the control group. The Beck Depression Inventory (Beck, Steer & Garbin, 1988) scores improved but state and trait anxiety measures did not. Follow up after three months revealed that 77% of the cognitive therapy participants sustained their improvements. Payne and Blanchard (1995) conducted what was essentially a replication study (n=34) of Greene and Blanchard (1994) with the addition of an extra psycho-education condition and achieved similar results, with 75% of the therapy group achieving significant symptom improvement and 83% sustaining improvement at three month follow-up. Thus, strong evidence for using cognitive therapy emerged in these studies rather than strictly CBT, albeit using small study samples.

Moss-Morris, McAlpine, Didsbury and Spence (2010) conducted an RCT (n=64) examining whether CBT self-management interventions were more effective compared with treatment as usual (TAU). The treatment condition

took place weekly (over seven weeks) and included one hour-long face-to-face therapy session at the beginning and two one-hour telephone sessions with a therapist. The CBT self-management material included IBS psycho-education, coping skills for IBS symptoms and managing cognitions, addressing perfectionist beliefs, regular activity engagement and relaxation/stress management.

The researchers found a significant difference between treatment conditions, with 76.7% of participants in the CBT group experiencing significant reduction in GI symptoms compared with 21.2% TAU. Improvements were sustained at three and six month follow-up which the researchers attributed to continued application of learning and coping skills post-treatment. However, depression measures remained unchanged in the treatment condition although anxiety measures were significantly reduced at six months follow-up measured by the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). This self-management study provides preliminary evidence that a more self-managed, client-driven treatment package can be efficacious and provides an alternative option to individual therapy.

Some studies have assessed the efficacy of delivering group CBT (see, for example, Van Dulmen et al., 1996; Toner et al., 1998). A review found CBT studies on the whole failed to exhibit consistent strong findings with 'substantial methodological flaws' that compromised interpretations of outcomes (Toner, Segal, Emmott & Myran, 2000, p. 12). The empirical evidence for using CBT to treat IBS is mixed despite the high prevalence of randomised controlled trials (Blanchard, 2001, 2005). Blanchard (2005) reviewing CBT studies concluded that CBT is more beneficial than standard medical treatment and mere symptom monitoring but not always better than psycho-education treatment.

Recent studies found preliminary success delivering brief internet CBT (Hunt, Moshier & Milonova, 2009), third-wave CBT approaches such as Mindfulness (Garland, Gaylord, Palsson, Faurot, Mann & Whitehead, 2012; Ljotsson, Andreewitch, Hedman, Ruck & Andersson, 2010) and Acceptance and

Commitment Therapy (Naliboff, Frese & Rapgay, 2008). However, further evidence is needed because the number of studies is insufficient to draw strong conclusions in support of using these IBS treatment approaches.

3.3.2 Hypnotherapy

Whorwell, Prior and Faragher (1984) conducted the first major RCT (n=30) of hypnotherapy for the treatment of IBS. Their treatment protocol subsequently became widely adopted by other hypnotherapy researchers/ practitioners. Their approach initially focuses on delivering general hypnotherapy skills to achieve a state of relaxation and calmness. Treatment then moves towards attending to gut movements and developing skills to achieve more normal gut motility with less distressing symptoms. Finally, treatment concludes with interventions directed towards ego strengthening.

This study found that over three months all participants in the hypnotherapy condition compared to a control condition enjoyed substantial improvement in all measured IBS symptoms including improvement in regular bowel habit, maintained at three month follow-up. Galovski and Blanchard (1999) attempted a replication study (n=33). Their results were almost as good with 55% of hypnotherapy participants experiencing improved symptoms (by at least 50%) after treatment. However, both studies could be accused of using small sample sizes, which makes it difficult to generalise findings.

Gholamrezaei, Ardestani and Emani (2006) conducted a systematic review of hypnotherapy research and found that despite regular methodological errors, hypnotherapy on the whole proved very efficacious at treating refractory IBS. However, the researchers suggested more RCTs were needed to confirm this. Findings showed hypnotherapy was useful for developing control over gut motility, reduction in gastrointestinal pain and sensitivity, reduced arousal and reduced psychological trait tendency for somatisisation. The researchers suggested hypnotherapy may also help reduce anxiety and depression in IBS patients as a consequence of treatment, an opinion also advocated by Whorwell (2008).

The exact mechanism for inducing change for individuals with IBS using hypnotherapy is unclear (Whorwell, 2008). Also, Whorwell approximated that only 70% of people are hypnotisable. Indeed it has been found that females and younger people are more susceptible to hypnotisation (Heap & Aravind, 2002). This may indicate that males are at a disadvantage with hypnotherapy. However, these studies on the whole present impressive findings supporting use of hypnotherapy as a treatment option.

3.3.3 Brief psychodynamic psychotherapy

A psychodynamic approach aims to help clients make sense of thoughts and feelings in present day experiences through efforts to make the unconscious conscious (Jacobs, 2004). Jacobs states this approach aims to enhance understanding about how clients actually, or wish to relate to others and comprehend how individuals relate to themselves. Guthrie et al. (1999) suggests a psychodynamic approach to IBS commences with a discussion of GI symptoms and connected emotions and how they impact upon interpersonal relationships. Information is gleaned from dialogue and through therapeutic interpretations. Efforts then explore and encourage change of client's beliefs, shifting negative perceptions about IBS to more hopeful ones.

Svetlund, Sjodin, Ottoson and Dotevall (1983) in a large, early RCT compared brief psychodynamic psychotherapy (ten sessions) along with medical care (n=50) to medical care alone (n=51). Medical care utilised dietary supplements and/ or drugs where appropriate. Psychotherapy treatment aimed at 'modifying maladaptive behaviours and finding new solutions to problems. The focus was on means of coping with stress and emotions and on relations between stressful life events and abdominal symptoms' (p. 589). The researchers stated their therapeutic approach was 'flexible' in that it focused on both psycho-educational components (linking stress to IBS symptoms) and exploring potential resolutions to specific 'conflicts' (p. 591). Outcomes were assessed by physician interviews (targeting GI symptoms) and also by participant self-report.

Significant improvement was found for the psychotherapy treatment condition relating to abdominal pain and reduction in the number of GI symptoms. These improvements were maintained at 12-month follow-up with the addition of improved bowel function. There was also improvement in anxiety and depression symptoms at follow up but with no significant difference between groups. However, there was a 14% attrition rate in the psychotherapy condition, which compromises the strength of findings. Also, the psychotherapy condition sounds somewhat cognitive-behavioural in orientation and not strictly psychodynamic psychotherapy.

Guthrie, Creed, Dawson and Tomeson (1991) in a UK study examined the effectiveness of psychodynamic interpersonal therapy over seven sessions (n=53) compared with a symptom-monitoring wait list (n=49). This study focused more on accessing participant feelings in therapy about any difficulties in interpersonal relationships discussed in relation to precipitation and/ or perpetuation of IBS symptoms. The client-therapist relationship as a means for understanding IBS difficulties associated with patterns of relating was also a focus. Outcomes were based on participant symptom diaries, self-report measures and physician report.

There was significant reduction of GI symptoms, anxiety and depression in the treatment condition compared with the control condition. Global Symptom self-report at 12-month follow-up revealed that 85% of participants in the treatment condition maintained their improvements. These were encouraging results but one questions the reliability of self-report as a sole means for measuring sustained improvement.

Blanchard (2001) states the therapeutic approaches in these two studies are ‘roughly equivalent’ but little effort is made to explore the ‘unconscious’ (p. 164). Perhaps these studies are not using psychodynamic psychotherapy in the strictest definition of the approach. Generally, there is a lack of RCTs but these two studies provide encouraging support for the psychodynamic approach (using a flexible definition). A later study (n=257) by Hyphantis, Guthrie, Tomeson and Creed (2009) compared psychodynamic interpersonal

therapy with an antidepressant condition and with a routine care condition. Despite finding significant improvement in the therapy and antidepressant conditions this study struggled to distinguish which is the most efficacious treatment approach.

3.3.4 Conclusions

After reviewing the literature on three psychological therapy approaches to treating IBS, no best approach emerges (Blanchard, 2005; Lackner, Mesmer, Morley, Dowzer & Hamilton, 2004). Lackner et al. state there have not been enough trials, and no 'common scale' to compare the effectiveness of the individual approaches (p. 1108). These reviews are now becoming old and would benefit from being updated. NICE guidelines (2008) propose that more research is needed into psychological interventions for 'global' IBS symptom improvement up until 52 weeks after commencing therapy (p. 19).

Lackner, Mesmer, Morley, Dowzer and Hamilton (2004) argue that comparison of the three approaches may be compromised by non-specific factors such as the therapeutic relationship, therapist's allegiance to approach orientation, and client expectations (associated with placebo effect) not often addressed in studies. A placebo can be defined as 'an inactive and physically identical medication or procedure used as a comparator in controlled clinical trials' (NICE, 2008, p. 22). Patel et al. (2005) in a meta-analysis of IBS trials found that the placebo response rate varied greatly between studies. They approximated its impact in bringing about change as high as 47%. The researchers state psychological treatments might be more useful at targeting somatic symptoms compared with more psychological symptoms. They suggest this might be influenced by co-morbidity and methodologies for measuring treatment outcomes.

Comparison of the different psychological approaches has ramifications for Counselling Psychologists who value pluralistic practice and can work using several therapeutic models (Cooper & McLeod, 2010; Hessian, 2010). Perhaps searching for the standout treatment approach is the wrong

emphasis as Counselling Psychologists are encouraged to reflect on the possibility of multiple truths being applicable to individual cases (Orlans, 2013). Thus, Counselling Psychologists may benefit from remaining flexible and considering the range of approaches available.

3.4 Individuals' experiences of help seeking for IBS

Despite various studies of psychological interventions for IBS, no fully convincing treatment option has emerged. The reviewed studies are aimed towards developing efficacious treatment protocols. Consequentially, these studies may provide descriptions of treatment outlines but do not shed much light on individual experiences of having IBS. There was a lack of information about how therapy was managed for individual clients along with reported gender differences. However, we know that IBS has complex symptomatology, and thus one would think that subjective IBS experiences and treatment experiences would differ widely between individuals. There is a void of literature that captures how individuals with IBS view and/ or have experienced psychological therapies. However, some studies examine accounts of people interfacing with medical treatment for IBS. These studies may have ramifications for Counselling Psychologists working with this client group.

Kennedy, Robinson and Rogers (2003) conducted a qualitative study using 5 focus groups with a total of 23 people with IBS to gain insight into personal and social aspects of coping with IBS and use of the health service. Findings were analysed using the framework technique (Ritchie & Spencer, 1994) to derive areas for focus group discussion. These researchers again identified participants' perceptions of feeling isolated with IBS and that health professionals did not take IBS seriously. The researchers found that for some participants experiencing IBS over time led to better understanding of symptoms and more adaptive ways of coping with symptoms. Some participants, on the other hand, despite health-seeking efforts struggled to develop and utilise personal self-management strategies. Researchers

proposed that the development of self-management skills would benefit from better information provided by healthcare professionals. Kennedy et al. suggested a need for more joint decision-making about treatment. There was normally no, or very minimal, reported consultation with patients. Findings are limited by using a predominantly female sample and little information was provided about the method of analysis and its validity.

Casiday, Hungin, Cornford, De Wit and Blell (2008) conducted a mixed method study using semi-structured interviews with primary care patients (31 UK, 20 The Netherlands) and Quality of Life self-report measures. They used Grounded Theory to analyse interview data. Patients highlighted importance for having personal explanatory models for IBS more so than receiving medical explanations of aetiology. Patients associated developing IBS with either personal attributions (their own doing) or the product of an event or incident from the past. Patients were interested in understanding the triggers for their IBS, of which stress and diet were highlighted.

Patients struggled to find effective treatments for IBS, found the diagnosis procedure frustrating and occasionally unsatisfying. However, this did not generally compromise the relationship they held with GPs nor did they highlight poor communication with their GPs. This contrasts with findings from the previous study. This study recommends that GPs gain a clearer understanding of client's worries and IBS conceptualisations. Researchers posited it would help if GPs treatment inventions match client explanatory models of IBS if possible, especially as IBS lacks a convincing pathophysiological explanation.

Farndale and Roberts (2011) conducted a qualitative UK study of the long-term impact of IBS. Eighteen participants underwent semi-structured interviews discussing their IBS prior to thematic analysis. Participants commented on a need for doctors to understand their fear relating to IBS and the threat of future IBS symptoms emerging. The pain and unpredictability of symptoms were strongly highlighted difficulties. Participants were pessimistic about primary care treatment and identified unsatisfactory relationships with

their GP (including a lack of information provided about IBS). Participants experienced compromised quality of life, emotional well-being and some daily activities due to the debilitating impact of IBS symptoms.

For some participants, living with IBS symptoms over the years had resulted in integrating IBS into their lives where it had became fused with their sense of identity. Some participants stated that normalising their IBS symptoms was a method of coping with their enduring condition. Some participants said the compromising impact of IBS threatened certain parts of their identity (e.g., role of mother or friend). However, this study lacks detail (including verbatim participant extracts) that would validate claims that IBS impacts on identity. The researchers state their participants generally had severe IBS symptoms and may not be wholly representative of the general population of people with IBS.

Studies that indicated struggles to relate well to healthcare professionals was often associated with negative emotions. Individuals with IBS seemed to struggle at times to feel contained by healthcare professionals (Casement, 1985). We should recall that perceived lack of understanding and empathy can feed IBS stigma (Toner, Segal, Emmott & Myran, 2000). Poor holding relationships with healthcare professionals may nurture perceived stigma for individuals with IBS.

Reaching collaborative treatment decisions is encouraged practice in Counselling Psychology and would likely strengthen therapeutic relationships with people with IBS. Encouraging self-management of symptoms may also nurture a sense of empowerment and autonomy to cope effectively. These notions are relevant for Counselling Psychologists who appreciate the utility of expertise residing within the client (Orlans, 2013). Unfortunately, the findings from the reviewed studies (in this chapter) are not gender specific. This could be relevant for men for whom personal stigma about IBS is associated with lower quality of life compared with women (Dancey, Hutton-Young, Moye & Devins, 2002). It may be valuable to know what thoughts and emotions

identified in these studies specifically relate to men coping with and seeking help for IBS?

The term ‘IBS sufferer’ is a label and perhaps implies proneness or weakness to suffer from the condition. The term implies an ongoing, enduring condition and perhaps has punitive connotations to it. The label could invite negative preconceptions/ the stigmatised views of others. The term ‘IBS sufferer’ is impersonal and perhaps fails to recognise the unique aspects of the individual and their condition. The generic quality of the term perhaps caters to a nomothetic urge to categorise people as data. Indeed, IBS sufferer is a term commonly used across IBS research and literature. If stigma has become associated with the term IBS sufferer then by continuing to share and use the term in IBS literature this could reinforce stigma. Maybe it is better to refer to people or individuals with IBS. This may seem less pathologising, impersonal and may reduce chance of triggering any stigmatised views about IBS/ individuals who have IBS.

3.5 Individuals’ experiences of chronic illnesses similar to IBS

Chronic illnesses such as Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis (CFS/ ME) and Fibromyalgia Syndrome (FMS) bare some similarity with IBS in terms of shared symptoms and potential compromising impact on functioning and quality of life. These medically unexplained conditions can all be described as invisible illnesses due to the lack of visible physical symptoms (Arroll & Dancey, 2014; Rodham, Rance & Blake, 2010). Some chronic illness studies employed the qualitative approach Interpretative Phenomenological Analysis (IPA) to analyse participant experiences and efforts of meaning making (gathered from semi-structured interviews).

FMS is a condition characterised by fatigue, muscle pain, tissue tenderness and stiffness in the joints that occurs in the absence of organic cause (Mease, 2005). Rodham, Rance and Blake (2010) used IPA to study the lived experiences of individuals with FMS and their carers who were spouse

(n=4+4). A prominent finding concerned loss of identity for individuals with FMS. These individuals described an inability to be themselves and to engage in their regular activities. Symptoms could be unpredictable, frustrating, proved difficult to explain and could invite sceptical responses from others. The struggle to convince friends, family and doctors of the realness of their condition contributed to participant perceptions of FMS being an invisible illness. The lack of external validation for FMS contributed to perceived isolation and nurtured loss of identity. Some participants began to question their sanity, or if illness was imagined. However, findings are limited as the study used a self-selected, all female sample of individuals with FMS which may not reflect the views of the wider population of people with FMS.

CFS/ ME is a complex condition characterised by severe fatigue, muscle and joint pain and a variety of possible cognitive difficulties including concentration, problem solving, memory and communication issues (Arroll & Senior, 2008). Dickson, Knussen and Flowers (2008) used IPA to study the accounts of 14 people with CFS/ ME. Loss of self was highlighted across participant findings and was associated with helplessness, and an impaired sense of control when carrying out mental and physical activities. Many participants questioned who they were following illness and wanted to recapture their more capable, pre-illness selves. Many felt they had lost their former ability to occupy their body and minds. Some participants questioned the realness of their ambiguous condition which the researchers' believed may have fuelled identity crises. Recovery from CFS/ ME was facilitated by a gradual process of acceptance over time, which for some was a process peppered with ambivalence. The researchers suggested individuals learned to re-integrate and accept their body and mind as part of themselves again. This study may have been limited by using participants who were at different stages of living with CFS/ ME which could have contributed to differences in their accounts and understandings of experiences.

These reviewed studies in some ways echoed findings from studies of individuals' experiences of help seeking for IBS (see section 3.4). There were similarities with struggles to manage symptoms, loss of functioning and

negative moods (particularly isolation and helplessness). However, CFS/ ME and FMS study findings perhaps more strongly emphasised the difficulties negotiating loss of self and accepting an emergent self (that integrated illness). Identity and sense of self themes often emerge in IPA studies (Smith & Eatough, 2012). The fact these issues are shared across similar types of invisible illness may reflect common struggles negotiating and enduring these chronic conditions. Identity issues are grappled with in the mind and could remain hidden from medical professionals and/ or therapists if they are not verbalised. Counselling Psychologists can work to strengthen identities, bolster sense of self for individuals with IBS and facilitate better acceptance of chronic illness.

3.6 Gender implications: Males and IBS

3.6.1 Gender research about IBS

There is little IBS gender-related research. Toner, Segal, Emmott and Myran (2000) in their review of IBS studies found few studies identified and/ or reported gender findings. Women are considered twice as likely to be diagnosed with IBS compared to men (Blanchard, Keefer, Galovski, Taylor & Turner, 2001). Research advances in our psychological understanding about people with IBS could arguably have emerged due to a female gender bias, as the majority of IBS studies use samples with considerably more females than males (Toner, Segal, Emmott & Myran, 2000).

The lack of males in mixed gender studies has often led to insufficient power to detect gender differences (Heitkemper & Jarret, 2008). Heitkemper and Jarrett concluded that there was not enough research to help resolve why more women seek treatment for IBS than men. They posited that the likely explanation is a combination of related factors: socio-cultural differences, along with physiological differences, influence of gonadal hormones, reactions to stress and inflammatory responses that can result from GI and pain symptoms. Previously, Mayer, Naliboff, Lee, Munakata and Chang (1999)

found that for gastrointestinal disorders women seem to have higher perception of pain compared with men, possibly related to differences in biological factors. Toner (1994) stated that little is known about the influence of gender differences and the ramifications this may have for psychological formulation and treatment of IBS. In summary, we are not sure whether more women being diagnosed with IBS than men is due to (a) difference in incidence, (b) difference in help seeking or, (c) a combination of differences in incidence and help seeking.

3.6.2 Masculinity implications concerning help seeking

In Britain, the psychology of men continues to be a much understudied area (White, 2009). Men are generally considered less likely to seek counselling/ therapy to help with their problems (McKelley, 2007; Wexler, 2009, 2010). For instance, men with depression are considered to be more likely to deny the existence of a problem in the first place, or to act out or abuse substances to cope (Wexler, 2009). Help seeking such as attending counselling has been said to oppose the inherent values of masculinity associated with male gender roles (Good, Thomson & Brathwaite, 2005). Through social and cultural influence men 'learn to be islands' and strive for independence in what they do (McKelley, 2007, p. 51). Thus, males with IBS are potentially more vulnerable to continue suffering psychological distress than women as they are less likely to seek help and more likely to try to cope alone. Also, enduring IBS can prove to be an isolating experience regardless of gender (Kennedy, Robinson & Rogers, 2003).

Men have a tendency to adhere to gender role expectations to be problem solving, to contain and limit expression of their emotions, and to endeavour to secure power and influence in their relationships (Good, Thomson & Brathwaite, 2005; Mahalik, Good & Englar-Carlson, 2003). However, this can lead to gender role conflict which has been defined as a 'psychological state in which socialised gender roles have negative consequences on the person and others' (O'Neil, Good & Holmes, 1995, p. 166). The conflict emerges through restricting emotions and the continual urge to appear manly at all

costs (Mahalik et al., 2003). Similarly, males could be suffering physical and psychological distress with IBS yet the constraints of masculinity could be hindering help seeking efforts? Further research in this area could reveal that men with IBS are vulnerable and suffering in solitude, without adequate coping skills.

3.7 Ramifications for Counselling Psychologists/ rationale for my study

The existing literature on IBS has no doubt enhanced our knowledge of IBS from a biopsychosocial perspective and has much relevance for Counselling Psychology. However, to date no existing psychological treatment for IBS is universally effective for all people with IBS.

Research on the experiences of individuals with IBS, particularly their interface with healthcare professionals, has helped expose the need for good working alliances with healthcare professionals during medical treatment. There is a dearth of research with psychologists/ therapists working with IBS clients but we know Counselling Psychologists strive to form collaborative, working relationships with clients.

Little is known about how IBS specifically affects men. We do know that men compared with women experience more personal stigma about IBS associated with lower quality of life (Dancey, Hutton-Young, Moye & Devins, 2002). Dancey et al. found that IBS illness intrusiveness is more of an issue for men, although men seem to be coping better with physical IBS symptoms. Men are considered less likely to seek help/ therapy to cope with their psychological problems (Wexler, 2009). Hence, perceptions that health professionals may hold stigmatised views about IBS (Kennedy, Robinson & Rogers, 2003) may contribute to reluctance to seek help.

The few existing findings about men with IBS are primarily based on quantitative measures and there is a void of in-depth subjective understanding. Exploring male subjective accounts of having IBS may

strengthen existing findings regarding the life impact of the condition and shed light on an understudied area. Insight into men with IBS may at the very least add to the bodies of research on masculinity and gender stigma. Subjective findings may perhaps improve our knowledge of IBS and provide suggestions for more effective therapeutic practice.

The biopsychosocial model is a good conceptual tool for embracing individual IBS case comprehension and will be adopted as a framework for interpreting current study findings. This fits with the aim for Counselling Psychologists to go beyond mere diagnosis to fully acknowledge the uniqueness of clients and tailor therapeutic treatment (Cooper, 2009). Cooper suggests putting diagnosis before the 'face' of the client can be an attempt to reduce subjective complexity to what is 'familiar' (p. 122). In light of this, it may help to view conceptual models and IBS diagnostic systems as guiding lights rather than as the realised boundaries of attainable knowledge. Particularly as modern IBS diagnostic systems to not address psychological aspects often associated with IBS.

Modern research has revealed the diversity of IBS symptom triggers and manifestation of the condition (Farndale & Roberts, 2011; Kennedy, Robinson & Rogers, 2003). This diversity suggests Counselling Psychologists will be required to individualise formulations and encourages flexibility when treating this client group. There is also more emphasis now on self-managing IBS symptoms (Kennedy, Robinson & Rogers, 2003; Moss-Morris, McAlpine, Didsbury & Spence, 2010). This fits with encouraged Counselling Psychology practice of promoting active client participation in treatment (Papadopoulos & Bor, 1995). Thus, an experiential study of how males relate to their symptoms and attitudes towards self-management may access male strengths (Good, Thomson & Brathwaite, 2005). The study findings will hopefully contribute to existing psychological treatments for IBS and potentially highlight the need for further case specification and individualised interventions for Counselling Psychologists treating male IBS clients.

Therefore, responding to current gaps in research this study was an exploration of adult male experiences of having, managing and receiving help for Irritable Bowel Syndrome (IBS). Research participants were asked to reflect upon their experiences and communicate how they try to make sense of these experiences. With specific focus on adult males this study aimed to explore:

(1) The personal and social impact of having IBS.

Findings might highlight the diversity of IBS experiences between individuals and expose the need for Counselling Psychologists to show greater individual understanding and empathy. The social influence on IBS symptoms may have consequences for individuals managing their interpersonal relationships and also for Counselling Psychologists managing the therapeutic relationship with male clients.

(2) The experiences coping with emotions, thoughts and physical symptoms associated with IBS.

Findings might help improve understanding of individual interpretations and perceptions associated with coping with IBS symptoms. Existing functional and dysfunctional coping strategies may help identify belief and value systems that could prove useful for Counselling Psychologists to work with.

(3) Attitudes and experiences self-managing/ help seeking for IBS.

Attitudes and experiences towards self-managing/ help seeking for IBS may have ramifications for men engaging in therapy, the therapeutic alliance and managing the power differential. Responsibility taking attitudes towards help and management of IBS could nurture increased self-efficacy and enhance empowerment for male clients.

4.0 METHODS AND PROCEDURES

4.1 Epistemological reflexivity

Lee (2009) believes that the process of reaching findings and the awareness of how this was achieved is central to professional doctorate research. Initially I considered whether qualitative or quantitative research methods were best suited for answering my research question. Quantitative methods are particularly useful for obtaining objective truths through testing a specific hypothesis (Coyle, 2007). Coyle states that quantitative approaches based on empirical principles aim to categorise research data. Whereas, Smith (2008) considers that qualitative approaches usually engage with exploratory, descriptive and interpretive experiences of individuals and extracting meaning.

Coyle (2007) states quantitative methodology suppresses complexity of subjective views. In contrast, qualitative approaches are considered to be better committed to embracing naturalistic, subjective perspectives as a primary interest without need for specific frameworks for extracting meaning (Coyle, 2007; Eatough, 2012). I was drawn to favour qualitative approaches which are better able to generate the type of knowledge that matched the exploratory focus of my study of individual males with IBS.

Epistemological reflexivity considers how the design of a study influences and potentially limits the type of knowledge that can be discovered and how this is achieved (Willig, 2008, 2013). Most epistemologies can be located within a realist-relativist continuum (Eatough, 2012; Willig, 2008). Realism at its most extreme assumes that we have unbridled access to the world and what already exists there (Eatough, 2012). In contrast, extreme relativism assumes there are multiple knowledges about the world which are socially constructed (Eatough, 2012). I needed to select an epistemological position and within this an appropriate qualitative approach deemed the best fit for answering my research question (Willig, 2013).

One possible approach for exploring human experiences is Grounded Theory. Grounded Theory focuses on *why* people hold the perceptions they do about their experiences, categorising this data with the greater goal of constructing new theories (Payne, 2007; Willig 2008). Early versions of grounded theory are rooted in the realist leaning epistemology of positivism. Positivism believes there is direct link between existing worldly objects and how we perceive them (Payne, 2007; Smith, 2008). More interpretative versions of grounded theory emerged later which resonated more with a constructivist epistemology (a relativist-orientated position), due to the researcher's role in constructing theories.

Willig (2008) explained that grounded theory was developed to extract theories from the data using an inductive process. However, Willig suggested grounded theory, with its positivist underpinnings, can be criticised for poor consideration of researcher reflexivity and influence in generating categories and theories (Willig, 2008). The researcher has an active role in shaping the research (e.g., personal assumptions, sampling choices) and that an unbiased process of induction (common to positivist approaches) is not wholly possible (Pidgeon & Henwood, 1997).

Another limitation is that grounded theory is primarily orientated towards embracing 'social processes' and perhaps less appropriate for research questions that focus on exploring the nature of experience (Willig, 2008, p. 46). Willig argues that for experience-orientated research questions grounded theory functions merely to categorise data and structures meaning-making but does a poor job of comprehending experience. Grounded Theory is suitable when there are large gaps in current knowledge about a research area and/ or when there is no significant theory that successfully explains the psychological area of investigation (Payne, 2007). However, we already have some understanding about IBS and the biopsychosocial model provides an adequate framework for conceptualisation. In light of these issues, grounded theory was not considered appropriate for thorough engagement with the nature of lived experience and associated meaning-making which was my principle study focus.

A relativist leaning epistemology to consider is social constructionism. Social constructionism assumes that human experiences (and perceptions of experience) are not directly connected with the environment but are filtered and influenced by socio-cultural, linguistic and historical processes (Willig, 2008). Social constructionism assumes multiple social realities can be constructed by people rather than there be a sole existing knowledge or reality (Willig, 2008).

The most prominent social constructionist methodology is discourse analysis (Coyle, 2007). Discourse analysis is interested in participant accounts and perceptions of experience expressed through language; however, the focus of discourse analysis is less concerned with reflections on psychological and social reality but rather how this is constructed by language (Coyle, 2007, 2012). Discourse analysis assumes that our worldly understandings are socially formed through linguistic exchanges in relation to context.

Smith (2008) states discourse analysis shifts attention away from the individual and more how language is used and driven by socially-orientated objectives. However, discourse analysis struggles to access an individual's thoughts and feelings in relation to phenomena and to embrace their internal world (Crossley, 2007; Parker, 1992). This is a concern given that peoples' thoughts and feelings about IBS were much highlighted in the review of IBS literature.

Discourse analysis does not address the experiential realities of the individual and has been accused of failing to shed light on their sense of self (Crossley, 2007; Eatough & Smith, 2008). Crossley describes this shortcoming of discourse analysis as 'losing the subject' (p. 132). Thus, discourse analysis was deemed inappropriate for best answering my research question because exploring subjective experiences is not a primary focus of this methodology and the approach embraces subjectivity in a somewhat impoverished way.

4.2 Selected epistemology and methodology

My study is very much focused on individual lived experience. After considering the range of epistemological positions it makes sense to embrace the epistemological approach of phenomenology which is particularly suited to understanding human experiences and their inherent complexity (Smith, Flowers & Larkin, 2009). Different phenomenological approaches place different emphasis on how they examine human experiences (Smith & Eatough, 2012). Interpretative Phenomenological Analysis (IPA) emerged as the most appropriate methodology for my study with its primary emphasis on subjective experiences and meaning-making (Smith & Eatough, 2012; Smith, Flowers & Larkin, 2009).

IPA assumes that it can access the participant's world through interpretations of verbal, cognitive and emotional information gathered from participant data (Smith & Eatough, 2007). Unlike grounded theory and discourse analysis IPA strives for a thorough 'examination of experience on its own terms' (Smith, 2011, p. 21). IPA has the primary epistemological underpinnings of both phenomenology and hermeneutics (Smith & Eatough, 2012). Hermeneutics is the theory of interpretation and particularly the interpretation of literary texts (Smith, Flowers & Larkin, 2009).

IPA asks the researcher to engage with data analysis using a double hermeneutic (Smith & Eatough, 2012; Smith, Flowers & Larkin, 2009). The researcher is not able to gain 'direct access' to a participant's internal world but rather the researcher interprets what they perceive the participant's world to be from the researchers own perspective (Willig, 2008, p. 57). This process demands reflexivity from the researcher engaging with the data and awareness of their own subjectivity to monitor how this might influence the research process.

IPA can be said to be a methodology that is theoretically grounded within critical realism (Reid et al., 2005; Shaw, 2010). Critical realists are located approximately in the middle of the realist-relativist continuum (Eatough, 2012).

IPA like critical realism assumes that direct access to a reality is not possible but can be partially achieved thorough interpretation and from a particular perspective (Eatough, 2012; Shaw, 2010).

IPA attempts to understand subjective meanings and individual experiences by adopting an idiographic approach that initially focuses on exploring individual descriptions comprehensively, prior to wider sample comparison and integration (Coyle, 2007; Willig, 2008). Firstly, idiography is concerned with in-depth and comprehensive analysis of the 'particular' (Smith, Flowers & Larkin, 2009, p. 29). Secondly, it comprehends phenomena through focusing on a particular type of person and context. IPA is well suited to my exploratory study of adult male experiences of IBS as it can engage with both descriptions of accounts as well as higher level interpretations of participant data (Storey, 2007).

To summarise, we can say IPA is positioned within critical realism and IPA has the principle theoretical underpinnings of phenomenology, hermeneutics and idiography (Smith, 2011). IPA strives to engage with the multiple aspects of lived experiences, including beliefs, motivations and behavioural manifestations (Eatough & Smith, 2008). This has particular relevance for my study objectives to engage with experiences of having and making sense of IBS and also behaviourally managing and seeking help for the condition. IPA is suited to exploring experiences of illness and 'bodily feelings' (Eatough & Smith, 2008, p. 186). This is relevant as difficulties with physical IBS symptoms were highlighted in existing IBS research and could emerge through the strongly experiential focus of IPA.

Smith and Eatough (2007) argue that IPA can have both empathic and critical elements in its approach. The empathic focus stems from researcher efforts to closely access the perspectives and perceptions of the participant. The critical aspect strives to step back and be more objective, asking questions of the participant's perceptions and experiences. In some ways this is reminiscent of the Counselling Psychology ethos of embracing phenomenological

understanding of what it is to be a human being alongside a more objective view through a scientific, evidence-based lens (Orlans, 2012). [1]

4.3 Design

A qualitative, IPA approach was selected for this study of adult male experiences of having IBS. Semi-structured interviews were carried out to construct narratives of participants' experiences. IPA was used for analysing the interview data drawing upon the epistemological position of phenomenology. IPA tries to examine subjective lived experience of the person, the world around them and the meanings their experiences have for them (Smith & Eatough, 2007; Smith, Flowers & Larkin, 2009). It is proposed that by using open questions that are non-directive this permits the participant to express their personal experiences in relation to the study focus (Willig, 2008). Semi-structured interviews (with open questions) are encouraged use with IPA as this permits use of specific questions or prompts to facilitate opportunity for optimum elaboration in participant answers (Smith & Eatough, 2012; Smith & Osborn, 2008; Willig, 2008).

There is more need to bracket researcher presuppositions at the research stages prior to analysis (Smith, Flowers & Larkin, 2009). Whereas, during analysis the researcher is an active, dynamic participant in this research process and the creation of the findings (Smith & Eatough, 2007, 2012).

4.4 Participants

The participants were outpatients recruited from a department of gastroenterology at a major hospital in the greater London area. A summary of participant demographics is presented below in Table 1.

[1] Text has changed from the third to the first person perspective as sections 4.1 and 4.2 concern the researcher's reflexivity.

Table 1. Summary of participant demographics

Participant	Age	Years with IBS symptoms (approx.)	Experience of counselling/ therapy	Organic co-morbidity
Keith	32	7	No	n/a
Eric	35	14	Yes	n/a
Jeff	35	15	Yes	Ankylosing Spondylitis
Dave	35	4	No	Ankylosing Spondylitis, Asthma
Rob	24	20	No	n/a
Eddie	47	7	No	n/a

Participants that took part satisfied the following inclusion criteria:

- Working diagnosis of IBS (ascertained by gastroenterologist)
- Endorse Rome II criteria for IBS diagnosis (ascertained by researcher)
- Male
- British
- Caucasian (later expanded to include all racial and ethnic groups)
- Between 20-39 years (later expanded to 20-59 years)
- Living in the London area

Participants would have been excluded from taking part if:

- They were having counselling/ therapy at the time of recruitment or during the previous six months.
- They had a long history of serious mental illness.
- They did not have a good understanding of written and verbal English language.

The inclusion criteria targeted a fairly homogenous sample for the practical purposes of recruitment (Smith & Eatough, 2012; Smith, Flowers & Larkin, 2009). IBS diagnosis using Rome II diagnostic criteria (Thompson et al., 1999) is commonly endorsed in the UK. The participants used in this study could all be said to have diarrhoea-predominent IBS. It is proposed a sample of six participants is an adequate number of participants to use in a professional

doctorate study (Smith, Flowers & Larkin, 2009). Smith and Osborn (2008) support this sample size to extract a sufficient range of similar and differing themes from analysis without running the risk of becoming flooded with data.

IBS studies that reported race/ ethnicity statistics stated 90-95% of participants were Caucasian (Keefer et al., 2005; Lackner & Quigley, 2005). Hence, this study originally aimed to recruit only Caucasian men for the purposes of homogeneity and for comparing findings with existing research. IBS is considered most prevalent for people in their 20's and 30's (Spiller et al., 2007). Therefore, for practical purposes participants in this age range were originally targeted to maximise chance of successful recruitment and establish a fairly homogenous sample.

4.5 Apparatus/ materials

Several study documents were drafted for the purposes of this study:

- Participant Recruitment Letter
- Participant Information Sheet
- Participant Consent Form
- Interview Schedule
- Distress Protocol
- Participant Debrief Sheet

It is recommended that IPA studies use between 6-10 questions for semi-structured interviews with adult participants (Smith, Flowers & Larkin, 2009). The interview schedule (Appendix 4) for this study consisted of 8 questions. The interview schedule was designed with reference to guidelines suggested by Smith, Flowers and Larkin (2009) and Kvale (1996):

(1) It addresses the research question - Interview questions related to the research question and addressed the three study objective areas (see section

3.6). The research question was derived in relation to existing IBS research and focused on addressing current gaps in research.

(2) It is grounded within the chosen epistemology/ methodology - Interview questions were crafted to be open, exploratory, and facilitate comprehension of experience and meaning-making (which fits with their phenomenological and hermeneutic underpinnings/ IPA framework).

(3) The interview questions are of an appropriate type - The interview schedule comprised of a combination of descriptive and evaluative interview questions that were considered most appropriate for generating good data which addressed the study objectives. Descriptive questions tried to elicit answers that embraced experience and opened up and shed light on the life worlds of interviewees. Evaluative questions had a more analytical emphasis on gaining knowledge about experiences. For example, an evaluative question was ‘How do you feel about seeking help for IBS?’ Prompts were included to address any difficulties answering questions.

(4) The interview questions are arranged with a purpose - Questions were logically and sequentially arranged to permit exploration of participant views. The interview schedule design aimed to achieve comfortable, dynamic interaction and rapport with interviewees and invite elaborate responses. The interview process commenced with a descriptive question that was considered easy to answer. Evaluative questions were generally delivered later during interviews. Descriptive or evaluative questions that addressed potentially sensitive topic areas (e.g., regarding IBS coping or help seeking) were presented later during interviews. It was assumed that participants would feel more confident answering more abstract or sensitive questions once they had settled into the interview process.

A digital voice recorder was used to record the participant interviews. Analysis of the raw data and the project write up was completed on the researcher’s home computer which was password protected. Each participant undergoing interview received one £10 retail voucher for taking part in the study.

4.6 Procedure

One semi-structured interview using open questions was conducted with each participant producing personal narratives of their experiences with IBS (Smith, Flowers & Larkin, 2009). Interviews (with 6 participants) lasted approximately 45 minutes each. Semi-structured interviews presented prepared questions to participants and provided flexibility and time to explore answers to optimise subjective understandings.

Potential participants (satisfying inclusion criteria) were identified by direct care team clinicians working in the hospital dietician clinics by examining patient clinical records. Suitable participants were initially approached by clinician staff for potential recruitment by telephone, email or in person. The clinicians presented my recruitment letter (Appendix 1) which outlined the nature of the study and what taking part entailed. Potential participants interested in taking part in the study permitted the clinician to forward on their name and contact details to the researcher.

Potential participants were then contacted by the researcher to confirm their inclusion suitability. Participants were then provided with an information sheet (Appendix 2) outlining the nature of the study asked if they have any questions regarding the study. Participants were provided with a consent form (Appendix 3) and given adequate time (at least 24 hours) to consider providing their signed consent for participation. A convenient interview date and time was set for participants. Interviews took place in a secure hospital room free from interruptions. The researcher read his personal reflexive statement (Etherington, 2004) prior to participant interviews to protect against potential interviewer bias.

Before commencing interviews participants were given further opportunity to ask any questions. A pilot interview was used to gauge the appropriateness of the interview questions/ procedure and following this it was judged no amendments were needed. The same interview schedule was followed for all interviews although the order of the questions differed for some participants to

aid flexibility. A distress protocol (Appendix 5) was outlined to follow if distress became evident during the interview process.

Participants were debriefed after interview and provided with the opportunity to ask questions or discuss any thoughts or feelings that may have emerged following the interview. A debrief sheet (Appendix 6) was provided to all participants post-interview which included information of services providing further information/ support if needed. Recorded interviews were transcribed for analysis.

It was later necessary to expand the participant inclusion criteria to complete recruitment of the required six participants. The changes permitted the recruitment of potential participants from all ethnic and racial groups (previously only Caucasian participants were considered) and expansion of the age inclusion range to 20-59 years (previously 20-39 years).

To protect against researcher bias and enhance critical reflexivity (Lee, 2009) the researcher kept a journal recording personal thoughts, experiences, decision-making over the course of the study (Appendix 7).

4.7 Ethical issues

As an ethical consideration for this study the participant inclusion criteria endeavoured to only use participants that were sufficiently robust from a psychological perspective. Selected participants have not been in counselling/ psychotherapy for psychological difficulties for at least six months and had no history of serious mental health problems. The direct care team introduced potential participants to the researcher. This served a gate-keeping function, preventing undue coercion to take part and only basic participant contact details and demographic information was forwarded.

No participant experienced high levels of distress during the study. Participants were informed they did not have to answer any interview

questions perceived as difficult. If a participant had shown signs of distress, the interviewer was a Trainee Counselling Psychologist and has experience responding to distressed individuals. A distress protocol was outlined (but not needed).

Information gathered from participant interviews was treated as confidential by the researcher. Identifying details were removed from the interview recording and replaced with pseudonyms in the interview transcript and study write up. Identifying personal details were stored separately and securely. Academic supervisors and study markers only had access to anonymised interview transcripts and audio recordings. The audio recordings of interviews will be destroyed after marking. Exceptions to maintaining confidentiality were stipulated should a participant reveal information during the interview process pertaining to criminal activities, or a plan to harm the self or others. No such exceptions occurred.

Post interview, participants were given a debrief sheet outlining further information/ support services. The information sheet lists contact details of my supervisor/ hospital complaints office should a participant have wished to complain. This study received ethical approval for managing the potential risks of conducting this study from the Research Ethics Review Panel (RERP), London Metropolitan University. Ethical approval (including proposed protocol amendments) was also received from the National Research Ethics Service (NRES) Committee East Midlands – Derby 1 (Appendix 8a & 8b) and the academic supervisor. An honorary contract (Appendix 9a) to conduct research at the collaborating hospital was obtained and later a contract extension (Appendix 9b).

4.8 Method of analysis

The process of using IPA began with coding each interview transcript along the left-hand margin with numbers ascending from one through until the end of the transcript. This functions to locate participant extracts that emerged

during analysis for the construction of themes. Before analysing each transcript the researcher reviewed his personal reflexive statement to recall his subjective presuppositions and promote reflexivity. Also, during analysis the researcher referred to his reflexive journal (kept throughout this study) recording thoughts and ideas.

The first interview transcript was read several times to familiarise the researcher with the participant and gain a increasingly clearer idea of what the material is about (Smith, Flowers & Larkin, 2009; Willig, 2013). This iterative process helped identify transcript sections that were particularly rich and of interest. During each reading the researcher recorded notes in the right-hand margin relating to three distinct processes (Smith, Flowers & Larkin, 2009): (a) descriptive information relating to spoken content and subject matter; (b) linguistic comments concerning use of language; (c) conceptual comments aiming to interrogate the data and gain a higher level conceptual understanding. The aim was to carry out a thorough analysis of the transcript (Smith, Flowers & Larkin, 2009). These notes were consolidated to help construct sub-ordinate themes recorded in the left-hand margin (Smith, Flowers & Larkin, 2009; Willig, 2013). Sub-ordinate themes deduce inherent meanings from the transcript at an interpretative level more sophisticated than the level than initial notes (Smith & Osborn, 2008). Emergent sub-ordinate theme labels aimed to be ‘conceptual’ and have an ‘experiential quality’ in their description (Willig, 2013, p. 88).

The same analysis process was followed for all subsequent transcripts. Efforts were made to consider each transcript on an individual basis to facilitate new themes to emerge with each transcript (Smith, Flowers & Larkin, 2009). Hence, there was need to bracket themes and thinking from previously analysed transcripts to support the idiographic focus of IPA (Smith, Flowers & Larkin, 2009). Sub-ordinate themes had titles that best captured their description or used participant quotations (Willig, 2013). The researcher then interpreted which sub-ordinate themes clustered together to form what became super-ordinate themes (Smith, Flowers & Larkin, 2009; Willig, 2013). See section 5.1 for a full account of how themes were structured.

4.9 Validity and quality in IPA

Validity and quality criteria are important when assessing how well an IPA study has been carried out and assessing the strength of findings (Smith, 2011). Validity and quality are associated concepts that will be discussed in turn.

Validity in qualitative research exhibits that the study was designed and conducted in a rigorous and trustworthy manner (Yardley, 2008). Qualitative research strives to recognise and embrace researcher contributions which form an integrative part of the findings. For the purposes of validity and ensuring the accuracy of findings this study adhered to the four central validity principles proposed by Yardley (2008):

(1) Sensitivity to context – The research gap emerged following contextual comparison with relevant existing IBS literature using a Counselling Psychology perspective. Interviews employed open questions to facilitate sufficient elaboration of participant experiences. Bracketing presuppositions helped protect against biased interview design/ delivery. This was particularly relevant as the study held associations with the researcher's personal experiences with IBS. The researcher held similar demographics to the sample participants.

Interview questions were redrafted in supervision, giving careful attention to wording and phrasing to help reduce possibility of researcher bias (Smith, Flowers & Larkin, 2009). The researcher tried not to present questions/ conduct interviews in a way that aimed to gain responses that reflected the researcher's personal experiences. Reflexivity was also required when interpreting data so not to generate findings that in a biased way reflected the researcher's own experiences.

(2) Commitment and rigour – The researcher has enduring experience and personal understanding of IBS which helped him engage with and interrogate participant data. The researcher made efforts to consult up-to-date references

on IPA theory and practice to enhance reflexive understanding of the approach and ensure quality of analysis. Study findings were grounded among relevant research/ literature.

(3) Coherence and transparency – The researcher tried to remain reflexive throughout the study to aid transparency and protect against bias. A discussion of epistemological reflexivity provided a rationale for the adopted design and methodology to address the research question. Salient quotes from the transcripts demonstrated coherence and the origin of interpretations. During analysis efforts were made check that interpretations and emergent themes were grounded in the data.

An example annotated participant interview transcript (Appendix 10) and master theme table (Appendix 11) demonstrated transparency and origin of quotations and themes. A cross case master theme table (Appendix 12) provided evidence via quotation extracts for all participants and all themes. The analysis chapter was reviewed by a research assistant who had experience conducting IPA research in psychology at Master's degree level. The research assistant had access to the personal reflexive statement, the analysis chapter and the participant interview transcripts. The research assistant was asked to check that emergent themes were grounded in the transcript data and not the result of biased interpretations from the researcher.

(4) Impact and importance – By discussing research findings against existing research and literature this helped to identify new findings and implications for Counselling Psychology. Suggestions were made for enhancing current therapeutic methods and for Counselling Psychologists working with this client group.

Smith (2011) highlighted need for specific criteria for assessing quality in IPA studies. Smith developed his criteria following careful evaluation of the existing corpus of published IPA research papers that addressed patient illness experiences. Hence, these criteria have particular relevance for this study of individual's experiences of having IBS. This study tried to ensure

quality in designing and carrying out this IPA study by adhering to seven criteria areas outlined by Smith (2011):

(1) The paper should have a clear focus – The study focused on an identified IBS research gap. This study specifically studied adult male experiences of having, managing and receiving help for IBS.

(2) The paper will have strong data – The interview schedule was used in a flexible way to explore novel or important issues that emerged during interviews and to encourage elaborate responses and result in rich data (Smith & Eatough, 2012; Smith, Flowers & Larkin, 2009). For example, gentle probing and encouragement helped access Eddie's nuanced concerns about disclosing IBS and his highlighted humiliation (894-908).

(3) The paper should be rigorous – All sub-ordinate themes were strongly evidenced using extracts from four to five participants. Guidelines suggest using at least three participant extracts per theme for a sample of six (Smith, 2011). Prevalence was highlighted in the analysis of each theme and transparent in the cross case master theme table (Appendix 12). The abundance of good data permitted careful selection of extracts to highlight convergence, divergence, depth and variation inherent to all themes. The analysis highlighted the rich individual contributions and variations within themes along with the compelling similarities shared between participants. There was explicit effort to highlight representativeness in themes. For example, for the sub-ordinate theme 'restriction, loss and identity' the restricted ability to engage with activities was a key aspect represented across all participants. Also, three participants in this theme highlighted their specific fear of becoming a 'recluse' with IBS. The study used proportionate sampling of participant extracts for themes throughout the analysis.

(4) Sufficient space must be given to the elaboration of each theme – Efforts were made to give justice to and fully elaborate themes. Extended space for provided to develop the analysis of particularly rich and insightful themes that emerged from the data. For example, the sub-ordinate theme 'It's weird this

whole IBS thing' had an extensive discussion of the various facets around the perceived weirdness and ambiguity of IBS.

(5) The analysis should be interpretative not just descriptive – An interpretative commentary followed each extract capturing participants' unique contribution to the development and presentation of each theme. Detailed interpretations of the data helped capture the subtleties of participants' accounts and efforts of meaning-making. Sustained efforts were made to exhibit the three levels of interpretation that are possible with IPA (Smith, 2004). Smith considers the first level of interpretation to be social comparison. For example, interpretations revealed Rob (1408-1417) held negative comparisons with friends and held concerns about appearing weak and potentially incurring social rejection. The second level of interpretation concerned use of metaphor. For example, Keith (132-139) used the word 'trudge' which metaphorically interprets his laboured, ebbing battle with IBS. Efforts were made to pursue the third level of interpretation and interpret participants' identity/ sense of self issues. For example, interpretations revealed that Eric's (201-214) enduring experience with IBS was eroding his pre-illness identity. Smith (2004) suggests student IPA projects should attempt interpretative analysis at the level of social comparison and if possible at the level of metaphor. However, in this study the researcher made rigorous efforts (where possible) to push analysis to the third level of interpretation.

(6) The analysis should be pointing to both convergence and divergence – Efforts were made to illustrate convergence and divergence between participants across all themes. For example, in the subordinate theme 'unpredictability and the struggle to control IBS' convergence emerged (for Jeff, Eddie and Rob) through interpretations bearing similarity with vulnerability, powerlessness and perceived lack of control over IBS symptoms. However, divergence was highlighted (within the same theme) by Eric (791-799) which through nuanced interpretation captured his urge to sever his emotional responses to his condition to pursue experiential relief.

The richness of the data permitted interpretation of the unique ways in which participants experienced and related to their condition. For example, Dave held a unique and recurrent concern with how bloating was affecting his desired self image. Rob's strong, distinctive tendency for critical, polarised thinking about IBS and IBS experience stretched across his analysis.

(7) The paper needs to be carefully written – Repeated efforts were made to draft and refine the paper. The detailed, evolving narrative traced the disempowering and compromising impact IBS had on participants and illustrated the challenges IBS presented for sustaining pre-illness identities. The analysis embraced the subjective difficulties of figuring out what to do about IBS, if anything, along with emotional upheaval this brought at times. The analysis tried to capture nuanced efforts to comprehend, adapt and come to terms with IBS and the extent to which individual participants achieved this.

5.0 ANALYSIS

5.1 Overview

After analysing all transcripts the emergent sub-ordinate themes were recorded chronologically on paper, in the order in which they were identified. Initially over one hundred sub-ordinate themes emerged. The list was then scrutinised, moving themes around mentally to help establish which themes gravitated towards each other (Smith, Flowers & Larkin, 2009). Efforts were made to structure and create links between emergent themes to highlight the most intriguing and important findings from the analysis. Sub-ordinate themes that were poorly evidenced were excluded from further consideration (Smith & Eatough, 2012).

The three super-ordinate themes and their constituent sub-ordinate themes that emerged following analysis of participant transcripts are presented in Table 1.

Table 1. Super-ordinate themes and constituent sub-ordinate themes.

Super-ordinate themes	**Sub-ordinate themes**
IBS consumes and compromises me	Cognitive preoccupation
	Restriction, loss and identity
	IBS threatens my relationships!
Responding to my condition	Unpredictability and the struggle to control IBS
	'I didn't see the point'
	Can you recognise and meet my needs?
Coming to terms with IBS my way	'It's weird this whole IBS thing'
	Dilemmas accepting and adapting to IBS as something given
	Concealment and negotiating disclosure of IBS

In trying to structure themes the researcher repeatedly checked that themes were emerging from the data (Willig, 2013). Abstraction, function and numeration techniques were deemed most appropriate for this data to establish connections between themes (Smith, Flowers & Larkin, 2009). Abstraction was involved in the construction of the first super-ordinate theme. Abstraction puts 'like for like' sub-ordinate themes together and establishes a new name for the cluster/ super-ordinate theme (p. 96). 'Cognitive preoccupation', 'restriction, loss and identity' and 'IBS threatens my relationships' were grouped together as they embrace the consuming and compromising impact of having IBS. For the second super-ordinate theme the sub-ordinate themes cluster together based on their specific function when 'responding to my condition'. Function was also the basis for constructing the third super-ordinate theme. Additionally, numeration served to select the most salient themes that were well grounded in evidence. Super-ordinate themes were given names that best embraced their 'essence' (Willig, 2013, p. 88). To try and establish links between sub-ordinate themes across cases some theme names were reconfigured or relabelled (Smith, Flowers & Larkin, 2009). Efforts were made to interpret evolving participant narratives along with cross case comparisons of similarity and difference in themes.

Each super-ordinate theme will be discussed in turn. This will involve analysing each constituent sub-ordinate theme belonging to each super-ordinate theme sequentially. By analysing the evidence for each sub-ordinate theme based on selected participant extracts this will help reveal the range of views that emerged between participants and contexts. A key for interpreting interview transcript annotations and omissions follows below.

5.2 Key

"..." denotes a pause in speech of about 1 second.
"….." denotes a pause in speech of about 2 seconds.
"[long pause]" denotes a pause in speech of about 5 seconds.
"[]" denotes the emission of minimal encourager by the interviewer.

"[laughs]" denotes laughter.
(Eddie, 234-235) denotes an example transcript extract. The participant's name precedes the transcript line location.

5.3 Super-ordinate theme 1: IBS consumes and compromises me

This super-ordinate theme brought to light the intrusive impact and consequences of having IBS. IBS appeared to have an occupying, consuming presence which compromised the vitality of participants' lives in many ways. The initial sub-ordinate theme embraced participant experiences forming cognitive preoccupations with IBS associated with a range of negative emotions. The second sub-ordinate theme encapsulates the restrictions and loss IBS imposed on participants' ability to embrace activities along with challenges to identity. The final sub-ordinate theme concerned the threat IBS presented towards managing and sustaining personal relationships.

5.3.1 Sub-ordinate theme A: Cognitive preoccupation

All participants indicated forming cognitive preoccupations with their physiological symptoms as a consequence of having IBS. These seemingly involuntary cognitive preoccupations and increased attention to gut symptoms varied between participants but commonly were perceived as intolerable or threatening. Participants tried to seek relief from their negative emotional experiences associated with preoccupation through practical or psychological means.

In the first extract Dave's distress was associated with his preoccupation about his stomach's bloated appearance.

I always, I used to notice it when I went into bed because I'm basically taking off my shirt I'd see this bloated stomach and then I'd try and burp. [] So it's almost more that I could see it, wanna get rid of it. [] But actually after a while

because it was distressing me quite a lot. It was, I'd almost forget about it. I'd take my shirt off and go straight to bed (Dave, 762-772).

Dave seemed to appraise his appearance as intolerable or revolting. Dave appeared to be trying to obliterate the bloating (from sight and mind) perhaps to help manage his apparent intolerance, anxiety and shame. Dave's externally-orientated use of language suggests his bloating seems strange or alien to him ('this bloated stomach', 'it'). Consequently, Dave seems eager to reject or annex this part of him perhaps to protect an unsullied, more attractive self image. His urge to 'forget' (and/or sleep) seems akin to denying or pushing his bloating preoccupation outside of conscious awareness to try to diminish his emotional distress.

Eddie's sense of preoccupation was highlighted by a loss of practical and cognitive functioning which seemed intrusive, intolerable and inescapable.

Well the biggest effect for that is err… it definitely effects my mood. [] I get… down. [] And erm… I get more irritable… more likely to lose my temper. I can't, I try to carry on doing all the things that I do and I find everything quite difficult. Like decision making… [] I find it. I get really fuzzy in the head and can't…make decisions (Eddie, 352-363).

Like Dave, he seemed motivated to avoid dealing with his psychological difficulties. Eddie's preoccupation held connotations with being a cognitive fog that descended on him, obscuring his clarity and ability to function. His disabling experience perhaps threatened an inherent masculine identity which values ability to manage one's problems. His urge to vent irritation perhaps represented a ploy to empower himself and escape feelings of helplessness and low mood.

Similar to Eddie, Eric's preoccupation with physical distress was associated with significant impaired cognitive ability.

And even when you're not going to the bathroom, bathroom you're in absolute… agony in the gut area. And it makes it very, very hard to concentrate on anything else. [] Importantly during the day to day job and also… just to feel positive. [] and feel well about anything [breaths in sharply]. [] It's just a constantly erm…. corrosive condition [] of the mind (Eric, 165-179).

However, for Eric there was a particularly strong sense of what IBS has taken away, such as the ability to sustain 'positive' emotions and concentration. He seems left with a compromised sense of agency and a simmering frustration, despondency and sense of powerlessness. His use of the word 'corrosive' conveys psychological debilitation as if preoccupation with IBS was grinding away and weakening his psychological resolve to cope. His enduring experience with IBS perhaps was eroding his sense of identity which was slowly being replaced by an encroaching illness identity.

Rob's preoccupation seemed all consuming and closely associated with his appraisal of being in a 'bad' illness state.

If I'm in a particularly bad sort of… way. And then I'll constantly be thinking about it. So…[] I'll be thinking… this might sound crazy but I, I might be thinking I'm on a tube and I'm feeling really bad. [] And I'll be thinking… can I make it to the, where I'm going or do I need to get off? [] I'm constantly thinking about that (Rob, 677-686).

Rob seemed eager to manoeuvre away from his perceived vulnerability coping with his condition. Use of the word 'crazy' suggests concern that others may view his anxiety and worry as dysfunctional, strange or might question the realness of his condition and concerns. Rob seems somewhat lost in his own head. Perhaps his appraisal of 'crazy' thinking suggests he himself doubts the validity, clarity or direction of his thinking.

Finally, Keith's preoccupation conveyed an insecure, almost persecutory relationship with IBS.

Five day working week. And you have a… three good days on the trot. [] And you find yourself… kind of lulled into a false sense of security. And these, these, you can easily wake up on the Thursday having done everything… that you've done the… all week. The same. [] And suddenly think, oh…you know? And… then it kind of scares you backward a step so then the Friday you are even more… [] aware and cautious and guarded and even into the weekend (Keith, 524-537).

Keith seems to perceive a threat of being swept away by symptom exacerbation. Perhaps he perceives symptom monitoring and preoccupation to provide a degree of safety with his condition. Similar to other participants his body seems to have a sense of agency outside of his influence or control. The 'false sense of security' perhaps alludes to distrust of his own mind and judgement about managing IBS. Keith seems to retreat into a defended, anxiety state associated with resumed cognitive preoccupation.

All participants exhibited tendencies for experiencing involuntary cognitive preoccupation with gastrointestinal symptoms associated with a range of negative emotions (irritation, intolerance to anxiety and low mood). Participants in varying ways strived to manoeuvre away from their emotional and physical discomfort to pursue relief. Cognitive preoccupation was often associated with powerlessness and helplessness. Enduring experience of IBS seemed to challenge established identities. Some participants seemed to develop distrustful relationships with physical symptoms and their own bodies.

5.3.2 Sub-ordinate theme B: Restriction, loss and identity

All participants associated IBS with the restricted ability to engage with activities along with perceptions of incurred loss. IBS seemed to have the capacity to sully many areas of their lives, compromising opportunities for self-nurture and realising positive emotions. Enduring experience of restricted living seemed to challenge pre-illness identities.

Eric's extract captured restriction and compromised motivation for activity when IBS was bad.

And then you eat or drink something that's gonna set it off because you can't really avoid it in those situations. [] You… it becomes almost a self-fulfilling prophecy. And then you end up with the symptoms after not too long which kind of ruins the event. [] And does put you off going to [] wanting to go out and do anything. You know? Other further socialising. You have to sort of force yourself to [] not become a bit of a recluse with it really (Eric, 201-214).

Eric's experience seems one of powerlessness and a growing despondency with symptom exacerbation. Eric struggles to freely engage with activities and extract emotional nurture from them. The word 'ruin', similar to the word 'corrosive' used in his previous extract provides further evidence of Eric's perception of IBS as a chronic, decaying condition and how this may be becoming assimilated within his identity. Eric (along with Keith and Jeff) held specific concern about becoming a 'recluse' with IBS. 'Recluse' (in this context) holds connotations with becoming an outcast, feeling pushed by illness experience further into isolation and potentially fuelling preoccupation with IBS.

Jeff's extract depicted invasive symptom exacerbation and the need to monitor his consumption.

I can't drink because of my stomach. [] And it's not just, it makes my stomach worse. It makes my bowels worse as well. Anything that's inside me… it's gonna make that hurry up. If you know what I mean? My stomach and bowel flares up. [] So I don't wanna go out drinkin'. I don't wanna go… [] out for something to eat. Do you know what I mean? That's mainly what people do with their social life innit? (Jeff, 406-419).

There seems an ebbing sense of unfairness, missing out, and frustrated ability to embrace normal freedoms. Perhaps Jeff's restricted ability to engage in social eating and drinking was hampering his ability to nurture a masculine

identity, through bonding with others and particularly other men. Jeff's restriction and experiences of loss seem to have left him with a perception of being different, separate from others and perhaps alludes to a depleted sense of self. Jeff was keen to ensure I understood him which suggests need to have his reality with IBS validated by others.

In a similar vain to Jeff, Keith reflected on loss and restricted ability to nurture a masculine identity through social activities as a young man.

I was young [] I should have been going out to the pub and, and I like going out to, to gigs and that as it was… it should have been…[] kind of easy but it just became a kind of trudge… (Keith, 132-139).

His 'trudge' experience suggests a frustrating, laboured effort and a consuming sense of inertia. Keith seems angry and struggling to accept what life with IBS withheld from him. Indeed, Keith reflects that life 'should have' been easy but perhaps this more accurately refers to a pre-illness capability unhampered by IBS. His extract leaves a sense of injustice, condemnation and mourning the loss of what could have been, of being able to embrace the freedoms of his youth.

Several participants emphasised struggle engaging with work when ill with IBS. Eddie highlighted the value he placed on his ability to succeed at work on several occasions.

I would… just… get through the day. [] I wouldn't excel at anything [laughs] (Eddie, 433-435).

Because you're not really…. you're really able to sort of… sparkle [laughs] (Eddie, 544-545).

Eddie suggested he led an impoverished, joyless and handicapped existence working while struggling to cope with IBS. The terms 'excel' and 'sparkle' perhaps exemplify excellent, special achievement or value. Perhaps Eddie

was trying to display his strengths, to stand out and gain praise and validation. IBS seems to be restricting and frustrating his ability to nurture his self-esteem through performance and perhaps threatens his construction of a masculine identity.

Across participants IBS seemed to compromise many facets of their day-to-day lives, eroding motivation to remain active and promoted isolating behaviours. Enduring experience of restriction and loss brought a sense of defeatism and likely challenged personal identities over time. Failure to remain active in the face of illness may have been perceived as emasculating, weak and could have threatened self-esteem. There was a general struggle across participants to facilitate and realise positive emotional experiences while enduring the intrusive restrictions of IBS.

5.3.3 Sub-ordinate theme C: IBS threatens my relationships!

For all participants IBS threatened ability to engage in, negotiate and maintain personal relationships. The type of personal relationship and context varied between participants. Concerns about relationships and social identities were often associated with anxiety, frustration and ebbing despondency.

Dave reflected on the tension and threat passing wind (to eradicate bloating) placed on his marriage.

Particularly when I'm in bed and I fart. She finds that really unpleasant and she'll give me a kind of slap around the head [shared laughter]. Erm… and that's probably one thing I've noticed a little bit more. I have to be slightly more conscious about that (Dave, 348-352).

Initially he seemed to try and laugh off the punitive consequences of farting perhaps to minimise perceived threat to his relationship. His implied ritual farting in bed could be a masculine behaviour, an act of deliberate risk taking. However, farting may potentially be hampering possibilities for romantic

intimacy. After his initial humour he begins to speak in a more serious, concerned tone which perhaps emphasises recognition of the strain his actions were placing on his relationship.

By contrast, Eddie struggled to engage with others and communicate when feeling ill which seemingly tested the robustness of his personal relationships.

So… personal, personal relationships do suffer and I… to help with the children. That suffers as well. The thing that I, I tended to do in the end… is erm… I wear a top with a hood on it. And if I've got my hood up… [] that means… I'm not really gonna answer … any questions. [] I know this sounds really self-indulgent and awful. But it's all, it's… it's like… almost beyond…it was beyond me…to you know? If somebody asked me a question it would be like…well [sighs]… I don't know? (Eddie, 365-376).

Eddie suggested IBS frustrates him and fosters guilt about his ability to maintain his duties and identity as a father and husband. Wearing the 'hood' may be an attempt to hide, or shield himself from difficulties with communication and perceived pressure to respond. Perhaps he was ashamed at being disabled, or emasculated by illness in this way. The term 'beyond me' perhaps highlights the extent of his perceived inability to communicate. His difficulties may have been construed as a flaw in his relational identity, placing strain on his relationships and isolating him with IBS.

Rob conveyed much anxiety about the disabling impact IBS had on his ability to maintain a desired social identity with friends.

My body is starting to give up. It's just like well…[] I felt …in that sense I felt, I felt rubbish. [] I'm not gonna be able to get the most out of this holiday. You know I'm gonna be a pain to everybody else… That's a lot…I'm more… I hate feeling like a burden on people. So I think that's one of the worst things really (Rob, 1408-1417).

Rob conveys a sense of powerlessness, defeat and an impoverished ability to embrace social freedoms. There seems a strong aversion to inconvenience others, to appear weak in managing his problems. Perhaps this compromises a desired masculine self image. The word 'rubbish' suggests worthlessness and provides increasing evidence of Rob's critical, polarised thinking about IBS. He may perceive he is being 'rubbish' by inconveniencing others with his condition. IBS seems to threaten the strength and security of his friendships. Perhaps he fears judgement, rejection or loss of these relationships. Fear of losing relationships and his body breaking down could represent deeper existential concerns about imposed isolation, annihilation and death.

Similar to Rob, Jeff seemed very concerned about his ability to maintain and potentially lose friendships.

They think that like I've got a problem with them… rather than it's my own personal problem. You know? [] I, it's got back to me from a coupla friends that saying like, ah, he never wants to come out with us. Or don't he like me? Or? [] You know? And it's not that all. [] So you get other crazy stuff going through your head (Jeff, 678-689).

Jeff seems worried and preoccupied that his friends have misconstrued his self-imposed removal from the social group (due to IBS). The words 'own personal problem' perhaps reflect an urge to hide IBS along with any potential shame this brings. Jeff appears isolated, vulnerable in his position outside the social group. IBS seems to compromise his ability to elicit nurture from interpersonal connections and secure his social identity. Jeff seems increasingly anxious and preoccupied with his 'crazy', disordered internal world. Perhaps 'crazy' refers to an evolving distrust of his mind, paranoia, or beginning to doubt the validity of his illness. Appraising one's self as 'crazy' or mad could highlight internalised stigma about having psychological difficulties.

Similarly to Jeff, Keith suggests lack of understanding about the impact and reality of having IBS can threaten his relationships.

So I sometimes felt that it was… [] erm… they, they didn't really understand… [] too well… even with, with this kind of Fodmaps diet thing. They try… but they… you know? I'm still and mum will say… do you want sugar in your tea or something and dad will say 'you can't have sugar'. Yeah, I can have sugar. [] But… he's kind of got it all twisted and, and back to front. So they try. [] But I think there's a gap there. I don't think probably anyone can really know just how bad it is unless they've… [] unless they've… been through it (Keith, 424-445).

Keith conveys a strong resignation about his parents' failed efforts to grasp his experience with IBS. His father can not physically see Keith's problem or appreciate where Keith's vulnerability lies. His father's confused comprehension seems to compromise the possibility of shared understanding about his IBS. The 'gap' in understanding conveys a sense of distance between them, a poor intersubjective connection which seems to leave Keith feeling annexed with his condition. His sense of isolation is reinforced by his appraisal that only subjective experience of IBS can facilitate real, authentic understanding of IBS and its severity for him.

There seemed to be a general struggle to find the resources to facilitate, nurture and maintain personal relationships alongside the demands of coping and living with IBS. Across participants there was pervasive suggestion of something having to give and illness challenging the stability of established personal relationship dynamics and preferred social identities. For most participants the struggle to achieve shared understanding, strain or fear of losing relationships presented a sense of unfairness, alienation and concern about becoming further isolated and taken over by IBS.

5.4 Super-ordinate theme 2: Responding to my condition

This theme addressed a general need for participants to respond to their condition and pursue relief. There was difficulty and doubt knowing how to best respond to IBS and gain some sense of control to counter pervasive

disempowerment. The first sub-ordinate theme concerned the unpredictability of exacerbating IBS symptoms and the struggle to find effective coping methods. The second sub-ordinate theme addressed dilemmas about reaching out for external help. The final sub-ordinate theme concerned health professional recognition and responses to subjective participant needs in treatment for IBS.

5.4.1 Sub-ordinate theme A: Unpredictability and the struggle to control IBS

All participants referred to times when symptoms seemed unpredictable or outside of their control. There was confusion around triggers and the manifestation of symptoms. Participants conveyed concern and struggled to logically manage IBS symptoms. For example, all participants referred to anxiety-laden experiences of urgently seeking out toilets when diarrhoea seemed imminent.

Jeff's experience conveyed powerless and ineffective coping in response to urgent and impending diarrhoea.

Like, I, they can't direct me to something cause I can't hold my toilet. It's that bad. [] You know it's not just diarrhoea. Ahhh, I'll go in a minute sort of thing. It's like [] It's there and then and you ain't got no chance. [] [laughs] so it's really embarrassing to be honest (Jeff, 142-148).

Jeff stated it was 'not just' diarrhoea perhaps to seek validation for the perceived seriousness and threat his condition brings, and also perhaps the ambiguity of his experience with diarrhoea. His appraisal that others could not assist him encapsulates the isolating and helpless nature of his experience. His extract suggests control over his bodily functioning can be ruthlessly taken away from him at times. His laughter may have been an attempt to make light of his futile efforts to cope with diarrhoea and diffuse embarrassment.

Jeff's experience was reactive to IBS. In contrast, many participants emphasised a need to plan ahead. For example, Eddie seemed to be trying to pre-empt and contain any exacerbating gastrointestinal symptoms.

I'm gonna do what I can do to get through this. You know? I'm not gonna… go out on a limb…[] So erm…so I was treading water for a while … (Eddie, 437-442).

He seems to be trying to survive an experience that was testing his available coping resources. Going 'out on a limb' and 'treading water' metaphorically suggest that overextending himself at work (when ill with IBS) is risky and presents a threat to perceived security. By holding back this seems to serve a protective function, or provides a sense of safety/ control over potentially exacerbating IBS symptoms and what this might mean for him.

Rob tried multiple coping approaches yet struggled to manage the intrusive development of IBS symptoms.

So it all sort of peaked at a time. [] Whereas, I was trying not to eat certain foods. And, and trying to be really good not drinking. All that sort of stuff. Increasing my exercise. [] Erm… it just worse and worse and worse [laughs]. [] So that's when you start doubting what people are telling you…you, you, I couldn't find… a pattern. I couldn't find… and it was really like… annoying me (Rob, 61-72).

Rob seems frustrated and helpless in controlling his symptoms as if they were exacerbating of their own accord. Rob (similar to Jeff) seemed bemused at the unfairness, futility and failure of his well-intentioned coping efforts. His struggle to logically cope with symptoms seems to be contributing to a growing sense of vulnerability with IBS. His doubt about received advice perhaps left him feeling increasingly isolated with IBS. Rob's use of the term 'really good' contrasts with the word 'rubbish' (theme 'IBS threatens my relationships') perhaps suggesting he appraises these kinds of experiences in polarised ways, reflecting the levels of distress they evoke.

Like Rob, Eric referred to efforts to apply logic to best cope with IBS.

If my response to the condition was gonna be like an android or... [] You know? Logically thinking robot rather than a complicated emotionally… you know? [] Difficult human being then…then perhaps…[] A whole, my own experience would be a lot easier (Eric, 791-799).

Eric struggled to meet perceived demand for very mechanical, emotionless ('robot') responses to coping which seemed fused with difficulties deciphering and managing his complex emotional life. Eric implies an urge to cut off his emotional responses to his condition and perhaps sabotage a significant aspect of what it is to be a human to achieve experiential relief. Eric's experience conveys pessimism, desperation and ongoing, unfair suffering with IBS.

Like other participants Keith's experience initially depicted an unfair struggle to manage the unpredictable triggering and manifestation of symptoms.

So I'm, I'm… more than happy to work really, really hard and… you know? And achieve a goal and put everything towards it. And then… [] the concept of unpredictability coming in and saying… doesn't matter how hard you work. Doesn't matter what you do. There will be a variable you've got no control over. Yeah, it was destabilising. [] And erm… when you feel like you've got a bit of that control back that's, that's kind of heartening that is…(Keith, 911-921).

IBS seemed to have the capacity to take on its own sense of agency and manifest independently of Keith, who felt like a passive host. His compromised ability to influence his physical symptoms suggested a disconnected, almost dissociative mind-body relationship. The uncontained 'variable' presents a threat that could create havoc at any time. His recognised lack of control perhaps compromised his ability to ground himself and quell his anxiety. However, in contrast with other participants Keith

conveys a greater shift towards empowerment, establishing more control and ability to manage his symptoms.

All participants expressed pervasive helplessness and vulnerability coping with exacerbating and unpredictable gastrointestinal symptoms. At worst, effective coping with IBS seemed beyond the realms human logic and control. For some participants IBS symptoms seemed to manifest of their own accord, appearing to take on their own agency and compromising sense of security. Enduring feelings of powerlessness seemed to contribute to growing despondency and futility about how to cope with IBS. However, Keith's experience illustrates how empowerment can emerge from developing an increased sense of efficacy to better control IBS symptoms.

5.4.2 Sub-ordinate theme B: 'I didn't see the point'

All participants struggled with individual dilemmas about reaching out for help from health professionals and what this might entail. These dilemmas seemed tied up with conflicts and tensions around what to do about IBS if anything. Some participants suggested having normalised distress with IBS over time which seemed to have informed help seeking attitudes.

Keith abruptly shifted emphasis to discuss self-management of symptoms. This may suggest a bias in his thinking and which allows him to relinquish his dilemma about reaching out for help.

So… [] the motivation to keep going was… was kind of lower… but erm…[] IBS it's… the, the fact that…in the very early days. They talked about a drug called Buscapan. [] And now you can pick it up off the shelf in saver centres. In Sainsbury and Tesco. [] You don't even have to ask for it over the counter. It's right there on the shelf. You know? [] That… that was the kind of cure all drug to begin with. [] Erm…so…you didn't have to ask for help (Keith, 711-728).

His emphasis on not having ‘to ask for help’ may suggest an aversion or fear of feeling shamed about asking for help. Possibly he did not recognise the value in asking for help or how others could help him. Getting drugs ‘off the shelf’ depicted ease of access and perhaps protects against exposing his condition to others. Keith’s urge to autonomously cope with symptoms and defend Buscapan’s effectiveness may also reflect perceived masculinity pressures to be self-reliant when managing one’s problems. Keith’s sense of apathy and efforts to avoid inconveniencing himself were a reoccurring theme across his analysis.

Eric’s dilemma is one of passively avoiding help seeking in preference of independent internet-based research into IBS.

And then I think… you know? I’ve gone through long periods of where I’ve just not bothered. But I didn’t see the point… in [] pushing it. [] Ah, of course in that time the internet has massively filled a huge gap in all of our medical knowledge (Eric, 624-631).

There is a profound mental blankness and ebbing despondency about seeking help. Eric seems emotionally cut-off from recollections of his experiences. His use of the term ‘pushing it’ implies a struggle to assertively pursue help as if there was an obstruction in his way. His struggle for motivation seemed coupled with downplaying (‘didn’t see the point’) the significance of his needs and difficulties. Eric alludes to having shifts in attitude about help seeking which suggests this is a dilemma that he revisits over time. His recognised lack of knowledge about IBS seems to have informed his passivity and sense of being unconvinced about help seeking. Eric’s preference for independently gaining internet-based knowledge could be viewed as a potentially non-shaming alternative to asking another person for help.

Jeff was caught in a similar dilemma to Eric about whether to remain passive or assertively push for treatment.

Sometimes maybe where I am used to things…[coughs]. I'm kind of… I don't push, push things as much as I maybe should. [] Don't know why? (Jeff, 1236-1240).

Jeff seemed bewildered and lacking awareness about his low motivation for needing help. His sense of helplessness and inertia may have been associated with normalising, or becoming resigned to having IBS. His mildly dissociative relationship with his IBS experiences perhaps was his only obvious means to psychologically cope with IBS.

Rob's dilemma was about passively accepting IBS or proactively seeking treatment.

Until I managed to come in here and actually do something [] pro-active about it. I think it, it needed to be really, really dramatic for me to even, for me to, to think that I needed to come in to… [] It had to be… because I've lived with it for so long. [] It just felt normal. [] So… it had to be something… that was really bad pain for long period of time before I would do anything about it… (Rob, 1019-1032).

Rob's dilemma seemed entwined with need to justify help seeking if his symptoms were sufficiently alarming and intrusive. Perhaps Rob feared appearing unmanly or weak in his inability to tolerate discomfort which may have compromised previous help seeking efforts. Perhaps in the past he felt there was little he or others could do about his IBS which would suggest having adopted an attitude of learned helplessness. Whereas, Jeff was outwardly critical of treatment Rob is self-critical about his own passivity. However, for both Jeff and Rob their critical attitudes may partly stem from the frustrations of living and coping with IBS. Rob seems conflicted about whether to normalise and accept helplessness with IBS, or to negotiate an escape from his plight by validating his needs and empowering himself through pro-activity.

Struggles to resolve help seeking dilemmas were highlighted by all participants and there was a recurring sense of helplessness with IBS. Eric's appraisal 'I didn't see the point' conveys the poor motivation and common efforts across participants to coolly downplay need to go beyond self-management and seek professional help for IBS. For many participants passive attitudes towards help seeking seemed associated with enduring experience with IBS and normalising having the condition. Normalising efforts seemed associated with degrees of learned helplessness with IBS which perhaps provided the most convenient and/or obvious means to cope with the anguish and suffering with experience of IBS. However, Rob recognised and validated his need for help with IBS which provided meaningful direction and helped alleviate his stuck predicament with IBS.

5.4.3 Sub-ordinate theme C: Can you recognise and meet my needs?

All participants highlighted varying levels of success trying to get their individual needs recognised and met in treatment with health professionals. Participant needs ranged from practical symptom management to emotional and relationship needs.

Dave seemed to be trying to getting his treatment needs met on his terms.

And if, I and I suppose if someone said the major thing that you can do about this stuff is change your diet I don't want to hear it [laughs]. Having said that, the irony was, the one thing she said was don't eat so much fruit in the morning. Erm… which I've done. Don't, I don't have a smoothie in the morning (Dave, 1092-1097).

Dave seems resistant to the notion that his IBS difficulties may be associated with his dietary choices. He suggests an urge to reject treatment advice and seems bothered by implications that he was not doing enough to help himself. Dave's unwillingness to sacrifice his dietary freedoms may have seemed unnecessary or unfair to him. However, his resistance could, in a way, be

reinforcing a sense of helplessness with IBS. Dave's partial and covert acceptance of advice ('don't have a smoothie') seems to have been taken retrospectively which perhaps does not outwardly display a strong need to accept help. His dismissive and somewhat combative stance could have been an effort to empower himself and escape vulnerability exposed on reaching out for help.

In comparison, Eric conveyed enduring disappointment trying to get his needs recognised and met in treatment which seemed to have engendered a simmering resentment.

Not, and then going to speak to doctors and GP's. Even today… still not really getting what I call… the very knowledgeable… even now… the particularly interested kind of response from the NHS. I think… it's always, I've always got the impression that… particularly for general practitioners that it's not something that you know an awful lot about (Eric, 66-73).

Eric seems to perceive a lack of interest to engage with him and his concerns as rejection, dismissal and not being adequately seen. Eric appears to question whether the health professionals themselves know what they are talking about. Treatment seems to have failed to provide convincing answers or a plan to tackle IBS which perhaps contributes to his sense of vulnerability with IBS. Perhaps Eric is implying IBS is too complicated for himself or the professionals to comprehend. There is a suggestion Eric believes he can not be helped which depicts him as a somewhat abandoned, isolated and despondent figure. Perhaps Eric's projected displeasure represents an effort to empower and defend himself in the face of disempowering treatment, illness and relationship experiences.

Jeff struggled to receive to validation and recognition that his IBS concerns and treatment needs were real.

You're thinkin' do they believe you? And…they think I'm making it up. [] Like… do, do you think you're trying to put it on to sound worse? You're thinking… you're over-thinking (Jeff, 889-893).

There is implied conflict between Jeff and his doctor around who, or what is responsible for Jeff's IBS difficulties. Perhaps Jeff construes blame for having IBS, or feels accused of inventing or exaggerating his difficulties. Jeff seems frustrated and anguished trying to communicate that IBS is something genuine, that acts upon him and which he struggles to have influence over. 'Over-thinking' seems to imply that his thinking is a liability in some way (similar to his past appraisals of having 'crazy' thoughts). Not being believed perhaps shifts the emphasis from IBS being a problem with real physiological symptoms towards primarily being a psychological problem, or an unreal creation of the mind.

In contrast, Eddie's dietician effectively recognised and met Eddie's needs for practical guidance on symptom management and provided understanding and validation of his experience with IBS.

And she, she talked me through everything and… pointed out where I was going wrong. Things that I excluded… she said no. She gave me a book with everything in it. [] It was all written there. So that was brilliant. She understood exactly what I was talking about as well and erm... (Eddie, 222-230).

Eddie emphasised the quality of effective communication and seems emotionally contained by the relational support. Perhaps receiving direction about past mistakes with IBS countered his uncertainties about what to do about IBS. Receiving the 'book' seemed to provide concrete guidance or something logical to rely on. In contrast previous participant extracts, Eddie seems more aware of the choices he is able to make to help himself.

Keith's emotional and relationship needs were of significant importance and were thoughtfully recognised and met by his GP.

He actually took the time to say… oh, that's not good. That's not right. Oh, no, no…[] ah… yeah. That's… clearly something wrong. Rather than just charging head strong, sorry head first into… [] Erm… the, the kind of… trying to fix it. So it, a real identification with, with the impact it was having. [] The kind then…showed the…bit of thought into, kind of…what he considered to help it rather than…just…[] take these pills and then those pills and then, then it's just a course of treatment (Keith, 667-681).

Keith appreciates his doctor's considerate efforts to validate his problem and empathise with his IBS experiences. His positive intersubjective connection with his doctor seems to embrace and contain a vulnerable part of Keith's self. This may allude to insecurity about extracting nurture from relationships and/ or past unmet relationship needs. Contrasting his positive, inclusive relationship experience with perceived impersonal ('head first', 'fix it') treatment Keith may highlight his preference for personal input and collaborative involvement with treatment. It seems more important for Keith to feel recognised and seen by his doctor rather than solved, processed or given practical guidance.

This theme highlighted the importance of health professionals recognising and responding to patients' subjective treatment and relationship needs. Needs ranged from very practical guidance, to feeling understood by health professionals and having their concerns validated as significant. Across participants there seemed to be implied vulnerability and discomfort engaging with professional help. Some men, more than others seemed to have difficulty communicating and extracting what they needed from treatment. Engaging with help seeking seemed disempowering for some participants and perhaps threatened self-reliant masculine identities. Emotional containment in relationships seems particularly important given the pervasive vulnerability participants have expressed about having IBS echoed across their analyses.

5.5 Super-ordinate theme 3: Coming to terms with IBS my way

This theme emphasised participants' efforts of meaning-making to subjectively come to terms with their condition. The first sub-ordinate theme concerned efforts to comprehend the weird and ambiguous aspects of having IBS. The second sub-ordinate theme concerned the dilemmas and issues accepting and adapting to life with IBS. The final sub-ordinate theme concerned coming to terms with disclosure of IBS.

5.5.1 Sub-ordinate theme A: 'It's weird this whole IBS thing'

All participants struggled to comprehend the ambiguity and weirdness of IBS. Participants often focused on IBS presentation and/ or cause to strive to make sense of their condition and feel more at ease and less bewildered with IBS.

'It's weird this whole IBS thing' was how Jeff described his general confusion and suspicion comprehending the dynamic change in his symptoms.

Yeah, well… because it's weird this whole IBS thing. Because my symptoms have changed. Changed. [] I just think. How, how can you say it's like the same thing? [] You know? Maybe I've got another problem somewhere (Jeff, 1041-1048).

Maybe IBS seems weird to Jeff because IBS seems to be occupying his body and manifesting of its own accord. IBS seems like an affliction to Jeff, with its own nature that he feels helpless to influence. Jeff is calling attention to the weird, ominous and unknown aspects of his condition that seem to be preventing him from feeling settled. It seems weird and nonsensical to Jeff that his IBS diagnosis can remain fixed despite recognised change in his symptoms. Jeff seems to be trying to reduce the anxiety and ambiguity of his condition by holding out hope for a different, more convincing problem. This perhaps implies an urge to reject the weirdness and obscurity of IBS.

Similar to Jeff, Dave endeavoured to unravel the weirdness around his ambiguous condition and its cause using rational deduction.

I think, well, I think it's one of those things, when something's going weird with you… it's the same with my back. It's like you want to… I'll think what's explanation for it? And whatever the explanation is you just want to know and is it something genetic. And I just remember thinking, 'oh my mum's had this'. That might make some sense (Dave, 394-400).

His eagerness to establish a frame of reference (e.g., 'something genetic') seems motivated to rid himself of the weird, ambiguous and unknown aspects of his condition. Dave suggests that his weird condition has been bestowed upon him and hence, is not of his generation or choosing. Dave's efforts to obliterate the weirdness seem akin to previous discomfort with his bloated appearance. Finding comparison with his mother's condition seems to normalise his experience and perhaps reduces the sense of helplessness and not knowing. Perhaps his comparative reasoning diminishes potential for being socially judged for having a weird or abnormal condition. Dave seems reassured that his issues might be genetically caused and hence perhaps impossible to avoid and not his responsibility.

Eric's struggle to understand IBS cause was associated with perceived lack of definition of IBS compared with similar conditions.

Erm… so… I, it's, the problem with it in many terms. Also with IBS it's an umbrella term for a whole range of conditions [breaths in]. And trying to actually [breaths in sharply] focus down, drill down into the one main thing that's been causing you the problems []. It's, it's like trying to nail jelly to the wall (Eric, 721-727).

Eric conveyed an urge to go beyond superficial labels, to coral and establish more precise causal explanation. His efforts seemed to project an implicit desire for certainty, reassurance and an escape from anxiety and not knowing. Perhaps it is weird that despite his ardent search he can not find the

answers he wants, leaving him feeling stuck. A degree of despondency seems to recur in his self-report, and emerges here as perceived futility at trying to establish a convincing cause for his IBS. Indeed 'trying to nail jelly to the wall' metaphorically creates a weird, ridiculous image and seems practically futile and impossible. The lack of fixity and rigidity of jelly perhaps alludes to an implicit desire for support to cling to, to ground himself while dealing with the ongoing, tempestuous uncertainties of his condition.

In contrast, Eddie seemed to be challenging assumptions that IBS is a condition that generally affects women and comes with bloating.

I didn't think it was IBS because the general thing about IBS is yogurt and bloating and women basically. [] You know that's the general idea that you get bloating. Everyone is obsessed with going on about this bloating thing and I didn't ever get bloating (Eddie, 799-805).

What seems weird for Eddie is that his experience of IBS presents a different reality compared with his existing preconceptions about who gets IBS and how it presents. This seems confusing for Eddie and perhaps leaves him feeling separate from others with IBS. Perhaps he sees himself as weird for having a condition that he believes should not apply to him. Similar to Dave, Eddie is struggling to establish a frame of reference or familiarity to build an understanding of his ambiguous condition. Eddie seems preoccupied with his absence of bloating which could suggest some cognitive inflexibility on his part. He seems frustrated and struggles to give his condition an identity that he can comprehend and accept.

Perhaps IBS is weird for Rob because it requires a complex personal understanding that brings together multiple contributory factors.

It has to, I have to have… you know there's part of me from him, and part of me from my mum. My mum is a huge worrier. She worries the whole time and frets the whole time. [] So a combination of having some genes that make me worry and… [] and having a bad stomach when you, you know intolerance to

certain foods may be slightly erm… has maybe… made me who I am now (Rob, 816-827).

Rob seems to be highlighting the importance of his inherited parental traits (aspects of nature) along with the vulnerabilities they bring. However, he also alludes to choice for managing food intolerances (aspects of nurture) which conveys an awareness of his responsibilities and ability to influence IBS. Therefore, in contrast with other participants Rob combines both nature and nurture elements to establish an integrated and arguably more holistic understanding of his condition. Rob's words 'made me who I am now' suggest IBS holds much importance for how he defines his identity. Although he alludes to having some influence over his condition it seems that IBS is very much something he has been given.

There was a general urge to explain a condition with an unknown and ambiguous cause. Anxiety, confusion and an intolerance of uncertainty were common. To varying degrees, participants viewed IBS as an unwelcome affliction, with given aspects that they were not responsible for creating. The weirdness of IBS and the invisibility of symptoms seemed to frustrate ability to establish a simple understanding for IBS that was wholly convincing. Thus, the weirdness may be tied up with the complexity of IBS. Subjective understanding of IBS may require flexible consideration of aspects of nature and nurture, helplessness and influence, blame and responsibility. Perhaps Rob conveyed the strongest attempt to reach a holistic comprehension of IBS that constructed a personal understanding that integrated multiple factors.

5.5.2 Sub-ordinate theme B: Dilemmas accepting and adapting to IBS as something given

All participants suggested being embroiled in dilemmas and experienced tensions accepting and adapting to having IBS. The responsibilities for managing the given aspects of IBS was often resisted, seemed unfair at times and for some clashed pre-illness freedoms in life.

Eddie's dilemma was whether or not to accept strict adherence to a safe diet to help cope with IBS.

Like…erm… there are all sorts of things like oats and stuff like that I'm supposed to eat but can't. [] But every now and again I think… well maybe… you know? I should try to eat them because… they must be fine. I, you know? Because it's difficult to hold on to the fact that no you can't (Eddie, 516-519).

Eddie tried to justify deviating from his safe diet. However, perhaps he is also choosing to relinquish responsibility for managing IBS. It seems he was trying to push restrictions and choice temporarily outside of conscious awareness. Perhaps he viewed his strict diet as a restriction of freedom or an injustice. Therefore, perhaps he was reacting to the given aspects of IBS that can not be influenced (i.e., some things he can not eat). His reckless, aberrant behaviour seems like a self-destructive reaction perhaps associated with the idea that his choices are relevant. Perhaps he was testing the boundaries about what he could get away. Or there was a yearning to reclaim a lost part of himself, to reconnect with an old carefree reality. There seems to be tension integrating and accepting those aspects that are given by IBS and those that can be influenced.

Similar to Eddie, Rob had a dilemma about choosing whether to stick rigidly to a sensible diet or risk eating 'crap' food.

When you feel fine. It's hard. It's hard for me anyway to actively do something about it by cutting out the crap. [] When you are feeling good. Because you just want to be normal again (Rob, 208-212).

The urge to eat 'crap' may represent pursuit of perceived liberties inherent to a masculine identity. In contrast to Eddie, Rob alludes to having two conscious realities (when feeling good and bad) both with different mentalities. Perhaps 'feeling good' represents a forgetting state where he can escape the confines of IBS and coping requirements for a while, to feel normal and carefree. Perhaps what is 'hard' for Rob is accepting the reality that the given

aspects of his condition (e.g., dietary restrictions) may compromise his quality of life at times. The given and choice aspects of his condition seem split, not integrated in how he adapts to, and manages life with IBS. This contrasts with Rob's more holistic understanding of IBS highlighted in the previous sub-ordinate theme.

In contrast, Dave's dilemma was whether to accept the given reality that IBS has led to a change in toilet habits.

It's just weird that one of things that I have to do is wipe my bum. I just remember thinking [] I literally never heard of anyone else that does this. There may be millions of people do it. And I've got no idea. [] That did felt weird that I was doing it. (Dave, 1241-1246).

Dave seems anxious, uncomfortable and objecting to imposed responsibility for managing 'wiping' needs. Similar to Eddie, Dave does not seem to have a holistic appreciation of his condition because he struggles to recognise the benefits of making good choices to responsibly manage IBS. By comparing his wiping habits with others perhaps Dave was trying to normalise his habits, to diminish their ambiguity and sense of feeling separate from others. Perhaps Dave was concerned with potential judgement for appearing preoccupied with bowel issues which could be shameful or expose him as different. Similar to previous extracts Dave seems very eager to rid himself of the weirdness, this time as a means of resolving his dilemma. His desired/ pre-illness identity could have been under threat by the encroaching weirdness associated with his adaptive coping behaviours.

Eric's dilemma was whether to choose to maintain self-management of IBS or hold out hope for an external cure.

I am where I am and… I'm just gonna have to get on with it now. [] Until erm... some massive medical breakthrough in [] understanding of the whole central nervous system and how it links to your gut. It's just [laughs]. Until there's

some, some breakthrough on that. You know? They tell you… [] I can sort it out now… with a magic drug or whatever (Eric, 601-613).

Eric initially conveys some evidence an integrated acceptance of the given aspects of IBS along with recognised responsibility for coping with his condition. However, Eric rapidly shifts perspective to highlight his desire for a 'cure'. Therefore, he appears to relinquish personal responsibility for managing IBS which might suggest his acceptance of IBS is fragile or transient at times. Eric's hope for improved understanding or a 'magic drug' perhaps represents an urge to escape, or transcend the reality of having to accept, and responsibly adapt to the given aspects of IBS. Perhaps an external cure represents a fervent desire to be rescued from his vulnerability with IBS by some external, omniscient protecting force. However, Eric's laughter seems cynical and again highlights his recurrent futility about successfully getting to grips with IBS.

Similar to Eric, Jeff's extract concerned fluctuating attitudes of acceptance for having IBS. Jeff's dilemma highlighted ambivalence about whether he or the health professionals who treated him were responsible for managing his condition.

What, what, what do I do? Live like this forever? [] I don't know?
But then I think to myself well, maybe they've done everything they can… and I have just got to live with it. So that's why I've sort of adapted my life around it (Jeff, 1252-1256).

Jeff initially conveys anguish, helplessness and feeling trapped with his punitive and ongoing experience with IBS. Similar to Eric, it seems Jeff was looking for a rescuer (from the health service) but appears abandoned and seems resigned to his fate. Jeff hesitantly but gradually moves towards a position of greater acceptance for his seemingly inescapable condition and begins to embrace the responsibilities for management and adaptation that come with it.

Participants exhibited varying degrees of difficulty moving towards acceptance of IBS that combined an integrated view of the given aspects of IBS and those which can be influenced. Acceptance of IBS, assuming ongoing personal responsibility for choices and coping needs was not an easy, clear cut decision-making process for these men. It was a process often fraught with dilemmas, resistance, and perceived unfairness. Vulnerabilities associated with these struggles and dilemmas were often implied and somewhat muted which perhaps protects any outward appearance of weakness. For most participants there was a wavering but enduring attraction to escape the harsh reality of life with IBS. Urges to realise temporary relief from IBS and engage with old freedoms seemed associated with memories of pre-illness identities.

5.5.3 Sub-ordinate theme C: Concealment and negotiating disclosure of IBS

All participants implied or explicitly made efforts to conceal or avoid direct disclosure of IBS. Participants conveyed difficulty coming to terms with how best to disclose their condition to others. There were shared concerns about how disclosure might be construed by others, possibly inviting stigma and could be shameful.

Keith's careful disclosure of his condition involved use of 'euphemisms.'

I used to still kind of… euph, euphemisms like feeling unwell, or nausea. [] Or your nausea rather than… saying… I've got diarrhoea. Because there's an element there of, of…[] … like one of [laughs] the more comical kind of afflictions to the people that haven't… kind of suffered with it. So…[] there's an element of embarrassment there and… and kind of you, you… you try… to, to kind of make light of it (Keith, 603-616).

Keith's indirect disclosure of diarrhoea using more palatable labels perhaps represents subtle efforts to manoeuvre away from threat of social ridicule and shame. Keith highlights his recurrent concern with encountering poor

understanding, acceptance and perhaps stigma from people who do not have IBS. Keith's laughter perhaps aimed to diffuse potential IBS stigma, downplay any concerns about disclosing a bowel-related condition and protect an outwardly robust masculine identity. Perhaps humour represented a ploy to laugh with the others rather than becoming an isolated, emasculated focus of ridicule.

Similar to Keith, Rob made efforts to negotiate disclosure by choosing his own label for his condition.

And they'll say it quiet. Do you think you've got Irritable Bowel Syndrome? Like, and you'll be like whenever I say I've got a bad stomach and then I'll be like, yeah I probably have yeah. I've got a sensitive… I then I'll try and, maybe try and deflect (Rob, 538-543).

Reference to IBS in hushed tones perhaps mutes potential shame of exposing IBS and implying awareness of an undercurrent of IBS stigma. Similar to other participants there seemed a subtle urge to conceal or manoeuvre away from admitting having IBS. Rob conveys ambivalence by switching labels ('bad stomach' to 'sensitive') as if he himself was unconvinced or uncomfortable with his choice. Rob's subtle deflection from discussing IBS may have minimised chance of feeling shamed and avoids stigma.

In contrast, Dave distinguished differing attitudes about disclosing IBS in intimate versus public contexts.

And I am very open with things. [] Other chaps will talk about. So it's not really… I never found it an embarrassing thing to talk about. [] I wouldn't talk about in a room with twenty people but when I'm one on one with close mates I'm more than happy to talk about it (Dave, 287-294).

Dave initially seems to be promoting a desired self image of appearing strong, open and unashamed to discuss bowel issues. Although later his implied discomfort with wider disclosure seems to contradict earlier suggested

immunity to IBS embarrassment. Perhaps his contradiction implies bowel-related stigma impacts upon his thinking in a covert manner, slightly outside of full conscious awareness. Also, the previous sub-ordinate theme highlighted Dave's discomfort with the weird and potentially stigmatised aspects of IBS. Contradiction could imply Dave has not fully come to terms with how to best disclose IBS. Dave's preference for intimate disclosure could imply trusted friends might better understand his experience and condition. Perhaps with them there is reduced chance of experiencing negative reactions and shame.

Eddie most explicitly stated IBS was something to be concealed (in a work context).

Eddie: And it's… [] not the kind of thing that you really go in and say oh I've got IBS… by the way. [] You know? Is it okay if I'm near the loo because I'm going to have to go that often. It's not something… you can really be that…sort of open about… and if you do tell them… anything. Which you have to in the end. They just look at you like… you know? You're basically a skiver who's not really got what it takes. [] You know? It's not, it's not great.
Interviewer: Hmm… what's it like to get that sort of response?
Eddie: It's sort of humiliating really. Really humiliating (Eddie, 894-908).

Eddie seemed to ridicule and mock divulging IBS coping needs as if they might invite negative judgements about being a demanding or needy person. Unlike the other participants, Eddie experienced explicit pressure to disclose his condition. His interpretation of belittling character judgments suggests concern with being judged weak, idle and uncommitted which perhaps threatens his self-esteem and self-worth. Eddie initially seems to downplay shame associated his exposure ('it's not great') before openly admitting to humiliation. His experience seems one of being castigated, emasculated and perhaps perceives loss of respect and status among colleagues.

All participants referred efforts to conceal or evade direct disclosure of IBS. Some participants were explicit about rejecting seemingly shameful or stigmatised labels. Others more subtly opted for non-shaming labels, or

downplayed/ laughed off discomfort with IBS disclosure. Behind disclosure concerns seemed to be fear of embarrassment, bowel-related stigma and desire to protect hardy masculine identities. It seemed these men lived with the burden and threat of feeling shamed and vulnerable if IBS was exposed for scrutiny. Participant efforts to conceal IBS may imply degrees of unwillingness to come to terms with and accept the condition. This may leave men feeling conflicted, isolated and somewhat stuck with IBS.

6.0 DISCUSSION

6.1 Overview

This study endeavoured to explore adult male experiences of having Irritable Bowel Syndrome (IBS), managing and help seeking for the condition. A personal reflexive statement was drafted to identify any researcher presuppositions and biases about IBS. This helped position the researcher in relation to IBS for all subsequent stages of the research process. Following a critical review of up-to-date IBS literature this helped expose the research gap and addressed the need for a study of adult male experiences of having IBS. The researcher engaged in a process of epistemological reflexivity by considering the various approaches and methodologies available to best answer the research question. A qualitative approach was selected using semi-structured interviews in conjunction with interpretive phenomenological analysis (IPA) as the most appropriate methodology for this study.

In effort to answer the research question findings will be interpreted against existing research and theory critiqued in the literature review. New findings emerged which required finding new research (not previously critiqued) to be used for interpreting and comprehending these findings.

6.2 Principle findings

The findings are presented across three overarching and interlinking super-ordinate themes: (a) IBS consumes and compromises me; (b) responding to my condition; (c) coming to terms with IBS my way. These themes highlighted participants' experiences with preoccupation, restrictions and the threat IBS posed to relationships. Themes also revealed need and success responding to IBS, along with efforts to comprehend the ambiguities of the condition and negotiate acceptance and disclosure of IBS.

6.3 IBS consumes and compromises me

The first super-ordinate theme revealed the difficulties of cognitive preoccupation with physical IBS symptoms. This super-ordinate theme also exhibited restriction and loss issues that can emerge with IBS and how this can impact on identities. Finally, this super-ordinate theme encapsulated the threat IBS can present towards personal relationships.

All participants suggested having involuntarily formed cognitive preoccupations with physical symptoms associated with IBS. Cognitive preoccupations varied between participants and respective contexts but often were associated with intolerance or perceived threat. Threat-related preoccupations suggested participants worried about GI symptoms flaring up. They suggested holding attitudes or beliefs of helplessness and vulnerability to bouts of IBS. These findings reflect existing literature that individuals with IBS can worry and/ or catastrophise the consequences of aggravated GI symptoms which are likely stemming from held dysfunctional attitudes/ threat-related beliefs about IBS (Keefer et al., 2005; Lackner & Quigley, 2004).

For other participants, cognitive preoccupation with IBS symptoms seemed more ruminative and implied intolerance. Their emotional distress was indicative of irritation, frustration and low mood more so than anxiety. Maintaining concentration on activities proved difficult and cognitive functioning appeared to suffer when IBS was bad. Some participants tried to subtly manoeuvre away from IBS difficulties and not directly deal with their distress. This seemed indicative of experiential avoidance (Drews & Hazlett-Stevens, 2008). Also, men sometimes avoid or deny existence of psychological problems (Wexler, 2009) or consider IBS an intrusive and unacceptable condition to have (Dancey, Hutton-Young, Moye & Devins, 2002). For these men, the beliefs fuelling cognitive preoccupation with IBS may be intolerance-related rather than specifically threat-related.

Therefore, considering the variability of higher order beliefs and participant experiences of with IBS suggests a need to acknowledge subjective

differences. Ongoing cognitive preoccupation seemed to maintain a sense of helplessness with IBS and poor psychological well-being. At worst, cognitive preoccupation with IBS seemed able to grind down an individual's ability to realise and sustain positive moods on a daily basis.

All participants spoke of restrictions and how IBS could intrude upon and compromise their daily lives. When IBS was bad, participants tried to cope by voluntarily or involuntarily removing themselves from activities. To varying extents, restrictions seemed isolating and disempowering for participants. Restricted ability to engage with activity has previously been associated with compromised quality of life and emotional well-being (Farndale & Roberts, 2011). Perceived isolation reflects previous findings that individuals can experience IBS as an isolating condition (Kennedy, Robinson & Rogers, 2003) Self-imposed isolation may reflect findings that men often choose to cope with their problems alone (McKelley, 2007). Some participants highlighted how IBS restrictions seemed to compromise their ability to nurture masculine identities through bonding with others at work, or via social activities (e.g., eating and drinking). Restriction seemed to frustrate their ability to nurture self-esteem through their endeavours. This seemed to contribute to a sense of helplessness or perhaps fuelled concerns about becoming emasculated by illness.

Over time the pervasive sense of restriction and growing despondency with IBS seemed to give way to perceptions of incurred loss. All participants implied mournful loss of opportunities that were taken away by illness/ concerns about illness. Enduring sense of restriction, loss and suffering with IBS together seemed to have the capacity to challenge and gradually erode participants' pre-illness identities and sense of self. This seemed particularly true for Jeff and Eric who had more enduring experience with IBS compared with most other participants. Their extracts convey more pervasive loss of self, disempowerment and suffering. In some ways this reflects findings that enduring distress with IBS can become normalised and integrated within the sufferer's sense of identity (Farndale & Roberts, 2011). However, current

study findings (across participants) reflect much difficulty normalising suffering with IBS rather than clear acceptance.

The concept of loss of self has rarely been addressed in existing IBS literature and it helps to incorporate new literature to explain findings. Charmaz (1983) considers loss of self to comprise of loss of control, loss of self-esteem and possibly also loss of identity following ongoing experience with a variety of chronic illnesses. Charmaz suggests that the unpredictability attributions with chronic illness can lead individuals to restrict life more than is needed. This can bring social isolation and forming pre-occupation with illness which over time can result in 're-evaluation and change of self' (p. 176). All these aspects are reflected in the findings (particularly for Eric and Jeff).

Taken for granted personal identities seemed vulnerable to becoming fractured and modified through compromising and enduring experience living and dealing with IBS. Loss of self seemed to compromise psychological well-being. Eric referred to IBS as being corrosive of the mind but perhaps the wider implication is that IBS over time can prove to be corrosive of the self. Current study findings resonate with existing research that highlighted similar difficulties with loss of identity for individuals with Fibromyalgia (Rodham, Rance & Blake, 2010) and Chronic Fatigue Syndrome (Dickson, Knussen & Flowers, 2008). Hence, loss of identity could be an important aspect associated with several invisible, chronic conditions bearing similarity with IBS.

For all participants IBS appeared to threaten the robustness of their personal relationships and retaining the acceptance of others alongside managing difficulties with IBS. Co-existence of relational difficulties, psychological and biological factors (aggravated GI symptoms) together support a biopsychosocial comprehension of the condition. Several current study findings are consistent with existing research. Some participants indicated need to gain other peoples approval (Lackner et al., 2005). Also, Lackner and Gurtman (2005) found that diarrhoea pre-dominant IBS sufferers are more

likely to be unassertive, over-affiliating and eager to please others which resonate with current study findings.

Participants generally tried not to burden others with their IBS difficulties. Indeed, risking speaking of IBS may prove an aversion due to the shame implications of IBS stigma (Toner, Segal, Emmott & Myran, 2000). For some participants being compromised by IBS seemed to present concern with becoming emasculated, appearing weak to others or could invite stigma. A central finding was that all participants appeared to be trying to figure out a place for IBS, if any, within their relational identities. IBS seemed to encroach upon on their ability to have relationships in ways they were familiar with.

All participants shared an implied fear of ultimately losing personal relationships and perhaps descending into an increasingly isolated existence with IBS. This was exemplified well by Keith's perception of the gap in understanding that existed between him and people without IBS. Existential isolation assumes there is 'an unbridgeable gulf between oneself and any other human being' which is considered to be a core cause of anxiety (Yalom, 1980, p. 355). Interestingly, Yalom believes people can become separated from others and also from parts of themselves. Perhaps this helps conceptualise how participants in the current study experienced interpersonal anxieties as well as risk of possible loss of self. Perhaps interpretations of data using IPA helped expose the complexity and relational nature of IBS experiences for men with IBS. This is consistent with the phenomenological capacity of IPA to convey an idiographic depiction of individual's experience while also permitting interpretation of experience from a 'worldly and relational' perspective (Smith, Flowers & Larkin, 2009, p. 29).

6.4 Responding to my condition

This super-ordinate theme concerned struggles with perceived unpredictability and uncontrollability of IBS symptoms. This super-ordinate theme embraced dilemmas about whether or not to reach out for help with IBS and also

participant experiences getting subjective needs recognised and met in treatment with health professionals.

All participants spoke of struggles to control seemingly unpredictable and random manifestation of GI symptoms. Consequently participants experienced much anxiety, annoyance and frustration with IBS. These findings held similarity with existing research that IBS (Farndale & Roberts, 2011) and chronic conditions in general (Charmaz, 1983) can seem unpredictable at times. Efforts and success trying to control IBS varied between participants. Findings generally support male tendencies to try and cope with problems by applying logic and using rational thinking (Good, Thomson & Brathwaite, 2005; Wexler, 2009). However, coping efforts often seemed ineffective, or appeared to defy logic at times. Similar to existing research participants struggled to identify symptom triggers and to develop and utilise effective coping strategies (Casiday, Hungin, Cornford, De Wit & Blell, 2008; Kennedy, Robinson & Rogers, 2003).

For many participants the lack of control and unpredictable threat of exacerbating symptoms seemed invasive, ominous and ever present. It appeared to maintain a sense of helplessness and growing despondency with IBS over time. For some participants controllability difficulties seemed associated with developing mildly dissociative mind-body relationships. In contrast, Keith eloquently emphasised the empowerment and diminished anxiety that came with improved ability to influence and control IBS.

All participants seemed embroiled in dilemmas about what to do about IBS. Participants often conveyed anguish or ambivalence and generally struggled to see the benefits of help seeking for IBS. Help seeking was often compared with a preference for self-managing IBS. Many participants implied concern about reaching out for professional help and perhaps encountering shame. These findings share similarities with masculinity research that suggests men tend to be self-reliant when managing their issues (Mahalik, Good & Englar-Carlson, 2003; McKelley, 2007). Also, perhaps male participants may have

been concerned about appearing weak (Good, Thomson & Brathwaite, 2005) for seeking help with IBS.

Some participants at times seemed to downplay or deny the significance of their IBS difficulties. The motivation to reach out for help seemed to dissipate over time. Participants with enduring experience of IBS seemed to become increasingly passive and appeared to normalise having IBS. Previous findings state diarrhoea-predominant IBS sufferers tend to have submissive, unassertive personality traits (Lackner & Gurtman, 2005). However, participant passivity may emerge more from long-term suffering with IBS rather than generic personality traits. For these men their attitudes at times conveyed helplessness that nothing could be done about IBS. These findings resonate with the concept of learned helplessness (Seligman & Seligman, 1975). Learned helpless emerges when people through personal experiences develop perceptions that nothing can be done to avoid negative consequences arising from such experiences. Participants who suggested having developed learned helplessness seemed somewhat stuck, vulnerable and isolated with IBS. In contrast, Rob underwent a shift in attitude to engage with professional help and be more proactive in helping himself. This seemed empowering for Rob and helped him move away from a previously helpless predicament with IBS.

Attitudes towards help seeking for IBS seemed to have been influenced by past successes getting subjective needs recognised and met by health professionals. Some participants suggested that their troubles with IBS were not adequately recognised, believed or empathised with by health professionals at times. These findings echo literature that people with IBS can feel stigmatised by doctors/ some doctors do not take IBS seriously (Arroll & Dancey, 2014; Kennedy, Robinson & Rogers, 2003). Arroll and Dancey suggest individuals with chronic conditions can perceive doubts from health professionals as rejection, or an implication of some form of personal blame for their difficulties. Indeed, some participants displayed resistant, critical or combative attitudes towards health professionals which perhaps functioned to empower themselves, protect robust masculine identities and any

vulnerabilities exposed on asking for help. Some men can hold fears about not being understood when seeking professional help for difficulties (Wexler, 2009). Indeed, poor understanding and difficulties getting treatment and relationship needs met with health professionals seemed to enhance helplessness and despondency with IBS. This could potentially jeopardise future help seeking behaviours and exacerbate any existing psychological difficulties.

In contrast, some participants highlighted their gratitude for feeling understood and having their difficulties with IBS validated and empathised with. For Keith this seemed associated with his attitude shift from seeming ambivalent about help seeking (as suggested by previous narrative extracts) to being appreciative and more positive about engaging with help. The value of good communication skills was integral to some participant perceptions that their needs were being met. Perhaps this resonates with male preference for 'direct, clear cut explanations and instructions' about what to do about problems (Wexler, 2010, p. 5). This also reflected appreciation by some participants for receiving good advice about GI symptom management.

Success getting individual needs recognised and met in treatment was not specific to particular healthcare professions but stretched across disciplines. This has ramifications for establishing good holistic care. Developing healthy, containing relationships with men who engage with help for IBS seems essential given that treatment may not always be able provide a cure, or sufficient alleviation of IBS symptoms.

6.5 Coming to terms with IBS my way

This super-ordinate theme embraced subjective efforts to comprehend the weirdness of IBS and resolve dilemmas accepting and adapting to having IBS. This theme also revealed concerns around concealing IBS and negotiating disclosure of the condition.

The unknown and weird aspects of having IBS presented much anxiety and confusion for participants. All participants made logical efforts to better understand their condition ranging from accepting an IBS label, seeking genetic understanding, social comparison or appraisal of personal experiences over time. Participant efforts to understand and alleviate the perceived weirdness of their condition shared some similarities with efforts to create personal explanatory models of IBS (Casiday, Hungin, Cornford, De Wit & Blell, 2008).

For some participants, frustration and doubt understanding their ambiguous condition may have stemmed partly from the lack of obvious cause and the largely invisible nature of symptoms (Arroll & Dancey, 2014). Also, we know that intolerance of uncertainty can be prominent for individuals with IBS (Keefer et al., 2005). Some participants suggested concern with incurring potential stigma about having a weird or unseemly condition. The sense of being involuntarily occupied by a strange condition seemed particularly troubling and disempowering for some participants.

Difficulty deciphering the weirdness of IBS seemed entwined with reasoning that IBS is a complex condition to comprehend (Blanchard, 2001). Most participants seemed to strive for a nature-based, given understanding of IBS that perhaps that did not thoroughly consider their personal influence. Perhaps Rob best encapsulated efforts to alleviate ambiguity by establishing a subjective understanding of IBS grounded within his sense of identity. Rob's holistic consideration of combined nature and nurture factors perhaps better embraces a biopsychosocial comprehension of IBS.

Most participants at times implied having split, non-integrated understanding of the given aspects of IBS along with those aspects which can be influenced. This seemed associated with dilemmas accepting and adapting to life with IBS. Participants often struggled to see the benefit of making good choices, or adhere to coping demands at times which may have represented a temporary desire to be normal for a while. Indeed, Charmaz (1983) found that a return to a normal life is symbolic of the valued self. Also, we recall that personal

freedoms can be strongly valued by some men with IBS (Dancey, Hutton-Young, Moye & Devins, 2002). Hence, breaking free of the demands and responsibility of coping with IBS may reflect a desire to reconnect with a previous (pre-illness) self in efforts to recapture something that was lost.

The issue of responsibility taking is less well addressed in existing IBS literature but has been highlighted by Stenner, Dancey and Watts (2000). These researchers highlighted need to ascertain the extent to which individuals with IBS perceived managing the condition was a personal responsibility. Responsibility taking also has potential ramifications for how well individuals work with medical professionals to better adjust to, and manage IBS. Similar findings exhibited in the current study may reflect difficulty adjusting to the given aspects of IBS and the sustained demands of managing a chronic condition.

There was much resistance to accept IBS which often seemed unfair, anguishing and potentially emasculating. Often the path towards acceptance and adaptation to IBS seemed wavering, transient and conflicting. This ambivalent experience of wrestling with acceptance/ non-acceptance of IBS is less well reflected in IBS literature. Perhaps men need to better recognise that resistance to accept IBS is a potentially futile misdirection of energies and could be fostering helplessness with the condition. The value of making good decisions about managing IBS perhaps could be better framed as efforts of self-empowerment, and not resigned efforts to put up with chronic illness. Working towards acceptance of the given aspects of IBS along with the responsibilities for managing IBS may benefit from better theoretical integration and focus in psychological therapies.

Difficulty disclosing IBS was highlighted by participants particularly in the contexts of friendships and work environments. There was a general reluctance for direct disclosure of IBS which may reflect participant beliefs associated with need for approval (Lacker et al., 2005). Hence, efforts to re-label IBS (e.g. bad stomach, diarrhoea) or use humour when disclosing IBS information may represent efforts to play down the significance of IBS, or

make disclosure more palatable for the recipient to hear. These efforts may reduce chance of incurring stigma. Indeed, previous research found individuals with IBS often used humour to convey information and fears about having IBS (Farndale & Roberts, 2011). In fact, all participants used humour at times when providing accounts of IBS experience during interviews (not always specific to stigma).

There was implied worry about experiencing shame or embarrassment on revealing IBS which perhaps threatened masculine identities. Concerns about disclosure may reflect literature that suggests lack of knowledge and empathy about IBS can contribute to stigma, and that individuals may feel ashamed and inhibited to discuss their condition (Dancey & Rutter, 2005; Toner, Segal, Emmott & Myran, 2000).

It helps to incorporate new research to further explain stigma findings. Jones et al. (2009) conducted structured interviews with 148 people with IBS about perceived stigma in IBS. These researchers found that limited disclosure of IBS and beliefs the public did not understand IBS, or take it seriously were commonly identified themes that resonated with current study findings. Participant efforts to re-label IBS may be associated with motivation for 'active concealment' of IBS due to stigma concerns (p. 373).

The stigmatised views of others could prove discrediting for sufferers of chronic conditions and threaten their fragile constructions of self (Charmaz, 1983). Internalised stigma about IBS could negatively impact on an individual's sense of identity. The current study findings suggest IBS stigma may be reinforcing male efforts to conceal shame and increasing likelihood of not sharing their struggles with IBS. Consequently, this could leave men vulnerable with unaddressed shame and any associated psychological difficulties.

By incorporating new literature we learn that Gilbert (1998) suggested that shame issues are not given enough recognition or integrated well enough in CBT client formulations (not specific to IBS). Indeed, shame has been labelled

the hidden emotion in general psychopathology and its negative impact can be overlooked (Lewis, 1987). This was reflected in the analysis of the current study where interpretation of shame was implied rather than explicitly revealed by most participants. Therefore, participants could have experienced more shame with IBS than they revealed during interviews.

Gilbert (1998) suggests shame needs to be clearly formulated in belief structures and attitudes that may include concealment of shame and/ or compensation strategies aimed to gain acceptance from others. Thus, better theoretical formulation of relevant IBS shame aspects in psychological therapy approaches may help individuals come to terms with their condition. This is importance as evidence of IBS stigma and associated shame experiences were highlighted across all three super-ordinate themes and could negatively influence male sense of self and psychological well-being.

6.6 Implications of findings for Counselling Psychologists

The findings have many implications for Counselling Psychologists for the purposes of: (a) clinical practice; (b) service provision; (c) training.

6.6.1 Clinical practice

Research is encouraged to contribute to the developing practice of Counselling Psychology (Kasket, 2013). The findings indicate several areas where adaptations could be made to therapeutic approaches to enhance treatment of this client group. Feelings of helplessness with IBS peppered the analysis of all study participants. Therefore, as a guiding principle Counselling Psychologists could aim to empower male clients in therapy to counter any helplessness with IBS.

The theme ‘I didn’t see the point’ encapsulated participants’ ambivalence and difficulty seeing the value of engaging with help. Counselling Psychologists at the early stages of therapy could try to elicit the subjective impact IBS (theme

'IBS consumes and compromises me') has on the lives of male clients with IBS. This could help motivate and convince male clients they have a problem worthy of attention (Wexler, 2010). There may be need to challenge any attitudes of learned helplessness with IBS which could be de-motivating and could obstruct therapeutic progress.

Men could benefit from developing better holistic understanding of not just the given aspects that come with IBS and also those aspects they can influence to achieve some relief (e.g., Rob, 816-827). Also, Rob (1019-1032) took an empowering, proactive stance to engage with treatment, learn about IBS and how to self-manage symptoms better. Counselling Psychologists could adopt a similar approach and help men realise the value of making good choices and taking responsibility for managing IBS. Indeed, Counselling Psychology aims to support client ability to make good decisions and enhance control over life (Division of Counselling Psychology, 2005).

Men in the current study showed much preference for self-managing IBS (theme 'I didn't see the point'). Perhaps Counselling Psychologists could focus on providing men with the psychological skills so that they can begin to better manage emotional distress with IBS by their own means. Indeed, Wexler (2010) suggests therapists should nurture masculine independence and provide clear guidance about what men can do to help and empower themselves (Wexler, 2010).

The theme 'cognitive preoccupation' emphasised worry and rumination about GI symptoms. Counselling Psychologists could provide men with practical CBT skills to help them develop awareness of the content of thoughts (involved with worry or rumination). Men could then learn skills to challenge, modify and reach more balanced ways of thinking to try and reduce their emotional distress (Beck, 1995). Controlled worry (or rumination) periods (e.g., only worry about IBS for 20 minutes at 8pm daily) could be introduced to help break recurrent problems with cognitive preoccupation (Wells, 1997). Patterns of worry or rumination could also be disrupted by distraction techniques, e.g., exercise, games requiring concentration (Kouimsidis,

Reynolds, Drummond, Davis & Tarrier, 2007). These skills could help men establish more control over the emotional and cognitive aspects of IBS. Any beliefs about the positive function of worry/ rumination could be challenged and modified by therapist-directed efforts (Wells, 1997).

The analysis revealed how IBS over time can threaten ability to maintain a healthy, valued sense of self (theme 'restriction, loss and identity'). Wilson, Sandoz and Kitchens (2010) highlighted how valued living and engaging with meaningful activities and interests can stretch across ten domains of life (family relations, intimate relationships, parenting, social relations, employment, education, recreation, spirituality, community life, physical well-being). Counselling Psychologists could encourage men to engage with domains of valued living with greater flexibility. For example, regarding with the social relations domain Jeff and Eric could not physically meet up with friends due to IBS difficulties (theme 'IBS threatens my relationships'). However, perhaps they could adapt and connect with friends from home via telephone, Skype or other forms of social media to maintain relational identities. If easier, men could consider shifting efforts to other domains altogether (e.g., spirituality instead of recreation). Men with IBS may need to reappraise their expectations of themselves and their capabilities when ill with IBS. These adaptive efforts may help individuals realise some choices and freedoms with chronic illness (Charmaz, 1983). Pursuing better valued living (across the range of domains) may help maintain valued sense of self and reduce chance of becoming preoccupied with IBS.

The findings generally support existing psychological interventions that target dysfunctional beliefs and assumptions about IBS that may be influencing IBS distress. However, emerging identities may need to better accept the limitations that IBS may bring. Some participants implied holding intolerance-related beliefs about IBS (e.g., Dave, 762-772; Eddie, 352-363). These men could learn to better accept suffering as part of IBS experience and begin to modify their beliefs accordingly. Developing more accepting attitudes are core aspects of Mindfulness-based Cognitive Therapy (Crane, 2009). Learning and integrating mindfulness skills may also help accept unpredictable emergence

of IBS symptoms (theme ‘unpredictability and the struggle to control IBS’) and perceived unfairness around adapting to IBS (theme ’dilemmas accepting and adapting to IBS as something given’). Mindfulness theory would imply that male resistance towards emerging IBS symptoms and experience could inadvertently serve to collaborate with, and exacerbate psychological distress with IBS. Learning mindfulness skills could help embrace and contain emotional distress with IBS and enhance psychological well-being.

Cooper (2009) suggests Counselling Psychologists should embrace and put into practice fundamental humanistic values such as understanding subjective client experiences and empathising with suffering. These qualities along with good communication and relational containment were particularly valued by Keith and Eddie (theme ‘can you recognise and meet my needs’). Counselling Psychologists could strive to better integrate and adopt the subjective language and style of relating that men bring to therapy. For example, Jeff (1041-1048) and Dave (394-400) both explicitly referred to IBS as ‘weird.’ Counselling Psychologists could help explore ‘weirdness’ to enhance and clarify understanding of IBS from the client’s frame of reference and respect ‘first person accounts as valid in their own terms’ (Division of Counselling Psychology, 2005, p. 1). Also, ‘weird’ for Dave seemed associated with stigma concerns. Hence, deliberately using the word ‘weird’ may represent use of a non-shaming label (Wexler, 2009) when working in areas that might expose male vulnerabilities.

All participants shared humour with the interviewer when discussing their experiences with IBS. For example, Eric (601-613) when conveying futility about IBS and Keith (603-616) on suggesting diarrhoea is comical. Therefore, Counselling Psychologists could encourage use of humour and male language to try to establish an air of informality with male clients. Working with the therapeutic relationship in these ways may help men feel more comfortable disclosing experiences and any difficulties with IBS. This could help build trust and rapport with male clients and enhance collaboration in therapy. Collaboration could be further enhanced by embracing and validating client’s personal explanatory models for IBS for formulation purposes

(Casiday, Hungin, Cornford, De Wit & Blell, 2008). For example, Dave (394-400) and Rob (816-827) both identified possible genetic causation.

The analysis revealed differing subjective narratives and the unique manner in which IBS can manifest and impact on men. This supports a Counselling Psychology appreciation for the 'complexity of difference' (Rafalin, 2010, p. 41) and 'empathic engagement of the psychologist with the world of the client' (Strawbridge & Woolf, 2003, p. 8). Therapeutic adaptations for men with IBS could be specified and embrace a Counselling Psychology emphasis to individualise treatment on a subjective basis. For example, Rob might benefit from CBT interventions that help him manage his subjective tendencies for worry and polarised thinking. Whereas, Jeff may benefit from CBT interventions that help him rationally reframe his confused thoughts along with interventions that promote valued living to bolster his sense of identity. The emergence of subjective needs encourages flexibility in how Counselling Psychologists work with male clients rather than rigidly embracing standard IBS psychological treatment protocols.

By engaging with subjective complexity of IBS experience rather than trying to crowbar individual presentations to fit with pre-established and arguably reductive IBS diagnostic criteria this may help to de-pathologise treatment experience. This echoes need to go beyond diagnosis for individuals in attempt to gain increasingly clearer and in-depth understanding of individuals and their condition (Cooper, 2009).

Cooper (2009) states a strong therapeutic relationship is needed before confronting the more difficult aspects of therapy. The therapeutic relationship is primary to treating any existing issues with shame (Gilbert, 1998). Male concerns about IBS stigma, shame and emasculation were evidenced across participant accounts. Counselling Psychologists could look out for evidence of possible compensatory strategies/ concealment (e.g., Keith and Rob's re-labeling of IBS) to help access hidden shame/ beliefs about shame.

Counselling Psychologists could utilise techniques from Dancey and Rutter (2005) to improve understanding of IBS stigma and help de-stigmatise men. Counselling Psychologists could inform and help convince male clients that IBS stigma is a societal problem and not their personal problem. It could help male clients to realise that stigmatised attitudes if accepted can become integrated within identities and damage self-esteem. Dave (287-294) implied concerns about stigma and shame when considering revealing IBS to a wider social group. Dancey and Rutter suggest that learning, talking about and accepting that IBS is not something to be ashamed or embarrassed about helps diminish perceived stigma/ shame. Counselling Psychologists could encourage men such as Dave to discuss any shame or embarrassment with IBS either in individual therapy or via male IBS support groups/ online IBS forums. This could be empowering and help men relinquish the burden of concealing IBS.

The theme 'IBS threatens my relationships' revealed much anxiety and pervasive need for better understanding of IBS from friends, partners or family members of men with IBS. Counselling psychologists perhaps via systemic efforts could try to improve understanding of IBS for others via sharing of experiences and perspectives on IBS. For example, this could have helped friends of Jeff (678-689) recognise his reality with IBS, how it compromised him and how his social withdrawal was not a personal rejection of them. Generating information leaflets, YouTube videos or mp3 downloads for friends, family or partners may help inform others about IBS, the impact IBS has on men, their lives and relationships. This may help others provide better support for men with IBS, help these men maintain their desired social identities and hopefully diffuse stigma about IBS.

6.6.2 Service provision

The findings revealed the potential benefits of adapting therapeutic approaches to meet the treatment needs of men with IBS. These adaptations could also form the basis for developing separate protocols for men and women and in therapy. Other professional disciplines who work with men with

IBS could be educated about highlighted male vulnerabilities and needs when seeking/ engaging with help for IBS. Indeed the positive and effective treatment experiences highlighted were non-specific to particular disciplines (theme 'can you recognise and meet my needs'). Therefore, the discussed adaptations for men could have relevance for achieving a coherent multi-disciplinary approach to treatment. Failure to adapt to male treatment needs could potentially drive men away from treatment.

Good relationships and communication between different professional disciplines could provide insight into how other disciplines work with IBS clients and the specific skills they provide. Different disciplines will likely have different ways of working with IBS clients informed by the contextual priorities of the respective disciplines. For example, an overworked GP despite their best efforts simply may not have time to provide IBS clients with sufficient empathic understanding of the psychological distress associated IBS (this resonates with Jeff's experience, 889-893). Therefore, perhaps Counselling Psychologists are better placed and arguably more specifically trained to provide clients with relational understanding and emotional support for IBS. Therefore, good holistic care for this client group could involve the different disciplines better focusing work in areas specific to their training while also sharing understanding of client needs with the multi-disciplinary team.

Hicks (2010) stated Counselling Psychologists may need to challenge the assumptions that colleagues may hold about an illness that reinforces any pathologising views represented in society. This is very relevant as current study findings revealed men with IBS seemed much concerned about incurring IBS stigma and shame. For example, Jeff (889-893) encountered stigma from his doctor who did not believe Jeff's experiences and concerns about IBS. Counselling Psychologists may need to potentially challenge stigmatised/ stereotypical views colleagues have about IBS patients and encourage more open-minded, individualised perceptions.

Counselling Psychologists could facilitate IBS groups, work as individual practitioners or in multi-disciplinary teams. Counselling Psychologists could

help several types of organisation in a consultation capacity, e.g., community based organisations such as Mind or IBS charities.

6.6.3 Training

More research is needed to confirm the efficacy of my proposals for clinical practice. Therefore, proposals for training others to treat IBS therapeutically are tentative. The findings of this exploratory study go some way towards identifying the need for training therapists to best treat men with IBS. This may be particularly relevant as there is a void of literature concerning how Counselling Psychologists can work with this client group. NICE (2008) guidelines may help psychological therapists outline treatment plans. Yet these guidelines are not gender specific and do not prepare therapists for the possible complexity and ambiguity of subjective client presentations, the compromising life impact of IBS and the challenges this brings (highlighted across current study findings). Therefore, perhaps training needs to encourage open-minded consideration and integration all important aspects within client formulations. Training could provide better adaptations for treating men and encourage flexible practice rather than rigid adherence to therapeutic protocol. This will likely need to be negotiated against the protocol demands of specific counselling services (Cooper, 2009).

Consideration may be needed for how well conditions like IBS are addressed in the current training of Counselling Psychologists. Perhaps there is not sufficient scope within curriculums to provide training in an arguably specialist area. Therefore, eventually more specialist IBS training (including specific training for treating men) may need to be offered via appropriate pathways (e.g., advertise courses on the British Psychological Society website).

6.7 Methodological considerations & limitations of current study

The current study does not propose that findings are generalisable to wider populations. However, the study findings may have relevance for theoretical

generalisation for men (with similar demographics) in other contexts that share similarities (Yardley, 2008). Thus, the current findings may have relevance for men who have chronic conditions that share similarities with IBS.

Findings could be limited in that all participants were treatment seeking which may not reflect the wider population of individuals with IBS. Some limitations could also apply to the degree of homogeneity in the participant sample. The severity of IBS symptoms was not measured (e.g., classed as mild, moderate, severe). For example, Dave seemed to have less severe IBS symptoms compared with the other participants which may have qualitatively coloured his interpretation of IBS experiences. The sample used participants that all could be said to have diarrhoea-predominant IBS. This may limit the relevance of findings to this particular sub-type of IBS. However, despite participants sharing an IBS sub-type their experiences of having IBS varied widely at times which may highlight the diversity of IBS manifestation.

The researcher made efforts to familiarise himself with up-to-date IPA literature. Using IPA to interpret findings involves a double hermeneutic. The participants strive to make sense of their worlds, whilst the researcher tries to make sense of participants' efforts to make sense of their worlds (Smith & Osborn, 2008). Hence, the researcher's interpretation of findings was likely influenced by the researcher's perspective and own pre-conceptions which were reflected on throughout this study.

During interviews the researcher became aware of differences in ability of individual participants to respond to and articulate answers. Hence, this may have influenced efforts to probe and encourage elaboration of participant answers at times where it was suspected richer information was to come. This held similarities with the methodological reflections for a study by Rizq and Target (2008). The interview schedule repeatedly used the term IBS to contextualise interview questions. However, the direct use of the label IBS may have had a pathologising effect on participants during interviews and could have influenced their answers.

Co-morbidity issues may have influenced the study findings. In particular, two participants suffered Arthritis (Ankylosing Spondylitis) in addition to IBS which may have constituted some symptom overlap (e.g., non-colonic symptoms) between conditions. These participants at times shifted from their discussion of IBS symptoms to arthritis complaints. Reflecting on these issues at the time, and subsequently, the researcher was proactive in directing discussion back to IBS and only included participant extracts that explicitly related to IBS experiences and perceptions.

6.8 Final Reflections

Engaging with reflexivity in qualitative research has the central aim of promoting rigour in research findings (McLeod, 2011). I made reflexive efforts to record my thoughts and conceptions throughout the course of this study. Lee (2009) stated reflexivity helps to theoretically position the researcher in relation to existing knowledge about the subject area and considers the researcher's influence in creating findings. However, reflexivity may have been compromised at times when conducting the interviews. When listening to participant accounts of experience with IBS I empathised easily with their difficulties. I had to hold back from offering help which likely relates to my external role as a counselling practitioner. Also, participants' difficulties with IBS on occasions resonated closely with my own experiences. In hearing of participants' frustration with IBS and IBS treatments this brought to mind my own struggles and negative emotions trying to cope with, and achieve adequate relief from the condition. Additionally, interpreting participants' shame with IBS seemed difficult to pinpoint at times. On reflection, this might have related to my own unconscious efforts to repress feelings of personal shame associated with my own IBS.

In contrast, at other times during analysis I found myself struggling to empathise with participant accounts when they criticised treatment, or health professionals or when they elaborated on their sustained struggles with IBS. On reflection I felt guilty at my lack of empathy on these occasions. This

highlights the importance of reflectively monitoring the counter-transference that could emerge for Counselling Psychologists when working therapeutically with this client group. This is relevant as Counselling Psychologists recognise therapy is experienced intersubjectively, with both parties contributing to and interpreting therapeutic experience (Kasket, 2013).

Reflecting on the role of the researcher's self helps to understand phenomena that can arise when conducting research (Lee, 2009; Stanley & Wise, 1993). It could be said that I possessed two selves in relation to this research project. First of all there is the individual with IBS self who can empathise with other people's experiences of having IBS. Secondly, there is my Counselling Psychologist practitioner-researcher self who is encouraged to empathise with client experiences but also strives to view matters objectively. These dual identities likely created tension and may explain the differing emotional reactions at times to participants and the research data. However, difficult, frustrating and sometimes conflicted feelings can be considered an intrinsic part of conducting and engaging with qualitative research (Lee, 2009).

From an existential perspective it is particularly relevant for therapists to examine and reflect upon their own experiences (Van Duerzen & Adams, 2011). Although I have not achieved significant therapeutic relief from IBS, my engagement with personal therapy (across three approaches) has provided scope to consider IBS in some depth, the implications it has had on my life and how I relate to the condition. This has provided personal insight into what it is like to be a client seeking help for IBS and potentially enriches understanding of participant's experiences. On the other hand I share many similarities with the participant sample and findings may have ramifications for me as a man with IBS. Hence, despite my best efforts to remain reflexive my personal assumptions could have subtly influenced the creation and presentation of the study findings. [2]

[2] Text has changed from the third to first person perspective as this section concerns the personal reflexivity of the researcher.

6.9 Implications for further research

As a result of conducting the current study many suggestions were made for adapting clinical practice to best meet the needs of men with IBS. However, more research is needed to build up the evidence base and confirm efficacy for using these interventions to treat IBS in widespread practice.

This study revealed many findings associated with IBS stigma and shame in various social contexts. However, Wexler (2010) stated we know relatively little about male experience of shame. Perhaps new research could follow this psychosocial focus and more directly explore the potential shame associated with IBS and IBS stigma which has often been overlooked by many researchers. Also, research on working systemically with individuals who have IBS could prove valuable for inclusion as a potential treatment option.

More research is badly needed that explores therapist and Counselling Psychologist experiences of working with IBS clients. Also, research efforts could explore the attitudes and experiences between the different professional disciplines that treat IBS clients. Perhaps a qualitative study collecting data via focus groups may help to expose the similarities, differences and potential tensions that may exist between disciplines and highlight areas for improving holistic treatment of IBS clients.

7.0 Conclusions

The findings highlighted the issues Counselling Psychologists can look out for and subsequently adapt therapeutic practice to best treat men with IBS. These suggestions are subtle additions to existing practices rather than radical deviations from current understandings.

Male participants experienced ongoing frustrations, intrusions and compromising difficulties with IBS. Yet men at times seemed to struggle to view IBS as a problem worth working on. Counselling psychologists could

help motivate and empower male clients to better recognise and respond to their own needs and counter any feelings of helplessness with IBS. This may involve accepting that there could be given, perhaps inescapable aspects of having IBS but also realising that assuming responsibility for making good choices could achieve degrees of relief with IBS.

Findings revealed male preference for logical self-management of IBS symptoms. Hence, Counselling Psychologists could provide men with clear guidance and practical skills to train men to better manage psychological difficulties with IBS by their own means. Enduring and debilitating experience with IBS highlighted need to bolster male sense of self in the face of illness. The erosion of pre-illness identities seemed able to threaten constructs of masculinity that value robustness and freedom of choice. Counselling Psychologists could help men realise more choice by encouraging practical, flexible pursuit of valued living (across the various domains of life) by adapting to any limitations posed by IBS. These efforts could nurture self-esteem, help maintain valued identities and counter any preoccupation or despondency with illness.

Findings highlighted the value men placed on having their experiences and understandings about IBS validated and empathised with in treatment. Counselling Psychologists embrace these core values and could adapt their therapeutic approach to better accommodate male client's subjective use of language and style of relating. Adapting therapy more to the client's frame of reference could help nurture trusting, collaborative therapeutic relationships.

Study findings conveyed many concerns about incurring IBS stigma or shame. Stigma could compromise male self-esteem and could become integrated within identities and beliefs. Therapeutic efforts could seek to identify and help de-stigmatise men with IBS to help them come to terms with their condition. Better understanding of male experience of IBS and the damaging impact of stigma is needed from health professions and in personal relationships.

The emergence of new findings with their subjective emphasis owes much to the facility of IPA to access and interpret individual experience of having IBS. Efforts were made to fully interpret and discuss emergent themes through a biopsychosocial framework whilst honouring the phenomenological qualities inherent to the accounts of participants. The subjective nature of findings promotes need for Counselling Psychologists to reflect on the potential complexity of IBS presentations and how it can vary between men. Counselling Psychologists are encouraged to be flexible and adapt their therapeutic approach with male IBS clients on a subjective basis to enhance likelihood for achieving positive treatment outcomes.

31,922 words

8.0 APPENDICES

Appendix 1: Participant recruitment letter (version 3- 20.10.2012)

Study title: An exploration of adult male experiences of having Irritable Bowel Syndrome

Dear Sir,

I am a trainee Counselling Psychologist at London Metropolitan University and I am conducting research exploring adult men's experiences of having Irritable Bowel Syndrome (IBS).

IBS is a functional bowel disorder which has no definite identifiable cause and is believed to affect between 10-20% of the general population in the UK. Existing research has not made sufficient efforts to comprehend how men experience IBS and cope with the condition. My proposed study into men's experiences of having IBS aims to identify areas that are difficult for men to experience. The findings may improve existing therapeutic support for men with the condition and tailor help to meet their needs.

Thus, I write to you in the hope that you would be willing to take part in this study and express your experiences of having IBS in an interview with me. An interview is expected to last about one hour and your voice (and my own) will be recorded. The interview material will form the information for this study.

Participation in this study is entirely voluntary. Participants that undergo interview will receive a £10 retail voucher in gratitude for taking part in this study. You are free to withdraw from the study at any time and you do not need to provide a reason. The recorded interview data will be treated as confidential at all times. Any names or identifying details provided during interview will be removed. Recorded interviews will be kept in secure storage until the study has been assessed and eventually will be erased.

Should you be willing to take part you would need to be:

- Diagnosed with IBS by a gastroenterologist
- Male

- British
- Between 20-59 years
- Living in the London area
- Not currently having/ or have been in counselling or therapy within the last six months
- Not have any other functional bowel disorder besides IBS

The nature of the interview questions may bring up thoughts and feelings associated with IBS symptoms which could be distressing. Please take adequate time to consider your participation in this study. Time will be provided after the interview to discuss any thoughts and feelings that came up during the interview and ask any questions. You will be fully debriefed about the purpose of the study and provided with information pertaining to further means of support if needed.

Thanks for your time. If you have any further queries or questions relating to this study then feel free to contact me on Tel: 07947 624009 or email: nigelcampbell@hotmail.com

I would very much look forward to hearing from you.

Yours faithfully,

Nigel Campbell

Appendix 2: Participant information sheet

Study title: An exploration of adult male experiences of having Irritable Bowel Syndrome (version 3- 20.10.2012)

Dear volunteer,

You are being asked to participate in a research study. Before you take part, it is important that you fully understand the purpose of the research and what is asked of you. Therefore, please read the points stated below on this information sheet. Any further questions or queries can be presented either to the researcher, Nigel Campbell or my Research Supervisor Dr Elaine Kasket (see contact details below) for clarification. Please take sufficient time to consider your involvement in this project.

What is the purpose of this study?

This research is being undertaken as a requirement for my study for a Professional Doctorate in Counselling Psychology. This study aims to gain an understanding of how men perceive having Irritable Bowel Syndrome (IBS). As a potential participant you would be encouraged to reflect upon and discuss personal experiences of having IBS and the impact this has had on your life.

Why have I been asked to take part in this study?

You have been chosen because you meet the conditions for participation and I am interested in learning about your experiences of having IBS and how you have coped with the condition.

Do I have to take part?

Participation in this study is voluntary. You may withdraw your involvement at any time, without consequence and without having to provide reason. Withdrawal means that none of your information will be used in the study. Participation will not affect your care at St George's Hospital. The researcher will describe the study and you will be given this information sheet and a consent form to take away and read. You will be given at least 24 hours to consider your participation. If you agree to take part, you will be asked to sign the consent form.

What will happen if I take part?

If you agree to participate you will be asked to attend an interview with myself (lasting approximately 1 hour) and will be asked several questions relating to how you have coped with IBS; the influence, if any, IBS has had your life; and any help you may have sought for IBS. You should understand that you will not be forced to answer any questions which may prove too difficult to talk about. A digital voice recorder will be used to record the interview. The interview will not interfere with your normal care at St George's Hospital.

Will my general practitioner (GP) be informed about my taking part?

No, your GP will not be informed as this study will not affect the current treatment you are receiving. Feel free to inform your GP if you wish.

Will I receive any payments for taking part?

If you participate and are interviewed you will be given a £10 retail (love2shop) voucher in gratitude for taking part in the study.

What are the possible advantages versus disadvantages of taking part?

The nature of the interview questions may prove to be of a sensitive nature and certain thoughts and feelings may be stirred up for the participant which could be potentially distressing. The benefits may be that by answering the interview questions this may bring greater awareness about how IBS personally affects you. Answering questions may highlight the existing coping strengths you have with IBS as well as highlight any coping weaknesses you might have. I can not promise that the study will help you but the information we get may help improve treatments for IBS in the future.

Will my taking part in this study be kept confidential?

What you say during the interview will be treated as confidential. A pseudonym will be used to protect your identity (and any other names) in the interview transcript and the study write-up. Identifying personal details will be stored separately. Designated university staff (and possibly external markers) for marking purposes will have access to the interview materials (but never your matching identity). Interview transcripts will be kept in the possession of London Metropolitan University for five years, in which time the study may be published, after which time it will be safely destroyed. The audio recording of the interview will be erased once the study has been marked by the University. To gain further perspective on possible interviewer bias a second transcriber will analyse the interview transcripts, again with identifying names protected with pseudonyms. Thus, your anonymity will be maintained by the researcher at all times. Confidentiality will be broken if you reveal information during the interview that indicates criminal activities or a plan to harm the self or another person.

What if something goes wrong?

In the event that something does go wrong and you are harmed during the research due to someone‘s negligence then you may have grounds for a legal action for compensation against St George’s Healthcare NHS Trust but you may have to pay your legal costs. The normal NHS complaints mechanisms will still be available to you (if appropriate*).*

Should you wish to complain about any part of your participation in this study, or the way it was conducted, the contact details of my Research Supervisor are as follows: Dr Elaine Kasket, London Metropolitan University, School of

Psychology, Tower Building, 166-220 Holloway Road, London N7 8DB, Tel: 020 7133 2667, e-mail: e.kasket@londonmet.ac.uk. Alternatively, you can complain to the Patient Advice and Liaison Service (PALS), St George's Hospital (in the main corridor between Grosvenor and Lanesborough Wing near the lift foyer) between 9am-5pm, Monday-Friday, Tel: 020 8725 2453, or e-mail: pals@stgeorges.nhs.uk

What will happen to the findings of the study?

Should the findings of this project be published, your identity will be protected and not forwarded to the publisher. A publisher will only receive research data with identifying details removed. Should you wish to know the findings, then they will be forwarded to you upon request.

Who has reviewed this study?

Before any research goes ahead it has to receive approved ethical clearance, to make sure that the research is fair. This study has been reviewed by the East Midlands – Derby 1 Research Ethics Proportionate Review Sub-Committee.

Thanks very much for your interest,

Regards,

Nigel Campbell
Trainee Counselling Psychologist

Tel: [redacted]
[redacted]

Appendix 3: Participant consent form

Study title: An exploration of adult male experiences of having Irritable Bowel syndrome

To be completed by the participant: **please insert initials in boxes**

I confirm that I have read and understand the information sheet dated 20.10.2012, version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that I can refuse to answer any questions I dislike and that the researcher or I can terminate the interview if undue distress becomes apparent. ☐

I understand that my anonymity will be maintained by the researcher at all times. Exceptions to maintaining confidentiality will occur if I provide information that indicates criminal activities, or a plan to harm myself or others. ☐

I understand that participation is voluntary and that my participation decision will not affect my treatment at St George's Hospital. I understand I can withdraw my participation at any time. ☐

I understand that a digital voice recorder will be used to record the interview and the information provided will be used for this study. ☐

I understand that relevant sections of my medical notes may be looked at by individuals from regulatory authorities or from St George's NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

I agree to take part in this study. ☐

Participant Name	Date	Signature
Researcher	Date	Signature

Appendix 4: Interview schedule (version 1 – 07.11.2011)

(A) Exploring the personal and social impact of having IBS

Q. Can you tell me about your history with IBS?
(prompt: beginnings, memories)

Q. What is your experience of living with IBS?
(prompt: freedom, illness obtrusiveness, life impact)

Q. Can you tell me about your interpersonal relationships and IBS?
(prompt: friends, family, work, romantic)

(B) Experiences coping with emotions and cognitions relating to IBS

Q. Can you tell me about the extent to which IBS symptoms are on your mind?
(prompt: duration of thinking, content/ process of thinking, avoidance)

Q. What are your emotional experiences of having IBS?
(prompt: changes in mood, regulation)

(C) Help seeking attitudes towards IBS

Q. How do you feel about seeking help generally?
(prompt: past examples, illness beliefs, medical help)

Q. How do you feel about seeking help for IBS?
(prompt: examples, IBS a serious disorder, stigma, IBS too ambiguous)

Q. What's it like to try to manage your IBS?
(prompt: controllability, outcomes, my vs. doctor's problem)

Appendix 5: Distress Protocol (version 1 – 07.11.2011)

In the event that a participant appears to be experiencing distress during participation in this study then adequate measures need to be taken to contain the participant. As a consequence of answering interview questions which may prove to be of sensitive nature, certain thoughts and feelings may be stirred up for the participant which could be potentially distressing for the participant. Suffers of IBS are thought to have a close relationship between their cognitions and gastrointestinal symptoms. Thus, as the researcher I am aware that upset experienced at a cognitive level may influence gastrointestinal symptoms and vice versa.

As an ethical consideration for this study, the inclusion/ exclusion criteria implemented for participant selection has endeavoured to only use participants that are sufficiently robust from a psychological and physical perspective. Participants selected for this study will not have been in counselling/ psychotherapy for psychological difficulties for at least six months. Also, selected participants will not have a history of serious mental health problems or other bowel disorders (in addition to IBS) Therefore, I do not expect that the participants selected for this study will experience high levels of distress as a consequence of taking part. If a participant does begin to show signs of distress whilst taking part in the study then the interviewer has experience containing distressed individuals gained through working/ volunteering as a Mental Health Practitioner. The following protocol is to be implemented in the event that a participant shows indications of distress:

Mild distress

Visible signs:

(1) Tearfulness
(2) Participant appears upset/ emotional, with difficulty speaking
(3) Participant appears distracted/ agitated
(4) Participant appears to be in physical discomfort

Proposed action:

(1) Check if the participant is willing to continue
(2) Offer participant time to compose themselves before continuing
(3) Remind participant that they can stop at any time if distress escalates including opportunities for a toilet break

Severe distress

Visible signs:

(1) Losing ability to talk clearly/ uncontrolled crying
(2) Fear/ anxiety attacks/ panic (including physical symptoms)
(3) Participant appears to be having great difficulty with agitation/ concentration

(4) Participant appears to be in significant physical discomfort.

Proposed action:

(1) The interview should be terminated by the researcher
(2) Commence study debriefing
(3) If physical discomfort is the central concern then offer a toilet break
(4) Offer appropriate relaxation techniques to ease distress (e.g. brief controlled breathing exercises)
(5) Offer reassurance that their distress is a reaction to the difficulties people can have about life problems and that distress will gradually dissipate
(6) Offer the participant the opportunity to phone a friend/ family member for additional reassurance
(7) If the interview unveils any further psychological difficulties that the participant has then efforts should be made to recognise and affirm their distress yet direct further discussion of such issues to a Mental Health Professional as the interview is not an appropriate environment to offer counselling
(8) Emphasize details of counselling/ emotional support services for accessing further help are listed on the debrief sheet

Extreme distress

Visible signs:

(1) Uncontrolled crying/ wailing, extreme emotional distress
(2) Extreme agitation with possibility of verbal/ physical threat
(3) Suicidal ideation/ planning and/ or expression of psychotic breakdown

Proposed action:

(1) Ascertain and ensure safety of both participant and researcher
(2) If it is apparent that the researcher has concerns for the participant's safety then the appropriate mental health services should be alerted
(3) If the researcher believes that the participant is vulnerable to the extent that he/ she is an immediate danger to themselves or others then it should be suggested the participant seeks immediate psychiatric assistance via a hospital Accident and Emergency Department
(4) Should a participant refuse the suggestion of accessing immediate help and becomes violent then Police should be alerted and suggested the participant is detailed under the Mental Health Act pending psychiatric assessment (only in very extreme cases will this be necessary)

Appendix 6: Participant debrief sheet (version 3 – 20.10.2012)

Study title: An exploration of adult male experiences of having IBS

Dear participant,

This study aims to know how men experience and make sense of having IBS. It is hoped that relevant themes will emerge from studying and comparing the participant interview transcripts. By focusing on adult males, the study aims to examine:

(1) The personal and social impact of having IBS.
(2) Experiences coping with emotions and thoughts about IBS.
(3) Help seeking attitudes towards IBS.

It is hoped that findings will have relevance for adult men who have difficulty coping with/ understanding their IBS. Findings may have relevance for improving the professional practice of treating IBS in Counselling Psychology, assessing attitudes and beliefs towards help-seeking relating to IBS. Findings might also highlight considerations for more effectively managing the therapeutic relationship between the client and counsellor in Counselling Psychology.

Should you have any questions about the study, wish to withdraw your participation, or wish to know the findings of the study then please email me: [redacted]

Any complaints you might have about any aspect of how the study was conducted then feel free to contact my course study supervisor Dr Elaine Kasket via email: e.kasket@londonmet.ac.uk or telephone 020 7133 2667. Or alternatively contact the Patient Advice and Liaison Service (PALS), by visiting the PALS office (in the main corridor between Grosvenor and Lanesborough Wing near the lift foyer) between 9am-5pm, Monday-Friday, Tel: 020 8725 2453, or Email: pals@stgeorges.nhs.uk

Should you have been affected by the sensitive nature of the interview questions and wish to discuss matters confidentially, then you may contact:

British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR
Tel: 0116 254 9568 Fax: 0116 227 1314
Website: http://www.bps.org.uk
(For details of qualified psychologists in the UK)

The British Association of Behavioural and Cognitive Psychotherapies (BABCP)
Imperial House**,** Hornsy Street**,** Bury BL9 5BN
Telephone: 0161 705 4304 Fax: 0161 705 4306
General Enquiries: babcp@babcp.com
(Details of qualified CBT practitioners)

British Association for Counselling and Psychotherapy (BACP)
BACP House, 35-37 Albert Street, Rugby, Warwickshire CV21 2SG
Tel: 0870 443 5252
Website: www.bacp.co.uk
(Details of qualified counsellors and psychotherapists)

Mind in Hammersmith and Fulham
309 Lillie Road, London, SW6 7LL
Tel: 020 7471 0580 Fax: 020 7381 5600
Email: enquiries@hfmind.org.uk
(Service providing counselling and psychotherapy – many other Mind locations in UK)

By contacting your **local GP** it should be possible for you to obtain free counselling/ psychological support.

The Samaritans
Write to: Chris, PO Box 9090, Stirling FK8 2SA
Tel: 08457 90 90 90
(24 hr counselling support help-line)
Email: jo@samaritans.org

Further information/ help about IBS

The Gut Trust (the national charity for Irritable Bowel Syndrome)
Unit 5
53 Mowbray Street
Sheffield, S3 8EN
Telephone: 0114 272 32 53 (general enquiries)
Fax: 0114 201 11 12
Helpline: 0872 300 4537
General enquiries: info@thegutrust.org

(Wealth of information about IBS, a helpline for IBS concerns and information on projects and self-help IBS groups throughout the UK)

Thank you for participating in this project.

Appendix 7: Example extracts from reflexive journal

04.02.11

Rational to explore wider/ general beliefs. It's not all about symptoms in isolation. Wider ramifications may relate to co-morbidity with anxiety/ depression and possible 'bigger picture' for treatment is needed. Treatment needs to tackle IBS and the co-morbid condition more effectively? Is this feasible? Or is it, for example, treating anxiety with IBS as an add-on issue?

27.03.11

Style of interpersonal communication. Can you tell me about your relationships with work colleagues, partners, family? Any difficulties with interpersonal relationships? Do interpersonal relationship difficulties have influence on your IBS? …..How would you like your interpersonal relationships to be in an ideal world?

29.10.11

Woke up today and I've been thinking that I 'hold stuff' inside too much. I take things in but then don't let them go. It's as if I can't trust my environment to let my guard down completely. I woke up and felt my body tighten up but not as much usual. I need to get into the mindful way of just letting tension enter and leave the body naturally.

01.08.12

I was reading a bit about Klein (Gomez, 1997) recently. Part of making the transition away from the paranoid schizoid position to the depressive position is realising that the anxieties we were experiencing in the former position are not real. That's similar to my IBS symptoms, it's like I'm reacting to them as if they are a real threat. But deep down I know they are an exaggerated reaction to normal GI sensations. I'm striving to reach that depressive position….if only I can find a way of embracing it, accepting what I find there.

13.11.12

Regarding the discussion I can talk pluralistically about findings. Can discuss a need for understanding (of IBS symptoms) and connect to a psychodynamic need to relate. Also, this impaired or non-understanding could contribute to isolation and I could discuss the existential implications of this.

18.01.13

After analysing two participant transcripts, maybe I could have explored the social anxiety/ cost of symptoms more in the interviews? Perhaps the questioning should have probed better to open up thinking/ meaning making?

11.05.13

Possible limitation is that I did not measure severity of my participant's IBS. Eric and Jeff [pseudonyms] seem to have most severe/ debilitating IBS. Also, Dave [pseudonym] seems to have the least severe IBS. It may be possible to discuss these issues with reference to the complexity of individual IBS presentations.

McDougall (1989) talk's about IBS manifesting due to unverbalised expression. I could connect this with Cooper (2009) who describes clients who just need to be heard. So, McDougall's idea may not just be psychodynamic/ analytic in focus but perhaps translates to a humanistic approach as well. Thus, we can appreciate pluralistic counselling perspectives.

12.07.13

I forgot to reflect on my 'failed' therapy for IBS in the discussion section. No doubt all three therapists provided enlightenment in their own ways. Yet IBS was the central issue I brought to the therapy room….and it was still there when I left. Now I think about it two of them tended to focus therapy more on issues not particularly related to IBS, areas maybe they were more confident or familiar working in.

Appendix 8a: NRES approval letter

NHS
Health Research Authority

NRES Committee East Midlands - Derby 1
Research Ethics Office
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839436
Facsimile: 0115 8839294

09 January 2012

Mr Nigel Campbell
Trainee Counselling Psychologist
[redacted]

Dear Mr Campbell

Study title: **An exploration of adult male experiences of having Irritable Bowel Syndrome (IBS): A qualitative study**

REC reference: **11/EM/0452**

Thank you for your letter of 28 December 2012, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved by the Committee are:

Document	Version	Date
Evidence of insurance or indemnity		18 November 2011
Interview Schedules/Topic Guides	1	07 November 2011
Investigator CV		26 October 2011
Letter of invitation to participant	2	11 December 2011
Other: CV for Dr Elaine Kaskel		02 November 2011
Other: Participant Distress Protocol	1	07 November 2011
Other: Professional Civil Liability Insurance		12 September 2011
Other: Participant Debrief Sheet	2	11 December 2011
Participant Consent Form	2	11 December 2011
Participant Information Sheet	2	11 December 2011
Protocol	1	07 November 2011
REC application		15 November 2011
Response to Request for Further Information		28 December 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/EM/0452	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Peter Korczak
Chair

Email: carol.marten@nottspct.nhs.uk

Enclosures: *"After ethical review – guidance for researchers" [SL-AR2]*

Copy to: Professor Christopher Branford-White
London Metropolitan University
166-220 Holloway Road,
London, N7 8DB

Dr Andrew Poullis,
St George's Healthcare NHS Trust
Blackshaw Road
Tooting, London, SW17 0QT

Appendix 8b: NRES amendment to protocol approval letter

NHS
Health Research Authority

NRES Committee East Midlands - Derby
Research Ethics Office
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 8839440
Fax: 0115 8839294

06 December 2012

Mr Nigel Campbell
Trainee Counselling Psychologist
[redacted]

Dear Mr Campbell

Study title:	**An exploration of adult male experiences of having Irritable Bowel Syndrome (IBS): A qualitative study**
REC reference:	**11/EM/0452**
Protocol number:	**N/A**
Amendment number:	**1**
Amendment date:	**13 November 2012**
IRAS project ID:	**86210**

The above amendment was reviewed at the meeting of the Sub-Committee held on 06 December 2012.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Summary of changes to the protocol		
Letter of invitation to participant	3	20 October 2012
Participant Information Sheet: Participant debrief sheet	2	20 October 2012
Participant Information Sheet	3	20 October 2012
Notice of Substantial Amendment (non-CTIMPs)	1	13 November 2012
Covering Letter		21 November 2012

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

11/EM/0452:	**Please quote this number on all correspondence**

Yours sincerely

Mr Peter Korczak (Chair)
Chair

E-mail: nrescommittee.eastmidlands-derby@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Dr Andrew Poullis, St George's Healthcare NHS Trust*
Professor Dominic Palmer-Brown

NRES Committee East Midlands - Derby

Attendance at Sub-Committee of the REC meeting on 06 December 2012

Name	Profession	Capacity
Mr Peter Korczak (Chair)	Consultant Maxillo-facial Surgeon	Expert
Dr Helen Sammons (Vice Chair)	Associate Professor in Child Health	Expert

Also in attendance:

Name	Position (or reason for attending)
Mrs Carol Marten	Coordinator

Appendix 9a: Honorary contract

St George's Healthcare NHS
NHS Trust

Human Resources Directorate
Room 1.054, Grosvenor Wing

St George's Hospital
Blackshaw Road
London
SW17 0QT

Tel: 020 8672 1255

www.stgeorges.nhs.uk

ST GEORGE'S HEALTHCARE NHS TRUST
HONORARY LETTER OF ATTACHMENT

24 April 2012

Private and Confidential
Mr N Campbell
[redacted]

Direct tel: 020 8725 3775
Direct fax: 020 8725 2038
Email: sarah.hemmings@stgeorges.nhs.uk

Dear Mr Campbell

Conditions of Attachment

I am writing to confirm your honorary attachment with St.George's Healthcare NHS Trust from 1 April 2012 until 31 October 2012.

1. The reason for the attachment is to undertake a placement as a Student Researcher within the Gastroenterology/Dietician Clinic. During your attachment you will be accountable to Dr Andrew Poullis, Consultant.

2. You will receive no remuneration from the Trust during this attachment and nothing in this agreement confers employment or employment rights either during the term of the attachment or at the end of the attachment. Travelling expenses or any other expenses will not be met by the Trust unless prior formal approval has been given.

3. The Trust will not be responsible for the reimbursement of course, lecture or examination fees unless prior application has been made for a refund of such expenses and formal approval given.

4. Whilst on St. George's Healthcare premises you are required to conform with the conditions of the Trust, and to the Trust and departmental policies and procedures, including but not limited to Equal Opportunities, Health and Safety Regulations, and use of Trust equipment including telephone, computer, internet and e-mail.

5. During the course of the attachment any matters of a confidential nature, including in particular information relating to the diagnosis and treatment of patients, individual staff records, and details of contracts and terms, must under no circumstances be divulged or passed on to any unauthorised person or persons. Breach of confidentiality will result in the termination of the attachment.

6. This honorary attachment is subject to health clearance by our Staff/Student Occupational Health Department and CRB clearance where there is contact with patients or working in a clinical area.

7. The Trust does not accept any responsibility for articles lost or damaged on Trust property.

8. If you agree to accept this attachment on the Terms and Conditions specified above, please sign the formal acceptance at the foot of this letter and return it to me. A copy of this letter is enclosed which should be retained by you for future reference.

Signed on behalf of St. George's Healthcare.

Sarah Hemmings
HR Administrator

Cc Dr Andrew Poulis

****

I hereby accept this honorary attachment on the terms and conditions specified above.

Signed: .....

Date: 29/04/17

Appendix 9b: Honorary contract extension

St George's Healthcare NHS
NHS Trust

Human Resources Directorate
Room 1.054, Grosvenor Wing

Our Ref: SJH

Private and Confidential
Mr N Campbell
[redacted]

St George's Hospital
Blackshaw Road
London
SW17 0QT

Tel: 020 8672 1255

www.stgeorges.nhs.uk

Direct tel: 020 8725 3775
Direct fax: 020 8725 xxxx
Email: sarah.hemmings@stgeorges.nhs.uk

Dear Mr Campbell

Re: Honorary contract extension

I write to confirm the extension of your honorary contract with St. George's Healthcare NHS until **1 September 2013.**

All other terms and conditions of your honorary appointment remain unchanged.

As this letter forms an amendment to your original contract, I should be grateful if you would sign and return the enclosed copy.

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Sarah Hemmings
Human Resources Administrator

.....

DO NOT DETACH

I, NIKKI CAMPBELL .... hereby accept the terms and conditions as set out above.

Sign ..... Dated ..... 27/10/12 .....

Chairman: Christopher Smallwood **Chief Executive:** Miles Scott

WHN 046 (07/07)

Appendix 10: Full annotated example participant transcript

Key to analysis notation (right-hand column)

- Normal text (e.g. ‘trying to predict’) denotes descriptive information
- Text lines beginning with a circled ‘L’ denotes linguistic comments concerning use of language
- Underlined text (e.g. ‘aversion to’) denotes conceptual comments and understandings.

INTERVIEW WITH KEITH (PSEUDONUM)

I: So…..erm…first question. Erm…can you tell me about your… history with IBS?

P: Yeah, sure. Erm…it, well, it seemed to have come out of nowhere. About seven years ago. Erm….which is, because I thought that would be question number one. So.

I: Right.

P: So I had a think about it. About seven years ago. I started having a bit of trouble with erm…nausea…predominantly first. And then erm…er then kind of the diarrhoea after that. And any…

I: Hmm.

P: It a…it kinda went on for about six months before I was kind of particularly worried. Being a… typical man.

I: Yeah?

P: I needed fancy a trip to the doctors. So I erm…

I: Hmm.

P: Carried on (sounds from microphone) and…yeah then started going to the, the GP and …you know then they referred on ta, to ah…(place name deleted) ultimately. I tried…

I: Right.

P: Different courses of…of, of medicine. And then they…okay, by the time it got to erm… (place name deleted)…they, they did the more, the more extreme end of things. The, the kind of more err…basic tests and, and….

I: Yeah.

- understanding and ambiguity
- masculinity
- psychological impact
- normalising efforts
- Trying to predict questions. Anticipatory anxiety?
- thought about it
- nausea
- diarrhoea
- worried
- Being typical man. Normalising? Masculine avoidance?
- aversion to GP?
- Trying various meds
- extreme tests… basic. Contradicting self?
- seriousness of attention

P: What not. So…yeah and…like I say it's been kind of seven years. Seven years and yeah…we were at the point where…and think we're finally turning a corner actually. So yeah…

I: Okay.

P: But that's the kind of potted history I'd have to say.

I: Hmm hmm…..Seven years is quite a while?

P: Yeah…yeah I mean thee…thee…I think there is a kind of a lot of slow moving going on in, in there as well. It was.

I: Hmm.

P: It was taking the time to kind of get around to seeing the GP and, and not being funny. Being the size I am. They take a look and go, you must be eating a load of… crap. And therefore you're feeling.

I: Right.

P: Crap. Pardon my French. But there's, there's an element there of not…I was lucky to have a pretty good doctor to begin with. Pretty understanding. I think he was a locum…actually.

I: Right.

P: Erm…and he, you know he…he kind of listened, and kind of listened beyond it rather than jus thinking, making a kind of judgement. But it, it.

I: Hmm.

P: Did seem to take a…a kinda little while to get things moving. But ah…that was even with his kind of…

I: Yeah.

P: Understanding nature. So erm…Yeah, I don't, you don't really think it's anything more than a bit inconvenient and then…

- empowerment/ realising +ve change
- struggle to be understood
- value of acknowledgement
- finally turning a corner. sense of establishing relief/change perception of previously being stuck.
- slow treatment. Dissatisfaction of treatment minimising condition?
- time
- size
- perceived judgements by GP? He's damaging himself?
- mindreading. Stigma?
- crap.
- good doctor/understanding
- lucky - Other GPs not so good? Vulnerability to doctor?
- listened beyond, rather than judging. Sense of taking the time to understand him. GP is active
- significant sense of connection. Lost before?
- understanding nature - was this containing for him? was he struggling to contain self/worry?

I: Hmm.

P: And if you're dealing with, with work everyone has an upset stomach and they…just kinda chuck it in a pigeon hole. So ah…

I: Right.

P: It was a kind of slow….kind of development of getting to here and…

I: Hmm.

P: I think, I've been under here for about…..five, six years now. So it's erm…

I: Hmm hmm.

P: It's just been, been a…yeah, quite a while.

I: Hmm.

P: Quite a while.

I: Six years of …attending this place?

P: Ah yeah. Yeah, on and off. The different kind of tests and erm…it…the way that the appointments would be kind of booked. They were really inconveniently… spaced as well. So, so you'd get one…have to push it back to the next available one. And then you, you kind of chucked a, a three…three month window into that. So the time … actually.

I: Hmm.

P: You know? That's probably…not too unusual. But ah…

I: Right.

P: Erm. Yeah, and it was…the…kind of…..probably doesn't seem as long to me because there was a really disjointed narrative during the treatment. So I didn't t really…kind of understand how A joined to B joined to C. So it was…

- lack of acknowledgment
- questioning helpfulness of treatment
- treatment direction confusing

everyone has upset stomach - Normalising?

- chucked in pigeon hole. Sense of quickly labelled, too quickly, with inadequate consideration?
- invisible illnesses not real enough -
- slow development. Impatient? A journey of discovery?

Metaphor for suppression in treatment, under control?

- criticising appointment scheduling. Struggling to accomodate treatment?

- lack of info/guidance? Poor communication?

I: Hmm.
P: You know? No idea. Have this test and come back. Inconclusive. Have that test. Come back. Inconclusive. Have that test. So it didn't…
I: Right.
P: Feel necessarily like a, like a linear kind of joined up process.
I: Oh okay.
P: Yeah, time kind of invariable flew by after that. I think. So…
I: Hmm. That's interesting…Okay, erm…So what is your erm experience with living with IBS then?
P:….Erm it….(laughs). It's inconvenient more than anything. It's, it's erm….thee…..thee…..probably the biggest thing is, is the unpredictability of it. Which, which has, has been really..
I: Right.
P: Erm….really unsettling to begin with because ah, you know when I first started getting, getting the problem erm… I was living out near, near (place name deleted). If you're…aware where that is. It's the other side of (place name deleted). Give or take.
I: Oh okay.
P: So… it was like a train journey in.
I: Hmm.
P: And that just took on epic proportions. And that wasn't even when it was at it's worst. But it was, it was like a thirty-five minute journey into (place name deleted) where I work.
I: Hmm.

- confusion with treatment
- laughing it off
- vulnerability to symptoms unpredictable
- commuting risk to security

- resulting logical procedure. Is he bothered by lack of human touch? Vulnerable, ~~undefined~~ illness?
- struggled to comprehend treatment pathway? Dis-joined.
- seems unconvinced by treatment/slightly uncontained
- laughter (make light). Masculine response?
- unpredictability is unsettling. Lack of control!! Containment? Lack of security
- vulnerable!
- took on epic proportions. Appraised experience as epic. Coping becoming arduous/threatening to his mind.

Endurance and Struggle

* preoccupation

- Loss of self
- masculinity/ restriction

need for planning

123 P: And ah…and it was, it was…leaving the house in the
124 morning feeling a bit ropey…and just…and just having
125 to get through it. It, it just became a kind of battle.
126 And…
127 I: Hmm hmm…
128 P: Being slightly pig headed it was a battle against
129 myself. And then not wanting to let my career kind of…
130 suffer…and…
131 I: Hmm.
132 P: You know? I was young.
133 I: Hmm.
134 P: I should have been going out to the pub and, and I
135 like going out to, to gigs and that so it was…it should
136 have been…
137 I: Hmm.
138 P: Kind of easy but it just became a… a kind of
139 trudge…erm…and…that was, that was… the kind
140 of…the…that kind of set the tone really just having
141 to…Having to think ahead for everything…
142 I: Right okay.
143 P: That you're doing. It's erm…I, I'm not. I have to say
144 I'm not a fan of this kind of…the fad of saying, oh yeah
145 OCD, OCD is really cool. It has become like a…thing
146 that people have.
147 I: Right.
148 P: You…have an element of needing to think ahead.
149 Needing to….without…getting it into too far at the
150 moment. But, but it's…you know what stations are on
151 your stop. Have loos…and you know which don't.
152 I: Oh okay.

feeling ropey.
having to get through it. Sense of endurance.
battle. Preoccupation of anxiety/intrusion.
pig headed/battle against self. Sense of internal fight with symptoms – not external. Hiding struggle?
illness impacting on many areas of life.
protecting career. aware of cost of submitting to illness.
young:
Should have been going out. Loss of youth? and restricting width of life/social life?
struggle to maintain masculine identity.
Should have been easy. results it wasn't easy?
set the tone. achieving/accepting a reality of coping/living with condition – Compromised
having to think ahead. Impressed sense of planning
OCD

Elaborate understanding of safety tabs.
Restrictions on freedoms.

P: You know the local pubs if you need to leave the station to find a toilet.
I: Right.
P: You break it down to that kind of level. That's a...
I: Hmm hmm.
P: You know erm....you... became slightly reclusive with it because of the unpredictable nature. So you start saying no to your mates. You know? I won't come out tonight. You know? Feeling a bit ropey or...
I: Right.
P: The classic one. Going for a curry and then some beers....I couldn't think of anything worse.
I: Hmm.
P: Even, even to this point. But ah, so you start kind of...thinking of, about the best way to.... kind of...you, it can be quite selfish in a way. You start thinking well...not being funny lads but...I know it's your birthday but...(laughs) I'm really not going to chance it for the sake of coming out... and point scoring. You know? So it was about just finding...kind of finding something that worked...kind of terms of a pattern.
I: Yeah yeah.
P: Even kind of moving and a...commute changing....
I: Hmm.
P: You, you think about everything. You think about...if I go to, to a...(place name deleted).
I: Yeah.
P: I know where the best loos are. Loos are to use in the building. And then if you...
I: Right.

- restriction and loss
- struggle to maintain rels.
- Struggle to maintain rel.
- Vulnerability to symptoms.
- need for planning.

- break it down micro analysis efforts. Trying to prepare for routine tasks.
- reclusive. social self restricted due to condition sense of loss sense of threat to security.
- rejection social invites. Compromising friendship/ maintenance/ place in the 'main' circle?
- lost opportunity to maintain masculine identity.
- quite selfish. Concern over choosing to focus on self over mates. Is he questioning workers IBS.
- Struggles/rejecting place in man group.
- finding a routine that worked. Establishing effective coping? Recognising logical way to gain some control and manage threat to security.

P: Go…and then, then you think, well I'll get to (place name deleted) and, and that pub's a bit grim. But that one I can use the loos in. So it's just…
I: Hmm.
P: Every, every night out, or every day out for that matter became a …kind of…
I: Yeah.
P: Just ah…bit of a...bit of an ordeal. Took any kind of spontaneity out of things as well.
I: Oh okay.
P: Just….ah….ah….the kind of…
I: Is that something you value then? The spontaneity?
P: Erm…(laughs). I really don't remember spontaneity to a point actually. But I think there was an element of, of, of erm…a holiday. Silly things like a holidaying in this country more.
I: Right.
P: Because you kind of…if you rent a… we took to renting a…flat in (place name deleted). His parents were originally from (place name deleted) and then they moved up here.
I: Oh okay.
P: So…we loved going to (place name deleted) anyway. But rather than…kind of stay in hotel you kind of rent a flat. Rather than going abroad where you're not sure what the kind of facilities are…then a… staying in this country. Feels safe, feels regular, you can rely on it.
I: Hmm.
P: And that's kind of…truly the, the best way to unwind. It, it…
I: Hmm.

- sense of connecting thoughts (worry) linked with safety Cons.
* DS impacting how he thinks about places.
- going out (social) becomes an ordeal (cognitively appraised as ordeal)
- spontaneity is sacrificed. Loss of freedom & autonomy.
- connects Wide to spontaniety.
* loss of spontaneity may reflect loss of self/identity
- Staying in UK Safer?
- not sure of facilities. Sense of not wanting to take risk, leave self vulnerable.
- Feels safe/ regular/ rely on it. Striving for security.
- can unwind — in perceived safe environment.
- However life has become more of an ordeal with perceived risks he needs to manage.

- restriction of freedoms
- loss of self
- restriction
- Uncertainty and need for security

P: I know some people like to experience new things but…I found more comfort in a…in kind of doing stuff…
I: Hmm.
P: That I knew (laughs) rather than trying to experience new things, foods….nights out.
I: Yeah.
P: And things. Yeah, I mean…Well, that's kind of thee key element of it really.
I: Hmm.
P: I suppose…. But, ah…adjusting the way I did everything and what I kind of approached it. How I…planned it.
I: Yeah yeah.
P: To...to, not necessarily become obsessive but thinking, look if I can stay on the train. Because (place name deleted) my commute was from (place name deleted). So if I can stay on the train until (place name deleted)…
I: Hmm.
P: That, that's one goal. And then if I can stay on until… (place name deleted)… that's, that's another goal. And then by the time I get to (place name deleted) you think, well you might as well stay on the train to (place name deleted) rather than hopping off. So…you break the day down into kind of different goals to meet and…
I: Yeah.
P: Luckily I'm…like I said I'm quite pig-headed. I can stick to that kind of thing prob, probably quite easily.
I: Hmm.

- restriction on experience and freedom
- restrictive self
- acceptance and adaptation
- preoccupation
- adapting to condition
- cognitive inflexibility

- choosing comfort over new experiences. Less risk involved. Less.
- laughter. I get sense of making sacrifices for comfort
- sense of having to 'readjust' compromised freedom. Loss.
- way I did everything - approached it - planned it
- significant changes. Impacting / integrating with new identity.
- security compromised on transport
- adopting a rational technique / small goals.
- breaking goals down. Does this help worry/anxiety?
- hopping off - counters his urge for avoidance/escape
- pig-headed. recognises the function to restrict self. But does pig-headedness come with cognitive inflexibility?
- preoccupation with rigid goals.

P: Can get quite…Once you learn the trick to…
I: Was it erm…was it like something that developed… overnight or did it develop over time? That kind of…you know? Planning ahead… route?
P: Ah…it. I've always been quite organised but it became a kind of erm…like ah, like a natural… thing really. I, I, I remember with the, with the first commute erm…(place name deleted). But for many, many nights out. So…kind of, (place name deleted) felt safe. As the train came through. Got to (place name deleted) station.
I: Yeah.
P: I knew that there was facilities there. But also I knew…kind of (name deleted)…so it was kind of…
I: Hmm.
P: Quite comfortable. So I, I, I…I think, it wasn't instantly something I found but erm…in a way it's kind of… passed the time a…What do they call it? They call it Klondike on the I, Ipad but Solitaire.
I: Right.
P: If you engage your mind doing other things like finding little things like that.
I: Okay.
P: Then…the train seems to go quicker.
I: Right.
P: Or you kind of…you know? Reading the Metro. You know? Things, things that you find…well that works. So I'll…
I: Hmm.
P: So I'll never…leave… without my Ipod.
I: Right.

learn trick for successful coping

always been organised. Need for order/control?

location felt safe. Lack of threat to execute symptoms? Does the unknown present anxiety then?

felt comfortable with location. sense of constants striving for 'comfort' with OCD.

use/effect of cognitive distraction. struggle to 'disrupt' preoccupation, as if it 'consumes' him.

train journey easier. Distraction seems to provide a relief.

Ipod/metro also safety locks. metaphorically, Ipod represents baggage he now needs to manage. Is all this stuff 'weighing him down'?

organisation and control

security

preoccupation

adapting to condition

P: Or something that kind of passed the time. So yeah, it wasn't, wasn't necessarily instant. But it became quite easily I think.
I: Yeah.
P: Yeah…so.
I: Okay.
P: Hmm.
I: That sounds good……Yes, erm….can you sort of tell me about interpersonal relationships and IBS? Yeah. I mean friends, family, work…?
P: Yeah, yeah. No problem. Erm, I…..kind of…I think…I'm one of the luckiest sufferers out there because I've found a partner… (laughs) who also happened to have…she had Ulcerative Colitis.
I: Right.
P: And so…we met at, at my kind of old work. Erm…when I started off I was in one relationship and then that, that broke up. Not… because of the condition. But that kind of finished…
I: Hmm.
P: And erm….er, then, then I met this other, the girl through work and she was on the road to recovery from Ulcerative Colitis.
I: Right.
P: And just as I was kind of getting worse she was kind of getting better. But, but she understood.
I: Hmm.
P: So erm….Probably because she was probably a bit further along the road…the, the kind of road map if you like than I was. She, she understood that nights in… were kind of better than nights out. And she felt

Becomes coping skills
Normalising to copy/reduce

lucky
lucky in that there is shared understanding? Sympathy?

She understood. Seems important ability to connect with her. Less isolating?

understood his restrictions. Seems to be looking for collaborator in living a restricted life.

- being understood in rels.
- restriction

- loss of freedom

- being understood in rels.

- security in rel.

- struggle to maintain rel/ threat

- aversion to risks/

306 that…erm…she could understand that you know,
307 holidaying in Britain. She, she…kind of…got those…
308 kind of feelings. Got those kind of a…plans kind of out
309 the way if you like. She's a bit more free spirited than I
310 am. But…
311 I: Right.
312 P: She…she understood. And, and it was never
313 judgemental. It was never like, ah can't we…
314 I: Hmm hmm.
315 P: Can't we go out. Whereas….I mean it easily could
316 have been.
317 I: Yeah. Is that important to you? That…having that
318 understanding?
319 P: I, you know what? I, I think it's…it's probably…it
320 made the relationship a lot… a lot kind of firmer. A lot
321 quicker.
322 I: Right.
323 P: So yeah…it kind of…like in any relationship.
324 I: Hmm.
325 P: Bit of common ground…(laughs). It's probably not
326 the best the common ground to have. But it, it, it
327 actually…erm…became…It was quite an important bit.
328 Because erm…
329 I: Hmm.
330 P: Friends…already touched on friends….you kind of
331 drifted apart. Drifted away erm from, from kind of
332 friends, friends group. As you… engage less and less.
333 And ah, erm…the… kind of… main group of friends
334 became work friends. Because I was already in work.
335 You didn't have to make that second effort if you like.
336 I: Right.

Understand. Does this make him feel less isolated with condition?

Recognise She is free spirited. He is acknowledging loss of freedoms (indirectly)

Seems important her understanding/non-judgemental attitude

understand led to strengthening of relationship. indicting a desire for 'firmness'/security in rels.

recognises importance of common ground

important bit.

Drifted from friends sense of loss and shrinking of social engagement.

Social focus on work friends. less effort. Sounds as if activities appraised as 'an effort' are aversive.

Also was he not willing to maintain masculine identity by engaging with old mates. Confirmed?

P: Like journey somewhere else. So…going for a couple of beers after work or…

I: Hmm.

P: Or they…became close to them. So…it's…kind of drifted away from my friends group. And they're, they're bridges that… I haven't necessarily been able to rebuild. In though with this kind of period of time…I mean.

I: Hmm.

P: I can go a couple of years without seeing some of the guys and it's…

I: Yeah….

P: It is, it's kind of strange because…we, you know? We did all the lads holidays when we were growing up. We…you know? We went, went camping. We went to school together and college together and all the rest of it. So…

I: Hmm.

P: It's kind of…that, that's kind of awkward. That's one of kind of one the bits I kind of…

I: Hmm.

P: I miss a bit. But erm….

I: Sounds like they were pretty close…mates?

P: Yeah, yeah. And they were. And it was erm…probably backing up, I mean rewind seven years and I would have been…sorry wouldn't have been thirty. I would have been twenty-fourish.

I: Yeah.

P: And I…you're at that kind of bit where you've finished Uni. Those of us that went. And we're in, and

journey. aversive to using a journey.
rejecting this old masculine activity?
Developed 'distance' from old friends. Struggle to relate?
bridges not rebuilt. Sense of loss / brokenness.
pushed further into isolation with IBS?
normalising not seeing them for long time periods?
lads holidays. bonding?
went to school together. close ties built over years / significant events. He BUILD MASCULINE IDENTITY WITH THIS MEN... BUT NOW WOULD STRUGGLE TO MAINTAIN THOSE
awkward. Doesn't know how to handle / address it.
perhaps tension is resolving what was masculinity is now in relation to these older.
miss a bit. Loss of relationships (strength of)?
finished Uni. Life Stages.

Struggle to maintain rels.

masculinity.

P: we were in the kind of second job…scenario. And
P: they've got their own girlfriends.
I: Hmm.
P: You know I've got my partner. They're buying
P: houses and we're looking at property and things.
P: So…kind of…probably wasn't as, as kind of jarring as it
P: would have been…three, four, five years before that.
I: Right.
P: So…it, it, yeah. Yeah, it was, it was an important part
P: actually and a…
I: Hmm.
P: And that's the joy of Facebook (laughs). Because you
P: can stay connected.
I: Alright (laughs).
P: Probably the sole joy of Facebook. You can stay
P: connected. So ah…yeah, I know when they're, they're
P: popping out sprogs and, and where they're
P: moving…and travelling and whatnot. So…it's…
I: Right.
P: It's erm…nice. And hopefully we're meetin' up soon.
I: Hmm.
P: To celebrate...someone has just got engaged. So
P: that…
I: Fair enough.
P: You know?
I: Hmm.
P: So it' s nice that they're still (laughs) willing to kind
P: persevere.
I: Hmm.
P: Erm…the, the other, you mentioned family as well.
I: Yeah.

2nd job
Got girlfriends
Buying houses. Investing in future/taking responsibility
Jarring. Definition: painful damaging shock through body - Emphasising the high impact
recognising the importance of time spent together indicating more needs for freedom & from restrictions
Laughter. Making light of?
Facebook connect. Effort to rebuild relationship but not have to journey
Stay connected. Anxiety when not possible?
Hopefully meeting up
Engaged. Significant event!
They're willing to persevere. Sense he made them suffer/tested strength of friendship.
Insecurity about maintaining relationship(s)?

imp. of interp. connection

Strength of rels.

-being understood in rels.

P: That might be an interesting one because erm…you know, my, my family are very understanding all the way along. You know? And….but I don't think ever…truly got it.
I: Right.
P: ….As….well as kind of….ah, my other half….did.
I: Yeah.
P: And I think there's a kind of……..I, do, don't. We're not a big family. But…
I: Hmm.
P: We're a close family. I'm one of…one of four boys. And ah…you know? They haven't moved too far from the local vicinity either.
I: Yeah.
P: The idea that, that I would be living just down the (place name deleted).
I: Hmm.
P: Yet was feeling too grim to come over to, to like a…a birthday party or something. I think….I don't think mum or dad truly understood….how bad I felt. And, and kind of how…
I: Yeah.
P: And how hard it was to me. So….kind of there's, there's times when you know? I thought…I should be making more of an effort. But…
I: Hmm.
P: You know? I'm trying as hard as I could. So I kind of sometimes felt that it was…
I: Hmm.
P: …erm….they, they didn't really understand….
I: Right.

-questioning condition/self

-being understood in rels.

Family Understanding.
Don't think ever truly got it. Contradiction previously. Sense of isolation in family due to lack of understanding.

Siblings & him stayed close to home.

Feeling too grim. Sense of obligation.

Parents didn't comprehend his distress/reasons for staying away. Does this put strain on relationship?
Again, remoteness of an invisible condition can be ALIENATING for self.
How hard it was.

questioning his personal efforts. self-critical due to condition? Is this a reaction to CFS?
Trying as hard as I could. Need to justify his efforts?

Didn't understand

-Invisibleness of IBS perhaps leading him to doubt of his condition is wrong of non-attendance of events.

-He has some doubts which may be fueled by family scepticism.

P: Too well.... Even with, with this kind of Fodmaps diet thing. They try...but they...you know? I'm still and mum will say...do you want sugar in your tea or something and dad will say, you can't have sugar. Yeah, I can have sugar.

I: Right.

P: But... he's kind of got it all twisted and, and back to front. So they try.

I: Hmm.

P: But I think there's a...there's a kind of gap there. I don't.

I: Right.

P: Think they truly appreciate it. I don't think probably anyone can really know just how bad it is unless they've....

I: hmm.

P: Unless they've...been through it. And...

I: Hmm.

P: You know? They kind of.....the, the (laughs) the, the knowing looks sometimes when, when I'm feeling ropey or my other half is feeling ropey. It's like...we're not going anywhere this weekend are we? And you know? It just...ah, yeah. It's kind hard to...to truly appreciate just how grim it gets.

I: Hmm hmm....yeah. Very comprehensively answered. Thank you.

P: Good (laughs).....

I: So can you...tell me about the extent to which IBS symptoms are on your mind?

P: Ah.....yeah, that's kind of... kind of one I expected as well.

- being understood in rels
- being understood in rels
- isolation

- Dad can't 'see' the illness and is struggling to get it.
- there's a gap there. Gap in understanding/gap caused by lack of understanding. Does that? Strain, put distance between the relationships?
- invisible IBS preventing objective understanding.
- Believes only IBS sufferers can only truly understand. United by suffering perspective?
- Knowing looks - subtle interpretations
- immobilised! Pulled back from action.
- Isolated by condition & stigma about condition
- predicted question again - Doesn't like surprises.

- preoccupation

I: Hmm.
P: It, it, it does kind of boil down to this, this kind of obsessive thing where…
I: Right.
P: Erm….we…as, as a couple, my partner and I. We tried…..thee not the self-hypnosis things…but the one guy…(name deleted) or something like that…it's a, it's a (name deleted). And a…
I: Oh yeah…
P: A very soothing voice. It's (name deleted) something I think.
I: I know who you mean. I can't remember his surname.
P:…And erm…we, we got these, these CDs to listen to. And we were going to do it together (laughs). You know like all the…every, every couple needs a…something to do. And a…we were going to do it together. And…one of the…the key messages. We didn't bother completing the course. Because one of the key kind of messages was, was not fixating on it and not focusing on it so…erm… Yeah, you find other fixations to distract yourself. Like the playing solitaire or erm…
I: Right.
P: Or, or the, the hand grips and what if you're…
I: Hmm.
P: You know? Rather than focusing on the symptoms. But…they do become a….you wake up in the morning and you think…what's my stomach doing? Or……
I: Right.
P: You get home from work and you think right. I'm going to hit the Gym.
I: Hmm.

boils down to obsessive thing. Is he referring to pre-occupation with IBS?

self-hypnosis

listened to CDs together. Couple activity/ bonding supportive exercise.

is he normalising the 'strangeness' of the CDs.

Key message: not fixating on it/focusing.

pro-active efforts to distract self

hand-grips

Scans body for threat in morning?

engaging in the activity.

vulnerability to symptoms unpredictable

491 P: But what's my stomach up to? You, you, you.
492 I: Hmm.
493 P: It is kind of the first kind of the first question you
494 ask....erm....or....or if someone says, oh you know?
495 You, you...mum...says are you coming over on
496 Sunday? For lunch? And...
497 I: Right.
498 P: Probably the furthest answer I can give is
499 probably....because I'm very conscious of...if I wake
500 up Friday, Saturday, Sunday. Whatever and, and
501 feel...you know? Grim.
502 I: Yeah.
503 P: Then I, I...you know? I won't... be going. So...
504 I: Hmm.
505 P: They're on...my mind pretty much all the time...and
506 ah...And how you kind of space your day. If I'm in
507 work. You know? Eating lunch at a certain time.
508 I: Yeah.
509 P: And gauging for how much time I need to leave
510 it...so if I've got a meeting at 2 O'clock?
511 I: Hmm.
512 P: Eat early because I'm conscious that I might
513 feel...unwell in that period and it's long enough for me
514 to...come up with some kind of contingency. So...
515 I: Right right.
516 P: Yeah...they're pretty much... they're, they're.
517 I: Hmm.
518 P: All the time.
519 I: Hmm hmm.....All the time. That's a lot.
520 P: All the time is a lot. Actually, not when you're
521 sleeping actually. I don't say I dream about it (laughs).

- restriction
- preoccupation
- adaptation and acceptance
- preoccupation

Sense stomach is dictating freedom to engage in activity; own body poses threat to security

Established question - has become normalised.

probably. Struggle to confirm social engagement.

Won't be going: Decisive in rigid way:

on mind all of time. Pre-occupation.

Kind of space your day. Plan ahead.

Employing safety back at eating at certain time.

there all the time

Dread effect sleep. Relief... when unconscious.

But erm….there's…there's….it, it lessons when you find something that works. Like the, like you, you find yourself erm….if you have…five day, five day working week. And you have ah…three good days on the trot.

I :Yeah.

P: And you find yourself …kind of lulled into a false sense of security. And these, these, you can easily wake up on the Thursday having done everything… that you're done the…all week. The same.

I: Hmm.

P: And suddenly think, oh….you know? And…..then it kind of…probably scares you backward a step so then the Friday you are even more…

I: Yeah.

P: Aware and cautious and guarded and even into the weekend.

I: Hmm.

P: That it's…erm…it, it, it…..not….I'm not going to say that it, it dictates your life. Because that's too far. But it, it, it's a consideration that's always there.

I: Right.

P: Erm.. you know? Even if you chance it. You think…we'll go out.

I: Hmm.

P: Yeah, we will…drive down country lanes. (laughs) but we know…that you know? You always…always think… about it.

I: Hmm.

P: Yeah, I think probably always is actually probably quite fair.

I: Yeah?

- Unpredictability and control
- preoccupation / worries
- intrusiveness
- vulnerability to symptoms/ unpredictable
- preoccupation

- lulled into false sense of security. Can't afford to relax / not monitor symptoms?
- scares you backwards. Threat to perceived security?
- aware / cautious / guarded — Sounds like fight or flight is activated. Preparing for worst.
- IBS concerns always there.
- even if you chance it
- when out and about he cognitively monitors symptoms if they are active.

P: Yeah.
I: That's fair enough……so erm…..hmm. What would you say your… emotional experiences of having IBS are then?
P: Emotional experiences...
I: What does it bring up for you?
P: Yeah….there's….I don't…like…ah….kind of….touched on thee erm…there's an element of….you feel you're missed out on things. There's kind of an element there of, of.
I: Hmm.
P: Ah….you know? You, you……it's like remorse. It's not as strong as remorse but erm….like regret…
I: Hmm.
P: (laughs) but not in a kind melancholy, rueful way. Just a kind of…
I: Right.
P: You know, you, you kind of. You know that was a shame. Or…
I: Hmm hmm.
P: That kind of element. Erm….and……you…I don't know? It's a….erm…I probably only felt guilty about it once. Where we went on holiday. We, we were…took…persuaded to go holiday with mum and dad over to (place name deleted).
I: Right.
P: And…….now, now….everyone I've spoken to since say, oh yeah, I always get an upset stomach in (place name deleted). But it…wiped out (laughs)…like the back end of the holiday….by description. The, the second half of the holiday was just a write off because

restriction and loss

feels he is missing out. loss?

regret.

melancholy alluding to loss

that was a shame

undesirable Feelings and aversion.

felt guilty once - linked to parents holiday.
Guilt seems to be linked to letting them down, after their investment.
was his IBS a threat to his connection in rels?

wiped out. alarming debilitating symptoms of IBS aggressively took over, limiting his freedom.
write off. Did it happen?

- restriction and debilitation

= imp. of interpersonal connection

- Struggle to access emotions

- indirect disclosure and reluctance

584 I.... I could barely make it to the pool because I was, I
585 was just.....
586 I: Hmm hmm.
587 P: In pain and....in, in kind of, no fit state to go
588 anywhere. And it was like mum and dad had taken us on
589 holiday. Paid. And... you know? Booked these
590 excursion and whatnot. And I was just having to say...
591 I: Hmm.
592 P: Probably, probably...down about four hundred quid
593 here and I'm afraid there's nothing...you know? I can
594 do. So...
595 I: Hmm.
596 P: Probably that, that...you know? Was a kind of...I did
597 feel guilty about that... but...
598 I: Hmm hmm.
599 P: Hmm....you know? But I think that's, that's...the
600 only time. Erm....emotional, emotional....I don't know?
601 There's an element of....I used to when, when it first
602 started and the, the nausea kind of gave way to the kind
603 of diarrhoea and stuff. I used to still kind of...euph,
604 euphemisms like feeling unwell. Or nausea.
605 I: Right.
606 P: Or your nausea rather than...saying...I've got
607 diarrhoea. Because there's and an element there of,
608 of.....
609 I: Hmm.
610 P: ....like one of (laughing) the more comical kind of
611 afflictions to the people that haven't...kind of suffered
612 with it. So...
613 I: Right.

- debilitated state
- no fit state
- Having to 'justify' not going. Again he may be doubting the realness of his condition or perhaps how it is being perceived.
- feel guilty.
- Struggling to access emotions? Recall struggle?
- nausea gave way to diarrhoea
- Used euphemisms: feeling unwell. Is this easier than saying ~~IBS~~? Stigma!
- laughter - Making light of?
- comical afflictions, he could be laughed at. What's it mean to be ridiculed?
- ridicule damages his desired sense of identity.

P: There's an element of embarrassment there
and….and kind of you, you…you try… to, to kind of
make light of it…but yeah….
I: Hmm.
P: And I think erm….when it, when it…….getting
better. Touch wood. It's on the mend….and, and an
element of relief.
I: hmm.
P: And doing things…that you really look forward
to…but actually come off and you've been able to.
I: Yeah.
P: You get like a double satisfaction I'd have to say
from that a…music festivals. We've, we've started to
going to a couple of years ago and a…
I: Hmm.
P: You know? I've wanted to go for ages…and..it was a
fantastic experience. And you feel…
I: Hmm.
P: Doublely… rejuvenated and, and.
I: Hmm.
P: Second lease…
I: Hmm.
P: And so yeah…. Yeah, ….probably that one.
I: (long pause) Fair enough….Erm….So…. how do you
feel about seeking help generally? You know, with
whatever… you might be ill with?
P:….Yeah…I'm not a fan. If you, you ….I work on the
adage if you, if you go looking for problems you'll find
them. Like ah there's….you know? You, you… I
only…probably was inspired to carry on…with the
doctor route…

- laughing it off.
- recognising the change
- vulnerability.
- recognising the change.
- reluctance for help seeking.

- Embarrassment.
- Makes effort to make light of symptoms!
- relief at symptom improvement. Doesn't have disguise symptoms? Relief at this?
- touch wood. Indicative sense of vulnerability to conditions return.
- being able to do things he values
- double satisfaction.
- Doubley rejuvenated
- Second lease — sense of given another chance to live fully/to embrace QOL?
  - reconnecting with lost self
- not a fan of help-seeking
- Believes that looking for problems will find them.
- Again, sense he sees self as vulnerable to what his own body could do. Distrustful relationship to health/body.

I: Hmm.
P: Because the guy, the locum a…was quite approachable. He was…quite open. Relatively young… bloke and there kind of an element there of…kind of identifying with him.
I: Right.
P: I dare say. I'd go as far as to say that if it was one of the usual doctors…As good as they are…you know? Not casting aspirations. But they…they engaged with it on a different level. There no kind of….
I: Right.
P: Empathetic connection that, that kind of…a…inspired me to probably carry on. I don't….generally I don't…I'll battle, I'll battle on through…Take loads of pills and get on with it. As far as I can. But a…erm…yeah.
I: So you…were you getting, getting more empathy from the locum?
P: Yeah. Yeah, yeah I think so yeah. Because he, he, he could actually…rather than just going, oh right, okay. Let's try and fix it.
I: Yeah.
P: He actually took the time to say…oh, that's not good. That's not right. Oh no, no…
I: Hmm.
P:…..ah…..yeah. That's…clearly something wrong. Rather than just charging head strong, sorry head first into…
I: Hmm.
P: Erm….the, the kind of….. trying to fix it. So it, a real identification with, with the impact it was having.

- Empathy and understanding
- Struggle to cope
- empathy and understanding

- Persevered with help-seeking due to approachable nature of locum
- identified with him. Important of being able to relate/connect when addressing IBS.
- Pointing out less 'empathy' from other doctors. Sense of not being acknowledged or held.
- battle with self
- Given motivation to carry on! In that.
- indicates self-medication tendency.
- Went beyond trying to fix it. Mechanical/dehumanised perspective? There is a person here!
- Locum sympathised with his condition. Does he feel isolated with IBS? Isolated with his extent of suffering?
- Charging head-strong. Not taking enough time to consider? Execution skills? Their personality. domineering? threatening.
- He identified with impact it was having - sense of acknowledgment.

empathy and understanding

reluctance for help seeking

Struggle to connect

676 I: Yeah.
677 P: The kind then…showed the…bit of thought into, kind
678 of…what he considered to help it rather than…just…
679 I: Hmm.
680 P: Take these pills and then those pills and then, then
681 it's just a course of treatment.
682 I: Right right.
683 P: So…but yeah, yeah. I tend not to harangue the doctor.
684 I: (laughs).
685 P: (laughs) If I'm being honest with you. But ah
686 yeah…(laughs). That was a positive experience.
687 I: Yeah.
688 P: So…
689 I: Yeah….hmm….it's interesting like…the different of
690 one…one doctor can do in a situation.
691 P: Totally, yeah yeah.
692 I:……but erm…..so…..how do you feel about seeking
693 help for IBS then?
694 P: Erm……it's a…… kind of…it's something
695 that…it's taken…a lot badgering (laughs) from my folks
696 and my other half to kind of persevere. Because
697 erm…when you hit the kind of hospital end of things.
698 I: Hmm.
699 P: I…….you know? There's, things tend to just
700 slow…right up. And erm, the particular consultant I was
701 seeing didn't…didn't seem to be able to communicate
702 very well…on, on a kind of number of levels. And it
703 was…
704 I: Hmm.

showed some thought rather than prescribing / sense of appreciating effort to understand his condition.

just a course of treatment. Not individualised

Don't harangue doctor. Perception of going on at doctor, an inconvenience? No. right to inconvenience

the op.

lot of badgering from folks / partner. External focus of motivation to persevere.

hospital appointments slow. Similar to health seeking at times?

criticising communication of consultants. didn't feel heard.

- reluctance for help seeking

- poor motivation

- reluctance for help seeking
- self-help

705 P: And it was just going through the motions. And if, if
706 mum and dad hadn't said, you know? You've got to go.
707 You've got to see if they can help. You know? Then…
708 I: Hmm hmm.
709 P: I probably would have packed it in. I dare say that
710 contributed to some of the rescheduled appointments
711 that kind of…I mentioned. So…
712 I: Hmm.
713 P: The motivation to keep going was…was kind of
714 lower….but erm…
715 I: Yeah.
716 P: IBS it's…the, the fact that, that…in the very early
717 days. They talked about a drug called Buscapan.
718 I: Right.
719 P: And now you can pick it up off the shelf in saver
720 centres. In Sainsbury and Tesco.
721 I: Hmm.
722 P: You don't even have to ask for it over the counter.
723 It's right there on the shelf. You know?
724 I: Hmm.
725 P: That…that was the kind of cure all drug to begin
726 with.
727 I: Right.
728 P: Erm…so…you didn't kind of have to ask for help.
729 You, you could….you know?
730 I: Hmm.
731 P: If Buscapan was working. You'd just get it from
732 Tesco. And you…
733 I: Okay.
734 P: Avoided having to, to deal with doctors at all. But
735 a…

- (E) Just going through the motions. Impersonal?
- Dismissed?
- Pack it in. would have gave up. Similar to feeling defeated by illness?
- Buscapan.
- Sense of 'anonymous' way to help symptoms. Stigma?
- cure all drug.
- didn't have to help-seek. Why? Difficult to ask for help? Not to many?
- Provided means to avoid doctors.

736 I: Hmm.
737 P: Erm....once you are on the (place name deleted)
738 merry-go-round. You might as well stay on it until the
739 end (laughs). You know?
740 I: Hmm.
741 P: Discharged last time. So...you know? They've given
742 hope of, of a...I've reached the end so it's a...fair point
743 you know?
744 I: Hmm.
745 P: But yeah...it was....kind of going through the
746 motions I, I, I started so I'll finish kind of element.
747 I: Right.
748 P: At (place name deleted). But...
749 I: Fair enough....and a... you've already...hinted at it.
750 But what's like... to try and manage your, your IBS
751 symptoms over the years?
752 P: Yeah, yeah I mean. It, it comes down to that thing
753 about erm.....er....about kind of finding a routine.
754 I: Right.
755 P: A routine that works. And if you're trying to manage
756 erm...you, you kind of cherry pick days....when it,
757 when it's at it's worst you kind of cherry pick days
758 where...where for example, work, luckily both of the
759 jobs I've had during, during it...
760 I: Hmm.
761 P: Have been quite flexible. Flexi-time working and
762 things so.
763 I: Yep.
764 P: Ah....you if feeling bad. Nip off. Or...if you wanna
765 work late because you don't want to be too far from the
766 loo (laughs). Then you can work late.

- control of self
- recognising the change
- struggle to cope/ vulnerable

- Treatment was going around in circles? No obvious progress? Or Indicating his perception Committing to 'stay on' at last visit in control of self.
- They're given hope of ..I've reached the end.
- going through motions started so I'll finish. Stubborn?
- finding a routine. Is their conflict in routine? As well as management routine that works.
- pro-active in cherry-picking days of productivity. Vulnerability perception? At mercy of flare-ups?
- Flexible permits Management.
- embarrassed here?

767 I: Right.
768 P: So, there's a…you, but it's about finding a routine.
769 So you cherry pick the days that were important. Big
770 meetings…
771 I: Hmm.
772 P: Important contracts. Whatever it might be and
773 a…you, you kind of work towards them. But a…
774 I: Hmm.
775 P: Erm…you, it's about…about a kind of…about kind
776 of being master of your own little kind of universe as
777 well.
778 I: Yeah.
779 P: Because you have a….a like an ability. Like my job
780 allows me to schedule things and leave that kind of gap
781 over lunch. And…
782 I: Yeah.
783 P: You know that, that's kind of …my time to play with
784 and I can finish at three O'clock if I want to.
785 I: Hmm.
786 P: So…it's about finding kind of coping mechanisms.
787 Taking your mind off it. Trying not to fixate on it.
788 I: Hmm hmm.
789 P: …erm….but conversely…..I find it hard to schedule
790 things too far in advance. You know?
791 I: Right.
792 P: I like going to gigs.
793 I: Hmm.
794 P: But I kind of, the amount of gigs I have to miss… has
795 cost me hundreds of pounds over the years because you
796 buy a ticket when they go on sale and six months before
797 the tour.

important days. Is this 'importance' inflated in his mind? Importance generated by how he sees day? Potential loss or embarrassment due to condition?

master of own universe. ? attraction to complete control of self. Was control difficult being 1 of 4 boys? Pig-headedness? desire for control over the unpredictableness.

Has ability to leave.

Finding coping mechanisms & not fixating / pre-occupied

loss of future-oriented perspective.

lost money due to cancelled gig plans

Sense he's buying early? Doesn't want to miss out? Financial loss could be how he chooses to validate the pervasive loss that IBS brings overall.

- security and control.

- vulnerability to symptoms

money loss

798 I: Yeah.
799 P: And yet you get to the day of it…and it's the one bad
800 day that week. And..
801 I: Hmm hmm
802 P: You could say it's a self-fulfilling prophecy because
803 you're probably on that day your focused more on how
804 you feel and, and you're kind of made more aware of…
805 I: Hmm.
806 P: You know? You don't feel right but...
807 I: Hmm.
808 P: Be that as it may….ah, you still miss the gig. So…
809 I: How does that make you feel? When you…?
810 P: Ah, that's, that's galling that is.
811 I: Right.
812 P: Especially like as a couple of….like, last ever tours,
813 like farewell tours and stuff and you just.
814 I: Okay.
815 P: (laughs) Think that's…literally the only time that I'm
816 going to get to see this. And you do miss out and
817 you…you know? It annoys you. You know? It does,
818 does kind of wind you up.
819 I: Hmm.
820 P: And you probably…. have a bit of a…probably have
821 a bit of a sulk. My other half probably…well she would
822 say I have a bit of sulk about it. But erm…
823 I: Right.
824 P: Ahh….yeah. It's galling but it becomes predictable.
825 After that period of time you…
826 I: Yeah.

- foretelling
- awareness/preoccupation
- restriction
- undesirable feelings
- interpersonal difficulty

one bad day of week - bemused?

self-fulfilling prophecy - setting self up to fail?

greater monitoring of symptoms.

pre-occupation?

sullied!

still miss the gig - Loss of QOL? Hobby compromised

galling - irritating? chafing?

missed one-off events due to illness.

missed out - Grieving loss?

annoyed. understated?

consequently sulks, influence relationship

lack of emotional expression in outward way?

turns distress inward/represses it.

developed ability to predict course of condition (over time).

827 P: ....You kind of...I'm supposed to be going to one
828 next Friday and touch wood, like I say I'm feeling
829 alright. So...
830 I: Hmm.
831 P: Hopefully...you can actually start to look forward to
832 it. but you almost have to surprise yourself..the day
833 before. Any say...you know? Are you feeling okay?
834 Great, great go go.
835 I: Right.
836 P: But yeah, yeah.
837 I: Hmm.
838 P: Routine and, and no surprises.
839 I: That's...that's like, the main things you use to
840 manage it then? It's routine...
841 P: (Breaths in deeply) Routine yeah...and, and a
842 erm...and just this, the, the kind of Fodmap diet. The,
843 the whole concept of it....
844 I: Yeah.
845 P: Is, is...it kind of works to the system that I've already
846 got in place.
847 I: Oh okay.
848 P: I mean if you were coming to Fodmaps cold.
849 I: Yeah.
850 P: Then...it's probably... is as alien as you can get. But
851 if you, if you're happy with your routine. And,
852 and...before the diet. I was eating the same thing for
853 lunch. The same thing for breakfast....Ah....I knew
854 what was good and was bad in the evenings. And...
855 I: Yeah.
856 P: You....you.....slip into the same...it, it's ano, just a
857 another routine. You slip into the same kind of pattern.

preoccupation

Vulnerability to symptoms.

surprise self day before. Urge not to become preoccupied with appraising symptoms. Realising a new way of being/living?

Comfort and security

Fodmap diet works to his system. Didn't have to make large assimilation. Integrating within own framework. Need to 'possess' coping approach, feel secure/familiar with coping.

alien as concept..

had an understanding of safe diets

858 I: Hmm.
859 P: It's just with different stuff in it.
860 I: Hmm.
861 P: So....
862 I: Right.
863 P: I was predisposed to, to kind of pick that up.
864 I: Hmm.
865 P: But yeah...I mean that, that...the kind of main things
866 really....and, a doing things at the same time. Wakin' up
867 at the same time everyday. Being at work at the same
868 time.
869 I: Right.
870 P: ...Literally do... break it down to that. The dieticians
871 have a laugh when I eat and, and do everyday. You
872 know it's like..what might...give us a range of days?
873 When like, that's it.
874 I: Yeah.
875 P: I do only one thing. It's oatcakes in the morning and
876 two cups of green tea.
877 I: Hmm.
878 P: Oatcakes for lunch. Two cups of green tea (laughs).
879 And that's it for the rest of the day.
880 I: Yeah.
881 P: So erm....you know that's...you know...yeah.
882 Doing...finding what works....
883 I: Hmm.....okay. Sounds like you've had to do a bit of
884 trial and error then to figure out what works for you?
885 P: Yeah, yeah there's...there's, there's...it's...I don't
886 know if it's trial and error but...you, you don't...I
887 haven't tried to test things.
888 I: Right.

adaptiveness to life

- predisposed for diet success. Didn't create chance for pig-headed dieter?
- routine timing of daily events importance of regularity. Less chance for surprise?
- rigidity maintaining security/equilibrium.
- pointing out the 'rigidity' of his diet
- laughing at coping needs/new 'illness self'

comfort and security

- Haven't tried testy things. Does this present risk?
- Vulnerability to change/chance.

Vulnerability to symptoms of Unpredictability

Is there a sense of loss of self and the disappearance of normality?

- adaptation and acceptance
- unpredictability/ vulnerability to symptoms

889 P: But it…you know? I think…you know? The team is
890 going out to lunch today. Yeah, great. I'll go out and do
891 what normal people do (laughs). And a…
892 I: Hmm.
893 P: And you end up paying for it. Oh, right that's why…
894 I: Hmm hmm.
895 P: I haven't…the, the, the unpredictable nature of it is
896 that you can do…the same thing…five days in a row
897 and…one of those five days you'll just…be afflicted.
898 I: Hmm.
899 P: With whatever it is and a….you'll erm, you'll think…
900 I: Hmm hmm.
901 P: I haven't done anything different. But erm….
902 I: Hmm.
903 P: It's just…the luck of the draw. That's what it feels
904 like at the times.
905 I: Unpredictability?
906 P: Unpredictability. Especially if you…you kind
907 of…erm…I like, generally liked routine…before.
908 I: Yeah.
909 P: You know?
910 I: Yeah.
911 P: Then came down. So I'm, I'm…more than happy to
912 work really, really hard and… you know? And achieve a
913 goal and put everything towards it. And then…
914 I: Hmm.
915 P: The concept of unpredictability coming in and
916 saying…doesn't matter how hard you work. Doesn't
917 matter what you do. There will be a variable you've got
918 no control over. Yeah, it was destablising.
919 I: Yeah.

- normal people. No longer sees self as normal?
- laughing it off!
- end of paying for negligence. Sense of being persecuted... by the unpredictable
- ① you'll just be afflicted. Unpredictable nature of exacerbation? Meaninglessness?
- Thinks hasn't done anything different. Sense of injustice over exacerbation? No complete control
- ② luck of the draw—
- predisposed to liking routine. Provides comfort to him? / sense of control
- works hard in goal orientated way.
- No control, defying logic & effort. Unfair?
- ③ destabilising impact of unpredictable decline
- real struggle for control.

- empowerment

P: And erm…when you feel like you've got a bit of that control back that's, that's kind of heartening that is…..
I: Oh okay…
P: Hmm.
I: How long would you say you've got, you've had a bit more of that control would you say?
P: Erm….probably…….the….last …where, where it's been good. Probably the last…..just before Christmas.
I: Yeah.
P: Erm…
I: Okay.
P: We, we lived. A…we, my partner and I. We lived in (place name deleted). Then She lost her job and we moved in with her parents for a period of like…two and half years.
I: Oh okay.
P: And we've…just moved out again.
I: Yeah.
P: Hmm, so…so they kind of move thee, move either end and the extra kind of a…you know? Living in someone else's house…. erm…as wonderful as they were. You're not….be able to control everything. About your kind of…environment.
I: Right.
P: When you cook. What you cook.
Erm….erm…….who's around and what kind of free space you've got.
I: Hmm hmm.
P: They have two bathrooms. That was the saving grace (laughs). But other than that it was erm…you know? It, it…it was, it was…when we moved, into, into our, our

- security and control
- oppression and freedom

heartening to regain control.

relinquishing control by moving in with folks?

associating improved symptoms with move?

Did move bring vulnerability to mind?

Struggled to control his environment. Do these efforts regulate worry?

Part of him wants to control everything!

Compromised sense of freedom

- establishing control

- recognition of the change
- comfort and security.

- embracing freedoms

- assertiveness and the affirmative self.

951 own place. That kind of stability really helped settle
952 down. And a....
953 I: Right. Yeah.
954 P: own space and whatnot.
955 I: Hmm.
956 P: And really since then, since about, about
957 Novemberish. It's been a...
958 I: Hmm.
959 P: Been really, really good.
960 I: That's something...that's important to you having that
961 personal space?
962 P: I think it is. I think, I think you kind of value it more
963 a...because we, we've lived under their roof for, for so
964 long
965 I: Hmm.
966 P: As I say they were very liberal. Very understanding.
967 Gave us our own space. Oh, you know? The, the let us
968 live our own lives but...it's not your space. And I do...
969 I: Yeah.
970 P: You know? Being a, being a kind of home body.
971 A...whether it's, I don't know playing computer games
972 or...pottering around the house. Watching the football
973 or something. You know?
974 I: Hmm hmm.
975 P: You can...if it's your own space... you can do what
976 you like. When you like.
977 I: Right.
978 P: And there's an element there of, of not having to fit
979 your life around someone else. That a...
980 I: Hmm.

Stability helped him settle down. Stabilising influence? provides relief? Security?

Own space. No intrusions? Similar to sharing with ex boys?

Perhaps urge for security counters longitudinal effects?

Recognises shift to good health.

Values personal space.

Need to be understood!

Need for own space + inwards appreciation of freedom?

Own space comes with freedom to do own thing. Perhaps freedoms become more important given IBS restrictions

Not having to fit your life around someone else. Sense of passive adherence to others

Difficult to assert self in face others? No perceived right to?

((awkward commiting to their plans.

Threat and imp. of interpar. connection

broken promises. guilty? Concern over damaging relationship? Loss of connection? toxicity?

relaxed with own space. Not being engulfed or imposed on!

981 P: That, that was always the awkward thing. Making
982 commitments that you can't keep. Even if it's…yeah I'll
983 go shopping with you. Help you with the shopping on
984 Saturday morning.
985 I: Hmm.
986 P: If you're not feeling well Saturday morning .Then
987 you've…broken another promise.
988 I: Yeah.
989 P: It's, it's, yeah. But a…Yeah, I do like having my own
990 space it's…much more relaxed.
991 I: Cool…hmm. So erm…..Yeah, that actually answers…
992 all the questions I had for you today.
993 P: Excellent.
994 I: So erm…that's great…shall we…. end it there?
995 P: Happy to. Yeah, fine.

Appendix 11: Master theme table for example transcript

Themes	Line	Key words
IBS consumes and compromises me		
Cognitive preoccupation	128	Slightly pig headed
	264	Engage your mind
	461	Kind of obsessive thing
	505	On my mind pretty much all the time
	518	All the time
	536	Cautious and guarded
	547	Always think about it
	803	Focuses more
Restriction, loss and identity	134	Should have been going to the pub
	158	Became slightly reclusive
	190	Spontaneity out of things
	214	Trying to experience new things
	304	Nights in were better than nights out
	503	I won't… be going
	561	Missed out on things
	584	Barely make it
IBS threatens my relationships!	159	Saying no to your mates
	300	She understood
	325	Bit of common ground
	331	Drifted apart
	379	Stay connected
	400	Don't think ever truly got it
	438	There's a kind of gap there
	820	Probably have a bit of a sulk
	987	Broken another promise
Responding to my condition		
Unpredictability and the struggle to control IBS	107	Unpredictability of it
	148	Think ahead
	173	Terms of a pattern
	486	What's my stomach

		doing
	543	Change it
	755	A routine that works
	853	Knew what was good and bad
	895	Unpredictable nature
	916	Doesn't matter what you do
'I didn't see the point'	683	Tend not to harangue the doctor
	695	Taken a lot of badgering
	728	Didn't have to ask for help
Can you recognise and meet my needs?	52	He kind of listened
	649	Identifying with him
	671	Identification with, with the impact
	701	Be able to communicate
Coming to terms with IBS my way		
'It's weird this whole IBS thing'	5	Come out of nowhere
Dilemmas accepting and adapting to IBS as something given	224	Adjusting the way I way did everything
	867	Same time everyday
	892	Do what normal people do
Concealment and negotiating disclosure of IBS	610	Comical kind of afflictions

Appendix 12: Cross case master theme table

1. IBS consumes and compromises me	**Line number**
A. Cognitive preoccupation	
Keith:	
Being slightly pig headed it was a battle against myself.	128-129
If you engage your mind doing other things like finding little things like that. [] Then…the train seems to go quicker.	264-267
It, it, it does kind of boil down to this, this kind of obsessive thing where…	461-462
They're on…my mind pretty much all the time…	505
Yeah…they're pretty much… there, there. [] All the time.	515-518
Five day working week. And you have a… three good days on the trot. [] And you find yourself… kind of lulled into a false sense of security. And these, these, you can easily wake up on the Thursday having done everything… that you've done the… all week. The same. [] And suddenly think, oh…you know? And… then it kind of scares you backward a step so then the Friday you are even more… [] aware and cautious and guarded and even into the weekend	524-537
You always…always think… about it.	547-548
You're probably on that day you're focused more on how you feel and, and you're kind of made more aware of…[] You know? You don't feel right but...	803-806
Eric:	
It's just been kind of constant grind mentally on me.	56-57
And even when you're not going to the bathroom, bathroom you're in absolute… agony in the gut area. And it makes it very, very hard to concentrate on anything else. [] Importantly during the day to day job and also… just to feel positive. [] and feel well about anything [breaths in sharply]. [] It's just a constantly erm… corrosive condition [] of the mind.	165-179
In terms of erm…if I've not been feeling very well with it. Then I'll be a lot more cautious.	221-222
Ah….in terms of…you know, you sort of think well, where am I going? Is there going to be a toilet on route?	228-229
It doesn't make it easier over all..I guess in terms of [] erm…….it's still a drag on you.	304-306
It's always there at the back of my mind.	375
It's become this whole sort of…complicated problem that erm…negative issues. It's really hard to switch off from.	394-396
I'm not very, I'm not one of those people that's good at switching off my mind from, from certain things and..[] refocusing.	435-439
Then erm…it's hard to switch it off completely from it.	460-461
It's erm….but it's also thee ah…cause of the whole. But is also thee…cause of thee whole…nature of it and the fact it creates so much excess wind it can be quite embarrassing if you're in the office [] and erm…. And very distracting from	493-499

being able to sort of….focus on a difficult piece of work of whatever.	
Erm…it focuses your …concentration and energies.	511
Jeff:	
It's just going on and on and on and on.	261
So it's…it's embarrassing. It, it just wears you down. [] It's a headache	348-351
All the time cause. [] So…like I've got things to remind me. I've got to rush to the toilet. I've got a, I like, I get sickness. I get a heartburn so…all those little kinda remind you.	476-480
I've got all these little signs and symptoms that do tend to…..remind ya.	501-502
But, like I said when you get symptoms and stuff you can't help but think about it. I don't sit there and mope about it all day.	528-530
I suppose it's how you deal with it innit. If you sit there moping about it, it's gonna be on your mind a whole lot worse innit. Cause you're gonna sit there with the hump.	558-561
And I have to plan…plan everything around it so…then it bumps up into your brain.	580-581
All sorts of things will pop through your mind.	626
There was a lot more day thinkin' about it…	1173
Dave:	
You just go to the toilet and hopefully [laughing] that's the end of it. It's not on my mind anymore [laughs].	496-498
I always, I used to notice it when I went into bed because I'm basically taking off my shirt I'd see this bloated stomach and then I'd try and burp. [] So it's almost more that I could see it, wanna get rid of it. [] But actually after a while because it was distressing me quite a lot. It was, I'd almost forget about it. I'd take my shirt off and go straight to bed.	762-772
I do watch the way I sit. There's a lot more that you need to have in the back of your mind.	1266-1267
Rob:	
If I'm in a particularly bad sort of… way. And then I'll constantly be thinking about it. So…[] I'll be thinking… this might sound crazy but I, I might be thinking I'm on a tube and I'm feeling really bad. [] And I'll be thinking… can I make it to the, where I'm going or do I need to get off? [] I'm constantly thinking about that.	677-686
My, my mind just takes over and says no.	718
I think very much even before then…I would… [] be thinking about it. And then if I knew it's a possibility?	754-757
I would start to think about it. Only if I was feeling bad. If, if, if I thought…this isn't, this isn't gonna be good.	887-889
And you might be worrying about it and thinking about it more.	905-906
Two or three Imodium. Done. Don't have to worry about it.	949-950
You can put your mind as ease.	1045
I think that's sort of always on my mind.	1469

Eddie:	
Well the biggest effect for that is err…if definitely effects my mood. [] I get…down. [] And erm…I get more irritable….more likely to lose my temper. I can't, I try to carry doing all the things that I do and I find everything quite difficult. Like decision making… [] I find it. I get really fuzzy in the head and I can't…make decisions.	352-363
But couldn't be able to even…[] think of it. It's…it was quite serious.	379-381
So I tried…as soon as things started to have to get, just take myself away from things. [] And just…disengage	390-393
Be erm…the erm…sort of, difficulty with...thinking.	549-550
That, the main thing was that, the, the sort of fuzzy headedness leading to sort of decision making. [] and anger. You know? Loss of temper really.	620-623
Personally I think if you don't get the thing that I got with the, with the massive crushing weight on your shoulders…[]….with erm….fuzzy headedness and aching arms and not being able to get out of bed and all that kind of stuff.	853-858
B. Restriction, loss and identity	
Keith:	
I was young [] I should have been going out to the pub and, and I like going out to, to gigs and that as it was… it should have been…[] kind of easy but it just became a kind of trudge…	134-135
You know erm….you… became slightly reclusive with it because of the unpredictable nature.	158-159
And then if you… [] go… and then, then you think, well I'll get to [place name deleted] and, and that pub's a bit grim. But that one I can use the loos in. So it's just… [] Every, every night out, or every day out for that matter became a… kind of… [] Just a… bit of a… bit of an ordeal. Took any kind of spontaneity out of things as well.	181-191
I know some people like to experience new things but…I found more comfort in a…in kind of doing stuff…[] that I knew [laughs] rather than trying to experience new things, foods….nights out.	214-219
She, she understood that nights in… were kind of better than nights out.	304-305
Probably the furthest answer I can give is probably….because I'm very conscious of…if I wake up Friday, Saturday, Sunday. Whatever and, and feel…you know? Grim. [] then I, I…you know? I won't… be going.	498-503
…there's an element of….you feel you're missed out on things.	560-561
I could barely make it to the pool because I was, I was just…..[] in pain and….in, in kind of, no fit state to go anywhere.	584-588

Be that as it may….ah, you still miss the gig.	808
Eric:	
I mean one of the problems is that it does limit... makes you forward plan what you need, at times if, if you're quite ill with it.	182-184
And then you eat or drink something that's gonna set it off because you can't really avoid it in those situations. [] You… it becomes almost a self-fulfilling prophecy. And then you end up with the symptoms after not too long which kind of ruins the event. [] And does put you off going to [] wanting to go out and do anything. You know? Other further socialising. You have to sort of force yourself to [] not become a bit of a recluse with it really.	201-214
If I've had a period where it's not been too bad I'll be a bit more adventurous.	225-226
Yes, it has at times, it's definitely made me less carefree than I would have been.	236-237
I think also it's just…the accumulative impact over the years. Over the years it's made me a…much more depressed person than I probably would be otherwise.	245-248
And erm…that can have an impact as well. And…so that's made me less reluctant to want to go to the gym and exercise or jog or…swim	338-340
I've already forgotten what it feels like to, feels like, to feel normal now.	385-387
In one way or another it's a constant… presence.	412
If I hadn't had this….it's acted in some ways as a bit of a brake on my career.	502-503
But again...the condition can undermine you wanting to do that.	786-787
Jeff:	
It's that bad. So, it's a nightmare you know? It, it puts me off of going places. If I am like, like today I've come here I haven't ate all day.	93-95
So…it really does effect me from day to day life. Even going places.	105-106
I either don't go out unless I can really help it. [] Or like I have to starve myself or something, you know?	135-139
But that's the last medicine in the world I can take.	219
It's a nightmare really. I've become a bit of a recluse even at my age.	314
I can't drink because of my stomach. [] And it's not just, it makes my stomach worse. It makes my bowels worse as well. Anything that's inside me… it's gonna make that hurry up. If you know what I mean? My stomach and bowel flares up. [] So I don't wanna go out drinkin'. I don't wanna go… [] out for something to eat. Do you know what I mean? That's mainly what people do with their social life innit?	406-419
But yeah there is certain things that like, I have to not do.	576-578

Like, like, like, so we do when we're going out and this, that and the other.	
Yeah, it does…It's going to really because I'm missing out on things.	651-652
Dave:	
So erm… see, I, I, I don't personally think of it as a thing. In terms of what I've got I don't feel like it erm, radically effects my quality of life. It just means that I have to spend longer on the toilet.	89-92
Particularly if I was trying to keep fit and what not. And keep meaning to do sit ups and things I'd. [] Look down at my stomach and it would be this horrible, kind of distended thing.	155-160
My stomach doesn't seem to work in the same way that it used to.	263-264
Bit of an inconvenience but that's just life. Isn't it, you know.	541-542
It's not like…it's not like living with IBS is this overarching thing which it is with my back.	637-638
Rob:	
If I have a pizza, I'll, that will ruin me for a couple of days. My stomach will just be hurting. [] Everything gone out. So…It's hard to be active… against…the sort of…how I would react to certain things when you're feeling well.	215-220
But it is sort of just ruining your day to day experience. Not wanting to go and do something. Not , you know? Not really wanting to go and exercise and stuff. [] And not really wanting to go and meet up with people because you just get into that rut.	226-232
It's not drastically made me, you know, a hundred percent, you know? I feel like I'm normal. [] But I feel like I'm better than I was.	264-268
I'd go home and I just wouldn't want to do anything. I'd just lie down. I just wouldn't want to do, go out and see anyone. I wouldn't wanna…[] Just really crap. It was just a really bad living.	383-387
And…you've got to queue to go to the toilets. And, you know? Things like that would be…you know I wouldn't go to a festival.	672-674
You just wanna go home and lie in bed. But….you need, you need to carry on.	863-865
To stop me. Because it just, it would…it would just ruin, ruin my days, ruin my nights.	956-957
So…you just about managed to get to work and back.	1009
It had to stop me in my tracks. Like…[] it had to physically…it had to physically…not allow me to carry on with day to day normal…	1083-1086
That's it done. Whereas, that would knock me out for two days.	1145-1146
Just feeling like you always…like you are managing to do was get up and go to work. [] Put a sort of brave face and then	1392-1397

come back. And that was pretty much your life [laughs] for a couple of months. It just isn't great.	
Eddie:	
I do exercise and everything just became really, really difficult. [] So a…erm…I would, I would still carry on with it but I was just…kind of maintaining things and everything was a struggle.	66-71
And then there was one, there was a particular episode and I was off work for four weeks. I couldn't….couldn't get out of bed. I couldn't do anything. [] You know it was really serious. So erm…I was, I didn't know what it was. And, and it was the doctor….that took it really seriously at that point.	88-95
Because the consequences…it just put me out of action for two days.	149-150
So.. .I've always been twelve and a half stone. That was always my normal weight and I ended up about eleven stone. I was just kind of going…going nowhere.	161-164
I've no, I've never got close to that and…I can't even remember the last time.	255-256
I would…just…get through the day. [] I wouldn't excel at anything [laughs].	433-435
I would still have…a good…the….going to toilet thing was almost constant. So even when I was feeling better. I still went to the toilet. Not twelve times a day…but it would be like…five times a day.	506-509
Because erm….at the time I was working on quite…complicated things and… [] Because I could, I could get through at a certain levels but I wasn't gonna be sort of….showing anyone what I can really do.	530-535
Because you're not really …you're really able to sort of… sparkle [laughs].	544-545
I can't do anything. [] You know? Nothing at all.	612-614
Fuzzy headedness and aching arms and not being able to get out of bed and all that kind of stuff.	857-858
Maybe don't eat anything at all.	884
C. IBS threatens my relationships!	
Keith:	
So you start saying no to your mates. You know? I won't come out tonight. You know? Feeling a bit ropey or... [] the classic one. Going for a curry and then some beers….I couldn't think of anything worse.	159-164
And just as I was kind of getting worse she was kind of getting better. But, but she understood.	299-300
Bit of common ground…[laughs]. It's probably not the best the common ground to have. But it, it, it actually…erm…became…It was quite an important bit.	325-327
Friends…already touched on friends….you kind of drifted apart. Drifted away erm from, from kind of friends, friends	330-343

group. As you… engage less and less. And ah, erm…the… kind of… main group of friends became work friends. Because I was already in work. You didn't have to make that second effort if you like. [] like journey somewhere else. So…going for a couple of beers after work or…[] or they…became close to them. So…it's…kind of drifted away from my friends group. And they're, they're bridges that… I haven't necessarily been able to rebuild.	
So…kind of…probably wasn't as, as kind of jarring as it would have been…three, four, five years before that. [] so…it, it, yeah. Yeah, it was, it was an important part actually and a…[] and that's the joy of Facebook [laughs]. Because you can stay connected.	372-379
That might be an interesting one because erm…you know, my, my family are very understanding all the way along. You know? And….but I don't think ever…truly got it. [] ….as….well as kind of….ah, my other half….did.	398-403
So I kind of sometimes felt that it was…[] …erm….they, they didn't really understand…. [] too well…. Even with, with this kind of Fodmaps diet thing. They try…but they…you know? I'm still and mum will say…do you want sugar in your tea or something and dad will say, you can't have sugar. Yeah, I can have sugar [] but… he's kind of got it all twisted and, and back to front. So they try [] but I think there's a…there's a kind of gap there. I don't [] think they truly appreciate it. I don't think probably anyone can really know just how bad it is unless they've [] …. unless they've…been through it.	424-445
And you probably…. have a bit of a…probably have a bit of a sulk. My other half probably…well she would say I have a bit of sulk about it.	820-822
Making commitments that you can't keep. Even if it's…yeah I'll go shopping with you. Help you with the shopping on Saturday morning. [] If you're not feeling well Saturday morning .Then you've…broken another promise.	981-987
Eric:	
And…erm, I'm sure it's annoyed my partner and friends at times who've been out with me. Erm...because I'll end up not being in a very good mood and I'm often [] looking for toilets [] and that kind of thing.	239-245
Erm..[breaths in deeply] honestly no one has ever directly ever asked me about it.	279-280
I would say it's just been…actually, for instance if we take my mum. Cause she seems to..she's suffered with this as well for years. So she understands. And you know? There's some sort of mutual sympathy and support there which is helpful. [] Erm, and I've also got another good friend who's suffered with this over the years so..you know? It's not like I'm alone having to deal with this but erm….	316-324
Jeff:	

So…yeah, you do have this problem with friends and girlfriends and stuff. [] I mean I have quite an understanding girlfriend.	353-356
So, they're just certain things that I have to say to her. No, I can't do that because of blah, blah, blah. [] And that' s when I will say, not moan but…[] when she moans that I don't wanna go out it's because of blah, blah, blah. It's not just because I can't be bothered. [] It's because I don't wanna deal with a whole load of other disasters [laughs].	368-378
So…yeah, it's, as time's going on…I'm sort of…losing contact with more and more people.	380-381
And it was like mum and dad had taken us on holiday. Paid. And… you know? Booked these excursion and whatnot.	588-590
Being up front and…say look I can't go out for a drink it's gonna make me ill. Or…[] I don't' fancy comin' out for dinner tonight because I'm being sick. And I don't want to be caught short. That's the last thing, I don't wanna be tellin' them that, you know?	593-599
It's how, how would they take it? Would they think I'm a hypochondriac? [] Would they think you're dying? You're at death's door.	614-618
But things still upset you like…when, when your friends want you to come out. And in the end they stop ringing you and…[] They think you're just avoiding them.	672-676
They think that like I've got a problem with them… rather than it's my own personal problem. You know? [] I, it's got back to me from a coupla friends that saying like, ah, he never wants to come out with us. Or don't he like me? Or? [] You know? And it's not that all. [] So you get other crazy stuff going through your head innit.	678-689
Dave:	
You know? So it's interesting. I think if anything it's quite [laughs]. I find it to be quite a good thing because you can sort of share. And I am very open with things.	285-287
Particularly when I'm in bed and I fart. She finds that really unpleasant and she'll give me a kind of slap around the head [shared laughter]. Erm… and that's probably one thing I've noticed a little bit more. I have to be slightly more conscious about that.	348-352
So I tell her I need to do it. She kind of gets annoyed with me. But…[] You know? I hope mainly in kinda light hearted way [laughs].	366-370
Knowing that my mum had it. And she had books lying around. So she wasn't …kind of embarrassed about it. But I guess that was a positive thing.	449-452
I've done this forty second… fart. It was like a sign of pride [laughs]. So yeah I don't, I'm not, there's, there's a bit of embarrassment or, or whatever about it but it's, I wouldn't say I'm too much traumatised by it still.	580-584

Rob:	
And I also think that something that's sort of changed… in sort of living arrangements is that I was living with a couple of lads. That erm…I sort of knew one of them well and not the other one that well. So it was sort of more…you know? We sort of…it would be fine but you wouldn't really get on with one of them. Well, not get on but not really talk. Where that lad has moved out. Another lad has moved in that I know very well.	343-351
That… it brings up so many other sort of emotions in people.	515-516
Erm…yes. I think because my family is very medical. [] I think I'd get straight down to the point with those guys. Like…you know?	565-568
Yeah, very much…..I, I find that supportive. [] A supportive network. I think it's helped me.	632-634
Especially feeling like your putting other people out. By making them having to stop. Or… [] You know, I didn't like that at all.	698-701
My, my mind just takes over and says no. You'll just worry yourself…into a…that, you know? You might have to stop. You might have to annoy people.	718-720
My body is starting to give up. It's just like well…[] I felt …in that sense I felt, I felt rubbish. [] I'm not gonna be able to get the most out of this holiday. You know I'm gonna be a pain to everybody else… That's a lot…I'm more… I hate feeling like a burden on people. So I think that's one of the worst things really.	1408-1417
Knowing that I was gonna be the one that always…it was gonna be that and the annoying one who might be worrying and fretting. And making sure I go to the toilet here. And always going as soon as I could and…you know? [] …..I didn't wanna be that person. And I try as hard as I could to…[] Either do it in a way that…they didn't notice….[] Or…try and be the least amount of a burden as possible.	1423-1435
So even bringing my mood down is having a negative effect on their day.	1454-1455
I think if you've got good enough friends…they do understand. [] It's not just, they're not gonna not talk to you.	1474-1477
But these are the sort of people that you've known forever. And been to uni with and [] so they, they're sort of used to it.	1491-1494
Eddie:	
So…personally, personal relationship do suffer and I…to help with children. That suffers as well. The thing that I, I tended to do in the end…is erm…I wear a top with a hood on it. And if I've got my hood up…[] That means…I'm not really gonna answer…any questions. [] Hmm. [] I know this sounds really self-indulgent and awful. But it's all, it's…it's like….almost beyond…it was beyond me…to you know? If somebody asked me a question it would be like….well [sighs]….I don't	365-376

know?	
And then…there was one person in particular who noticed when that was happening….[] and erm..[long pause] But it's not anything that anyone can understand really. They don't…it's not…many people can…because you know? You're not gonna die from it.	409-416
So…you know? It does seem like maybe you're being a bit self-indulgent. So…Erm…I, I definitely say the per…relationships at home suffered, suffered more…because I was a bit more kind of…there was less consequences I suppose.	418-420
And if I was out, as well, at the weekend. If I was out with the kids. I have to really… think about how I was gonna get around.	466-468
So…erm…and then of course… your……sort of interpersonal skills go downhill a bit. You know? [] Because you're not really…your really able to sort of…sparkle [laughs].	540-545
Especially like at work I was trying….[] to hold everything in. And then at home I was trying to…and then it would always get, get to a point and I would lose my temper. And I would just be like very sort of like. You know? I've heard enough of this….this is pheww. I can't deal with it anymore and I just go, go away…[] I go on my own. I don't want to be with anyone. I just want to lie, lie on the couch…	599-610
2. Responding to my condition	
A. Unpredictability and the struggle to control IBS	
Keith:	
It's inconvenient more than anything. It's, it's erm ….thee …..thee….. probably the biggest thing is, is the unpredictability of it. Which, which has, has been really..	105-108
You…have an element of needing to think ahead. Needing to….without…getting it into too far at the moment. But, but it's…you know what stations are on your stop. Have loos…and you know which don't.	148-151
So it was about just finding…kind of finding something that worked…kind of terms of a pattern.	172-173
But…they do become a….you wake up in the morning and you think…what's my stomach doing?	485-486
Even if you chance it.	543
It, it comes down to that thing about erm…..er….about kind of finding a routine. [] A routine that works.	752-755
And, and…before the diet. I was eating the same thing for lunch. The same thing for breakfast….Ah….I knew what was good and was bad in the evenings. And…[] You….you…….slip into the same…it, it's ano, just a another routine. You slip into the same kind of pattern. [] It's just with different stuff in it.	851-859
I haven't…the, the, the unpredictable nature of it is that you	895-904

can do…the same thing…five days in a row and…one of those five days you'll just…be afflicted. [] With whatever it is and a….you'll erm, you'll think… [] I haven't done anything different. But erm….[] It's just…the luck of the draw. That's what it feels like at the times.	
So I'm, I'm…more than happy to work really, really hard and… you know? And achieve a goal and put everything towards it. And then…[] The concept of unpredictability coming in and saying…doesn't matter how hard you work. Doesn't matter what you do. There will be a variable you've got no control over. Yeah, it was destablising. [] And erm…when you feel like you've got a bit of that control back that's, that's kind of heartening that is…..	911-921
Eric:	
It would settle down and then it would be okay. And something else would set it off.	36-38
But the other thing I have tried over the years is the anti-spasmodic tablets you can take. And, and they've had limited success.	143-145
And then you eat of drink something that's gonna set it off because you can't really avoid it in those of situations.	201-203
I think it's, it's thee, with these long-term chronic conditions it's not knowing what to do to sort of relieve the symptoms. Or, or…erm, and to sort of basically solve it.	264-267
Because I can find that if I do a lot of exercising and jogging or anything that's gonna shake my gut up it can set it off.	334-336
On one or two occasions in the past where I have been to the gym and I've actually….had an accident as it were. [] And had to…leg out of the gym.	351-355
Because, you, you know I can just feel it just…[] Going overtime ha!	489-491
And then you have and….you know that there is nothing that you could have done to stop it. Or, or there doesn't seem to be a huge amount you can do to…[] To cure it [knocking noise on table]. And it is curable. Erm…so a sense of help, helplessness.	528-533
If my response to the condition was gonna be like an android or... [] You know? Logically thinking robot rather than a complicated emotionally… you know? [] Difficult human being then…then perhaps…[] A whole, my own experience would be a lot easier.	791-799
Is ma, not ever made it [noise of knocking table] immediately obvious what is setting it off.	838-839
Jeff:	
So, if I'm planning to go out I can't eat. Otherwise I'm gonna get caught short somewhere or something. It's that bad.	91-93
Have, like I have to do that rather than risk getting caught short somewhere.	97-98
Like, I, they can't direct me to something cause I can't hold	142-148

my toilet. It's that bad. [] You know it's not just diarrhoea. Ahhh, I'll go in a minute sort of thing. It's like [] It's there and then and you ain't got no chance. [] [laughs] so it's really embarrassing to be honest.	
It's just certain things I can do to help myself to a certain extent. [] As it was. [] It doesn't fix me but… [] But it makes it a little bit more bearable.	241-248
And then it's…made something else happen. [] It's like a knock on effect.	261-271
It's a nightmare when it comes to…people just going and giving me medicines for this and that and then not realising what it, what it's gonna do. You know? [] Because of my belly and bowel…problems.	283-287
So I have to be. It has to be. Because if I'm going out or something. Because…[] I, I have to plan everything around my belly and my bowel.	515-519
And there are certain things I can do for myself to avoid. [] Like certain foods and medicines and so on. [] It's not there so strongly. But going back five years or so. It was there, all day and all night.	535-541
And I have to plan…plan everything around it so…then it bumps up into your brain.	580-581
Yeah, yeah it's took a long time to get… to get my head round it and find out what helps and what don't. [] And still this kind of….. loosely what helps and what doesn't. You know? [] Like I said before things were here there and everywhere. And that was really stressful.	1164-1171
It ain't until I'm taking it for a little while and…things start to change that…I ain't got a clue what's going on again.	1282-1284
Dave:	
I'm trying think whether there's, there's probably been a few occasions when I'd be out and about…..oh no, oh Christ…you know I've got to rush to the toilet.	117-119
And then the next thing I know I've got to literally leg it.	137-138
I've gotta be more, slightly more careful about what I eat and…things like that.	525-526
Rob:	
Where it's a day to day sort of challenge.	40
So it all sort of peaked at a time. [] Whereas, I was trying not to eat certain foods. And, and trying to be really good not drinking. All that sort of stuff. Increasing my exercise. [] Erm…it just worse and worse and worse [laughs]. [] So that's when you start doubting. Well, you start doubting what people are telling you…..you, you, I couldn't find…a pattern. I couldn't find…and it was really like…annoying me.	61-72
And even when I felt I was actively doing something with it when I felt bad. It didn't feel like it was getting any better.	250-252
I've cut out a lot of crap. Which, which is helping.	263-264
I think I still haven't got there… with things like…eating at the	275-277

right time of day. And food in controlled portions and all that sort of stuff.	
I think about…I would plan…before.	742
You make those decisions before because you just learn how to deal with it. So…[] You know make yourself go to the toilet before.	913-916
Erm…because then…nor, normally the times where it catches you out a little bit when you might have to…you know? Rush off and do whatever. Is normally when you've forgotten about it.	921-924
Of making sure the few bits and pieces that you've done. I normally carry around Imodium or codeine with me.	931-933
And it was still getting worse and worse. And I was thinking…you know I'm not drinking, I'm not doing this and…what's going on?	1098-1100
Eddie:	
I was sort of left then…with my own…management…of the, of the condition. And because erm, because I'm really strict with things. [] If, if, if something doesn't agree with me I won't eat it. So I ended up with a really, really limited diet. Like basically tuna fish and rice.	134-140
Because I was terrified of eating things. [] Because the consequences…it just put me out of action for two days.	147-150
It's just really odd. Erm…this is strange. What's going on? And everything seems to be kind of changing slightly.	184-186
I'm really, really, really wary of the whole thing. [] I mean she says…she said it's...it's important that I do it. But it's because there's not been a time when everything is kind of calm..	276-280
I'm gonna do what I can do to get through this. You know? I'm not gonna… go out on a limb…[] So erm…so I was treading water for a while …	437-442
It was really easy for things to go wrong.	463-464
So I was eating chick peas as well as tuna fish and rice. [] And erm….and that was causing me. Even though I was on this really mental diet. That was causing me loads and loads of problems.	560-565
It's like, you have to have a strategy for everything. Like…geographically and erm….[] With people socially you have to have a strategy.	872-876
So….there are, there are the odd occasion I don't feel quite right and I don't know what's happened.	944-945
B. 'I didn't see the point'	
Keith:	
So…but yeah, yeah. I tend not to harangue the doctor.	683
Erm……it's a…… kind of…it's something that…it's taken…a lot badgering [laughs] from my folks and my other half to kind of persevere. Because erm…when you hit the kind of hospital end of things. [] I…….you know? There's, things	694-700

tend to just slow…right up.	
So… [] The motivation to keep going was…was kind of lower….but erm…[] IBS it's…the, the fact that, that…in the very early days. They talked about a drug called Buscapan. [] And now you can pick it up off the shelf in saver centres. In Sainsbury and Tesco. [] You don't even have to ask for it over the counter. It's right there on the shelf. You know? [] That…that was the kind of cure all drug to begin with. [] Erm…so…you didn't kind of have to ask for help.	711-728
Eric:	
And to the point where I've just got older and generally….I don't know? Erm….. less willing to be put off. [] By…[] The medical system. The health system. [] And be a lot more willing to push back. Which I think	587-595
And then I think… you know? I've gone through long periods of where I've just not bothered. But I didn't see the point… in [] pushing it. [] Ah, of course in that time the internet has massively filled a huge gap in all of our medical knowledge.	624-631
Just, just to see whether actually it's worth going to bother the doctor with.	657-659
Jeff:	
It's just about looking…looking for an answer with the erm…doctors.	198-199
Because there was…a coupla years where I kind of…excuse the language but I said, oh fuck it! [] I ain't bothering no more. I ain't gonna come into the hospital 'cause it ain't helping.	962-966
Well, yeah…the past, I kind of more enthusiastic to try and get better. [] But now…if, if I've got certain a health problem I think, oh okay. I'll leave it might get better.	997-1001
I don't want it to get worse worse. [] You know? So I do have to sort of continue with it, you know?	1063-1066
Sometimes, maybe where I am used to things…[coughs]. I'm kind of…I don't push, push things as much as I maybe should. [] Don't know why? You know what I mean? [] I'll see you in six months. O, o, okay doc. [] Thanks. I'll see ya in six months. See ya. [] And I should really just sit on the chair and say, I ain't moving [laughs].	1236-1247
Dave:	
But maybe that's what…I don't, my guess is that is that I probably wouldn't have seen anyone about it because it's not inconveniencing. It's not… [] If you said tomorrow…you are never gonna have these symptoms again. I'd be like…oh that's pretty cool. I wouldn't be, oh my life is so much better.	941-947
So I've done it but the reason I mention that is because my wife always, was always the person who said, you've got to go and see these people and the GP about it. And I've always kind of gone what? They're not gonna do anything about it. It's not really worth it. Fine. I'll go because she's. [] Really nagging at me.	1029-1036

It's not killing me. Are they really gonna do anything about it. I probably won't bother.	1038-1040
Well, I suppose I…apart from really going to see the gastroenterologist. [] I've not really…done anything about it. If you like. [] I've gone to see her because she said well, I can tell you some stuff about your diet and we'll do the colonoscopy. And I guess that's the only time I've gone to that kind of thing because I can live with it. So I'm not fussed about…	1062-1071
I don't really want to speak to anyone about it because it's not killing me.	1098-1099
Rob:	
I'd only ever go to the doctor if it was really really bad. And it tended to be because I had food poisoning because I had something else. It wasn't that underlying week on week bad stomach and etc etc. It tended to be when it hit a peak or whatever.	131-135
There is a few bits and pieces of advice where…sometimes you just need to break free of that and go and see someone separate.	636-638
Until I managed to come in here and actually do something [] pro-active about it. I think it, it needed to be really, really dramatic for me to even, for me to, to think that I needed to come in to… [] It had to be… because I've lived with it for so long. [] It just felt normal. [] So… it had to be something… that was really bad pain for long period of time before I would do anything about it…	1019-1032
And then I was just like…speaking to mum and everything she was just look, go in and have it done.	1041-1043
So to come in to have a quite…you know? Not a nice procedure done. [] Wasn't…you know? Top of my to do list. [] And…you know? You almost squirm and I don't want to do that type of thing. But I did it. Got it out of the way.	1053-1060
Erm…thinking that…you know? If I actually just sorted myself, if I did more exercise and actually ate better…[] And you know? That would have a big effect. So…you know? I almost don't deserve to come and seek help.	1110-1116
But you do feel in some way…that you need to seek help and etc etc. But…..[] …..you still feel that you can do a lot about it before you go and see them.	1157-1161
Eddie:	
I've been in and out with this thing for…you know? For quite a while for it. And a…and I said…you know? It is…a medical thing…it's not a New Age or anything like that. And it's a new thing. I don't know anything about it. [] I've tried my little version of it. I really need help. All I want is help. You know? I just want somebody to sit down with me and say look, this, this and this and then…[] And that will work really well.	190-201
So….you, you do get the feeling that you don't wanna bother	736-739

people. And especially when it's something…that's about going to the toilet.	
So….I don't know…I can't really answer the question about going to get help for me personally because I didn't really think that I had it but…	863-865
C. Can you recognise and meet my needs?	
Keith:	
It was taking the time to kind of get around to seeing the GP and, and not being funny. Being the size I am. They take a look and go, you must be eating a load of… crap. And therefore you're feeling. [] Crap. Pardon my French. But there's, there's an element there of not…I was lucky to have a pretty good doctor to begin with. Pretty understanding. I think he was a locum…actually. [] Erm…and he, you know he…he kind of listened, and kind of listened beyond it rather than jus thinking, making a kind of judgement. But it, it.	42-54
Because the guy, the locum a…was quite approachable. He was…quite open. Relatively young… bloke and there kind of an element there of…kind of identifying with him.	646-649
He actually took the time to say…oh, that's not good. That's not right. Oh no, no…[] …..ah…..yeah. That's…clearly something wrong. Rather than just charging head strong, sorry head first into…[] Erm….the, the kind of….. trying to fix it. So it, a real identification with, with the impact it was having. [] The kind then…showed the…bit of thought into, kind of…what he considered to help it rather than…just… [] Take these pills and then those pills and then, then it's just a course of treatment.	667-681
And erm, the particular consultant I was seeing didn't…didn't seem to be able to communicate very well…on, on a kind of number of levels.	700-702
Eric:	
Not, and then going to speak to doctors and GP's. Even today…still not really getting what I call…the very knowledgeable…even now…the particularly interested kind of response from the NHS. [] I think…it's always, I've always got the impression that…particularly for general practitioners that it's not something that you know an awful lot about.	66-73
Yeah, I mean..I think the GP has not really given me much other than… lastly referred. I mean. They obvious did the whole range of tests, the blood tests and things. Check for..[] what else could be causing it and things.	118-123
I would say that I think..the lack of information and support that I received from the NHS over the years has been has been an issue.	324-327
But I think…also because of that……because of the lack of help….or information you are giving. And the fact that people just…particularly when I first started…when it, just put down	570-576

to..oh…you know? It's nothing that important just….sort of deal with it whatever. Or just sort of…food allergy or…	
Jeff:	
I couldn't really go to the toilet properly [breaths in deeply]. Erm…then a surgeon said he'd help me out. Erm, he did an operation that I didn't really need [laughs]. And made it a whole lot worse.	15-18
It's a nightmare when it comes to…people just going and giving me medicines for this and that and then not realising what it, what it's gonna do. You know?	283-285
Once upon a time. When, when the doctor really thought, oh I know what's best for you. And tried explaining the…I don't think that's the best way forward because I live with my symptoms. [] I'm not be funny but a doctor's only got ten minutes for you. So…it, it's kinda awkward innit. [] You know? And I've gone back said, I've still got this problem blah blah. Nothing's changed. You've just operated on me. Blah, blah, blah. And they ain't got the time of day for you.	697-708
Had a root around and then shoved me out the door [laughs]. [] And then not wanting to be interested. [] Which is, I got really angry about that.	713-718
Sometimes I just truly believe doctors say IBS. It means haven't got a clue what it is [laughing]. [] Don't know how to help ya.	742-745
Stick me in the hospital for a week if you don't believe me. You can come follow me to the toilet every ten minutes.	845-847
You're thinkin' do they believe you? And…they think I'm making it up. [] Like… do, do you think you're trying to put it on to sound worse? You're thinking… you're over-thinking.	889-893
Yeah…like where some doctors tried to help me, some doctors are just not wanting to know and they palm you off. [] Shove you on to someone else. [] Then you get the odd doctor the, the, that my belly/ bowel doctor now bless her, she's lovely.	926-933
Thinkin' that like…have I got a battle to get my point across. You know? [] Just being swept under the carpet is no good.	947-950
So…it's all good. I've seen dieticians and stuff and certain things have…obviously like, sort of made a slight little bit of difference. But certain, certain things really don't make a difference.	1079-1082
I say to them I'll try anything if it's gonna help me. [] But it's, when someone says to me ah, it's all in your head. It ain't. It's in my spine, my belly, my bowel [laughs].	1145-1149
It's…it is like…it's a lot easier to write something down than it is to deal with it.	1232-1234
Dave:	
Because the irony was the gastro person said you know? Don't eat so much fruit. And I was like well…..you know somebody else will tell me to have my five portions a day.	529-532

For example, let's say I went back to the dietician. Sorry, it's the dietician that told me about the change in my diet. If I went back to her…she would tell me to change my again and I don't really want to again.	1075-1078
And if, I and I suppose if someone said the major thing that you can do about this stuff is change your diet I don't want to hear it [laughs]. Having said that, the irony was, the one thing she said was don't eat so much fruit in the morning. Erm… which I've done. Don't, I don't have a smoothie in the morning.	1092-1097
To be honest through conversations with the GP's and whatever. But…[] Yeah, and it's definitely made a difference. I can tell it's… [] It's a lot, I have a lot less problems with bloody…toilet tissue.	1220-1227
Rob:	
So I went and saw the dietician. And erm…she was very helpful and she suggested that maybe try the fodmap.	187-189
Yeah. Well I think, that definitely helped when going…when coming here. [] And seeing, you know? Some consultants and erm…Because they actually are…you know? Specialists in that field.	642-647
Was very nice in the way that she explained why these different…you know, these different foods are…you know? Can be absorbed differently in different people. Some…you know. [] And what it does was…you know? Bringing in water and that sort of stuff. And causing pain and wind.	842-848
It was something where I was able to say I had done this…and it's not really worked. What's your advice type of thing?	1172-1174
I've always started, I've almost sort of decided. [] What it is. What I need. And what I'm gonna tell them.	1227-1230
Less confident about faith in them as a doctor. And faith in my…[] Own feeling about what it is.	1253-1256
Eddie:	
Erm…there's lots of different things and you've got…one of those. But…because it's not…kind of life threatening…going back to my GP… It's sort of dismissed then…It's a bit like…okay, you manage it yourself. You'll know the best…you know if don't like. If there is something that doesn't agree with you don't eat it.	125-132
So I went to my GP. Who's a very old school GP. And she looked at me and sort of rolled her eyes.	188-189
And she, she talked me through everything and…pointed out where I was going wrong. Things that I had excluded…she said no. She gave me a book with everything in it. [] It was all written there. So that was brilliant. She understood exactly what I was talking about as well and erm…	222-230
I'd go to the doctors and they'd be like…well, you know your body better than I do…you know? Shrugged the shoulders.	582-586

But anyway. You know? Managed to finally get someone who knew something about it.	
But the suggestion constantly from doctors was that it was to do with stress……Which used to annoy me a lot because I…in stressful times my, my had twins… [] Erm.….and a year later my, my mum died…but during both of those…I didn't get any symptoms.	627-633
The only thing that I have is that…erm…..I think…..my experience with specialists is really positive.	699-701
With GPs…I don't get that at all. I don't get any…so you feel intimidated going to talk to them. Because you sort of think they are gonna dismiss you straight away.	711-713
They seem to really interested in actually solving the problem. And there's a lot of feedback and, and…and they seemed quite pleased if…things moved forward.	726-728
It's really important because it's like…it's also….getting treated like you're involved. You know? You've got a brain and you can actually have a conversation with someone.	754-757
I mean I tried to loads of different things. I went to a nutritionist. Because originally I didn't know the difference and that was…a complete waste of money and…everything else.	951-954
3. Coming to terms with IBS my way	
A. 'It's weird this whole IBS thing'	
Keith:	
Erm…it, well, it seemed to have come out of nowhere. About seven years ago.	5-6
Eric:	
I think the worst thing about it not knowing really what it was in the beginning to begin with.	63-64
Or just tryin' to find out what caused the problem in the first place. Not really…[] knowing. But having a potential rough guess about of what it might have been.	86-90
I mean kind of, it's almost a relief to know in a way that what's caused it….you know, what's caused it and what it, the central problem is.	99-101
The fact that I've had to do a lot of self-research. I've had to go and find stuff. [] Which, which has helped.	327-330
Ah, of course in that time the internet has massively filled a huge gap in all of our medical knowledge.	630-631
You know, I think you can say with almost anybody who, who's got an ill….an ailment of some sort today. [] and….er, it's gonna, it's gonna be some element of self diagnosis and googling the erm… [] the condition to see what you've got.	650-657
And erm….and I think it was during that I picked up the bug that. [] turned into this IBS.	678-681
Well, part of me thinks it's, it's just down to, at this time…quite a lack, big lack of medical knowledge around it.	711-713
Erm….so….I, it's, the problem with it in many terms, also with	721-727

IBS it's an umbrella term for a whole range of conditions. [breaths in] and trying to actually [breaths in sharply] focus down, drill down into the one main thing that's be causing you the problems. [] It's, it's like trying to nail jelly to a wall.	
You've got this, much more information which makes you realise how, how little you still know about it. And how more big and complex the problem is.	753-755
Erm…It's only in the most recent year or two that I've become more aware of the kinds of foods that are really…not just what I'd say just obviously setting it off. But which medical knowledge is telling me it's more prone to it off.	826-828
Jeff:	
But it's still classed as I, IBS even though it's completely different	31-32
So. Don't know what, don't know what went wrong there? But [breaths in deeply] it's just changed. So, it's gone from one extreme to another.	51-53
That was before…everything was here there and I didn't have a clue what was going on.	159-160
I couldn't get my head around it. I didn't know what was going on.	238-239
But like I said before I couldn't, like my symptoms were slightly different.	263-264
See, it's meant to be like I've got this stomach infection. Which is…I don't know if it's part of the bowel thing or what but. [] It certainly does effect my bowel.	319-323
And right back when…I couldn't, I didn't know what was going on with what I was being sick all day long.	448-449
I'm trying to get my head around it.	535
It's…..a lot of people have IBS and it's different. Their symptoms is different.	739-740
Yeah, I used to worry. When I, when I didn't have a clue…what was where, who, what and you think, you know?	776-778
It's the not finding something which is worse if you ask me.	874-875
The unknown is whole lot worse.	886
Yeah, well… because it's weird this whole IBS thing. Because my symptoms have changed. Changed. [] I just think. How, how can you say it's like the same thing? [] You know? Maybe I've got another problem somewhere? Blah, blah, blah.	1041-1048
So it's like. If things can change that much how can it be the same thing? Unless there's a big range.	1120-1121
Dave:	
And I thought there's something weird going on here.	75-76
It's like if things feel like they've changed a lot. And they have, like massively then ….then, something's happened to trigger it.	98-100
My stomach doesn't seem to work in the same way that it used to.	263-264
It often comes up 'cause we're talking about beer or say…oh,	269-272

we don't drink lager anymore 'cause it's really gassy. And maybe that's one of the things that causes bloating.	
Erm…Because she had IBS. I remember as a kid she had IBS. And she had books about it around the house. [] Erm…And I've mentioned it to her because…I've basically said to her. You know when I was trying to work out what was going on. I sort of said, I remember you having these books when you were young. You know, what was all that about. We talked about that a bit.	377-385
I think, well, I think it's one of those things, when something's going weird with you… it's the same with my back. It's like you want to… I'll think what's explanation for it? And whatever the explanation is you just want to know and is it something genetic. And I just remember thinking, 'oh my mum's had this'. That might make some sense.	394-400
So what is it? So what, what is it that's causing it? Is it just…getting less tolerant of certain foods or whatever.	431-433
But knowing my mum had those things. I don't know what caused it with her but just, I guess it's thinking well…these things might be connected to a degree and. [] and it may be…I guess it makes you feel less odd….	439-445
I don't know, I think it's, it's, because I associate it with this thing that my mum had.	605-606
And probably the reason I don't say IBS is it…a, I'm not. I don't really under, I don't really think…that is what I've got I suppose. I just think I've got a series of little symptoms that… [] maybe make up this overall thing.	630-635
Whereas, in a way, I suppose I was thinking…I, I certainly think of the farting and the bloating is linked but in the way I kind of think, I don't see that…[] the going to the toilet stuff is quite the same way, as kind of, these kind of…[] little things that happen to me rather than this big condition.	665-673
And I think fruit is one of the things that makes things really kind of gassy and, I don't know.	1137-1138
I'm not sure that's an IBS thing. It feels like it's more of kind of a piles thing [breaths in]. But I don't know? As I say, I'm not really sure how they're all.	1296-1298
That's why I didn't wanna…say I have IBS because I feel it's just lots of little things.[] That are hard to explain what's…what's going on. Is it one? It would be brilliant to say, all of these are caused by this one thing IBS. But to me, what I've heard about IBS it's not exactly, it's not like…[] You know? You have this virus that causes all these things. It's like a term that describes…[] All these things. And potentially, a thing that can be caused by lots of different things from what I can see. So I don't. So I don't find it that helpful in terms of encapsulating evidence going on.	1310-1324
Rob:	
I couldn't find…a pattern. I couldn't find…and it was really	71-72

like…annoying me.	
Obviously, sort of something that erm…fit well with me. When someone said…like diagnosis before I had…is that they said erm…what did they say? They said I had a very sensitive gut [] and…that kind of sat a lot better than…	116-121
That sort of fitted with me thinking that I had a very sensitive gut. I would react differently to somebody else who might have it.	168-170
You know there's obviously, there's a link to stress causing …you know? Stuff. So…[] Doesn't fit perfectly well with me.	306-309
Then I had the colonoscopy. Then I found out that everything was okay which... which put your mind at ease a tiny bit.	401-403
It has to, I have to have…you know there's part of me from him, and part of me from my mum. My mum is a huge worrier. She worries the whole time and frets the whole time [sound of alarm in corridor goes quiet]. [] So a combination of having some genes that make me worry and…[] and having a bad stomach when you, you know intolerance to certain foods may be slightly erm….as maybe…made me who I am now.	816-827
That's, that's all I try and do. Is always try and make sense.	833-834
I think when you turn up with stomach ache and stomach issues it's different in the way that…[] An idea of what it is but don't really know.	1245-1249
Eddie:	
But that I found really confusing because I was in agony, absolute agony. I'm sort of…screaming. But is was shaking and, and sweating and…[] went completely white and, and the other people that were having the test there were all having tea and biscuits.	111-117
So I knew that there was something that was a bit different….but thee. When I saw the specialist afterwards he said it's IBS. But IBS covers massive range of things and it's not…it's not just like stomach cramps and bloating and that kind of thing.	119-123
I suddenly felt like…oh, this is weird. I feel…like I've got energy all of a sudden.	181-182
It was almost instantaneous. It's just really odd. Erm…this is strange. What's going on? And everything seems to be kind of changing slightly.	184-186
But people will tell, they'll say, oh I've got IBS you know? [] [long pause] So maybe, yeah it is…I know it's very wide ranging. So I'm not going to sort of…say to them, no you haven't got it but…[] you know? I think there's…there's a lot of different kind of facets to it…..	340-348
But……when I kept getting told it was stress. Do you suffer from stress? I'm like hmm…I know that there is something else to it. You know?	652-655
Well….well originally when I, when I, when I went to the doctors I didn't know that it was IBS. I didn't think it was IBS	798-807

because the general thing about IBS is yogurt and bloating and women basically. [] You know that's the general idea that you get bloating. Everyone is obsessed with going about this bloating thing and I didn't ever get bloating. Erm….so I just didn't think it was anything to do with IBS. I didn't know anything about it really.	
B. Dilemmas accepting and adapting to IBS as something given	
Keith:	
But, ah…adjusting the way I did everything and what I kind of approached it. How I…planned it.	224-226
I mean that, that…the kind of main things really….and, a doing things at the same time. Wakin' up at the same time everyday. Being at work at the same time.	865-868
The team is going out to lunch today. Yeah, great. I'll go out and do what normal people do [laughs]. And a…[] and you end up paying for it. Oh, right that's why…	889-893
Eric:	
And then somewhere over the last ten years it's just become …almost …normal now. Just a sort daily occurrence really.	40-42
Over the years you do become better at self-managing these things. [] And dealing with these things and dealing with them emotionally.	298-302
It's probably I've, I've already forgotten what it feels like to, feels like, to feel normal now. [] With regards to the whole..bowel habit and going to the toilet and all this…what most, a lot of people take for just you know? Being a regular non-event of the day	385-391
Erm…but to the point where I think…you know? I am where I am and …I'm just gonna have to get on with it now. [] Until erm…some massive medical breakthrough in…[] Understanding of the whole central nervous system and how it links to your gut it's just [laughs].Until there's some, some breakthrough on that. You know? They tell you…[] I can sort it out now….with a magic drug or whatever. I just get on with it really [breaths in sharply].	601-613
I can re, be reassured of….just what I've got to do to deal with it and get on with it.	704-705
I guess if I wanted to I could probably make, make things a bit, a bit easier for myself. [] At the risk of having a more boring life. [] But ahhhh less, sort of, problematic health wise (knocking noise). So …it's trade off.	849-856
Jeff:	
I've kind of got used to…know, as in a way that, I have to get used to it. I've got no choice.	155-156
I'd go back to work and be healthy any day of the week. [] Sick to death of being sick. [] But there is not really a lot I can do about that.	466-471

I was getting bounced around from clinic to clinic. [] And now I just try and deal with it as such.	780-782
Where I've done things for so long…and got used to things. It's kind of…I do them naturally now. [] But there are things you sort of think about. [] You know? A normal person you'd have to like…you know? It's awkward to understand really…..Erm, yeah like there's certain things I'd do that…I shouldn't have to do. [] You know like when I say about eatin'. [] If I'm going out I don't eat…all day.	1181-1194
I do certain things and…it, it shouldn't be havin', sort of natural to do those things. But they kind of [] I've done it for so long now. They do help me and I don't have to think about things so much.	1207-1212
What, what, what do I do? Live like this forever? [] I don't know? But then I think to myself well, maybe they've done everything they can…and I have just got to live with it. So that's why I've sort of adapted my life around it.	1252-1257
Dave:	
And I spend more time on the toilet. Frankly I just get my iphone out and I sit on the toilet and I. [] Read the news for fifteen minutes if that's what it takes.	168-172
I don't drink lager anymore because it's too gassy and I got…stomach problems	282-283
Whereas now it's, it's a practical thing that you have to deal with, you know? [] If I've gotta get rid of wind, I've gotta rid of wind and you know.	515-519
I've gotta be more, slightly more careful about what I eat and…things like that. [] I don't really. I've changed my diet a bit…but not much.	525-529
If you monitor your health you…make certain compromises.	544-545
In terms of, it's inconveniencing, without really thinkin' about…getting old in the same way. [] I shouldn't be, I'm in my early thirties and I don't feel old. [] So…it was a weird thing to tryin' have to just …detach the physical side of things that were going wrong.	893-901
The fact actually I'm only thirty. It's not that I've got old and…	903-904
So actually…my hygiene…[] Is probably improved because I do that. To be honest that feels really weird. [] And I remember I've had this conversation with my wife a couple of times. You can't come into the toilet I'm just wiping my bum, you know? And it just feels like really weird. I don't like the fact. [] That I do that. Because it just feels like…who has to wipe their bum at random times unless they are going to the toilet.	999-1009
If it was a question of eating tablet, or having tablets then I probably wouldn't. [] I'd probably try and avoid doing that if I can.	1117-1120
But again I'm more than happy to…[] [laughs] make that trade off.	1157-1159

If I'd had three or four pints of lager I'd look at my stomach and that would be one of the big things. I, as I said, I just drink bitter now. But that, that wasn't anything to do what the dietician said. That was just…my gut instinct	1165-1169
I feel everyone has problems of some description. It's just weird that one of things that I have to do is wipe my bum. I just remember thinking. [] I literally never heard of anyone else. That does this. There may be millions of people do it. And I've got no idea. [] That did felt weird that I was doing it. But I don't really thing like that anymore. [] I just think of it as something that I do every so often…..	1240-1253
Rob:	
And then it sort of just became part of a normal, normal life. I, I never, you know? It never was…I had to live with it from day one.	29-31
Because I wanted to do something logical. Something I could, you know? Plan. Right exclude these foods and see how I feel. [] Fitted, fitted better for me. Felt like I was doing…being active.	193-198
When you feel fine. It's hard. It's hard for me anyway to actively do something about it by cutting out the crap. [] When you are feeling good. Because you just want to normal again.	208-212
But I've told myself that…it's not a crazy diet. You know? I'm going to do it for a period of time. It's just changing what I do. [] It's more like a lifestyle type thing rather than…	279-283
I just sort of feel that…there's enough to eat without having to eat these bits and pieces.	324-325
Erm, and he says he eats less bits of…big blobs of cheese and stuff like that. [] Erm…and, and I'm….I never really lived by that at all…..	795-799
It's just, you just learn…so many different…so many different little tips and tricks.	900-901
I think that, that's the worst…..erm…no…. I think I feel in a better place now. Thinking back about how bad it was. [] You take it for granted. Because it's more of a day to day getting better type thing.	999-1004
It had to be…because I've lived with it for so long. [] It just felt normal.	1026-1028
Erm, I think a mixture of things. I think…thinking it was normal….in my head.	1107-1108
Because I don't ever feel that I'm gonna get any, get any better. I'll just have to manage [] the symptoms better.	1268-1271
It's, it's just making these small changes I think. Rather than one big change that…[] That you are not going to be able to hold.	1290-1293
Eddie:	
But every now and again I think…well maybe…you know? I should try to eat them because…they must be fine. I, you	516-525

know? Because it's difficult to hold on to the fact that no you can't. [] So then I'd eat them and….I'd have a massive kind of reaction to it. [] And erm…it would be erm…it would happen…it would happen quite a lot.	
Finding a way to deal with it. [] That was what my outlook was. [] So whatever it is. I've got to deal with it.	673-677
I was still coming out of it thinking…you know? I've gotta try and find a way of living like this.	686-687
Then I end up being someone who's got all of these things so ...you know? I think there are …there's things that people don't quite understand about it and they kind of put up with it.	849-852
So…the only thing that I would say…that I can do. I manage, besides management goes if I…if I wanted…you know? Occasionally… have something that I know I'm not supposed to have.	937-940
C. Concealment and negotiating disclosure of IBS	
Keith:	
I used to still kind of…euph, euphemisms like feeling unwell. Or nausea. [] Or your nausea rather than…saying…I've got diarrhoea. Because there's and an element there of, of…. [] ….like one of [laughing] the more comical kind of afflictions to the people that haven't…kind of suffered with it. So…[] there's an element of embarrassment there and….and kind of you, you…you try… to, to kind of make light of it.	603-616
Eric:	
I think….more…willing to be quite open about the fact that the you know, at times I'm not too well. I've got this problem.	282-284
Jeff:	
With going out with my friends and that I don't wanna explain to them like why and …why I've got to shoot off.	343-345
But like…my friends. I don't want to be tellin' them all…my personal…in depth things like, oh yeah can't go out for dinner with you lot because… [] I might shit myself…frankly [laughs]. Sorry, I don't know how else to say it. [] But yeah…I just, like to them I just don't wanna tell them that.	394-402
Yeah, I tell them as least as possible.	430
My friends say to me, why don't you wanna do this? And I, I tend to make other excuses.	588-589
Depends how you explain it. [] Will, will they swerve ya? Thinkin' they, they're gonna catch something from ya [laughs]. You know? All sorts of things will pop through your mind.	622-626
But you know, people have reacted different to it.	636
What people don't know scares them.	642
Dave:	
And I am very open with things. [] Other chaps will talk about. So it's not really… I never found it an embarrassing thing to talk about. [] I wouldn't talk about in a room with twenty people but when I'm one on one with close mates I'm more than	287-294

happy to talk about it.	
I remember once, actually I can remember talking…Because when you talk to people about it, you don't say, oh I've got IBS. But you might say, oh, I had really bad bloating yesterday.	568-571
I don't I've ever said to anyone I've got IBS. Because I still find it a bit weird to be honest.	589-591
Rob:	
You know you can't rule out a lot of things apart from saying, you know? You don't feel too well. Every now and again. It's hard to like…[] speak to people about it.	433-437
I'm very, very, very open with just telling anyone that wants to listen.	453-454
So I just say normally I'm just excluding certain foods [] rather than say I'm doing the fodmap diet.	477-480
I mean, you can hear I always bad stomach but I never say, never say IBS at all. [] Especially if you're in a group. [] I think it has got some negative connotations in a sort of public arena.	485-490
I think it's embarrassing. [] Erm…it's not really something that you really bring up normally. Talking about, you know? How many times you go to the toilet. Or, if you've got a bad you know? [] You don't bring it up. So…I think probably by saying…I just taking it one step back. [] And saying. You know…bad stomach or bad guts sort of. You know?	497-508
It feel like one of those words that's quite…erm…You know it's very…it's quite …erm…sort of vivid.	519-521
I would never use IBS or say Irritable Bowel Syndrome. [] I just wouldn't. Just wouldn't.	527-530
And they'll say it quiet. Do you think you've got Irritable Bowel Syndrome? Like, and you'll be like whenever I say I've got a bad stomach and then I'll be like, yeah I probably have yeah. I've got a sensitive…I then I'll try and, maybe try and deflect.	538-543
I wouldn't hide it. [] If the time was right and they asked me about it. I would talk to them about it.	591-594
So I'm a lot more comfortable ... [] Maybe bringing things up or…mentionin' anything	1503-1506
Eddie:	
And also…people really scoff at it. [] So you don't get any kind of…if you say you're got it….people are immediately suspicious of you. P: So…employers….think you're… taking the mick really. They don't, they don't take it seriously at all. I mean when I, I was off for four weeks…I got in a lot of trouble at work. [] Because they didn't…they were really suspicious of the whole thing	307-318
Because they were so sort of scathing…of anything that's…to do with that.	327-328
I mean you can't really behave like that at work…there was a couple of people at work knew that it was happening but…like	402-405

could cover it….at work.	
And it's… [] not the kind of thing that you really go in and say oh I've got IBS… by the way. [] You know? Is it okay if I'm near the loo because I'm going to have to go that often. It's not something… you can really be that…sort of open about… and if you do tell them… anything. Which you have to in the end. They just look at you like… you know? You're basically a skiver who's not really got what it takes. [] You know? It's not, it's not great.	894-906
It's…sort of humiliating really. Really humiliating.	908

9.0 REFERENCES

Akehurst, R. L., Brazier, J. E., Mathers, N., O'Keefe, C., Kaltenthaler, E., Morgan, A., Platts, M., & Walters, S. J. (2002). Health-related quality of life and cost of irritable bowel syndrome. *Pharmacoeconomics, 20*, 455-462.

Alpers, D. H. (2008). Multidimensionality of symptom complexes in irritable bowel syndrome and other functional gastrointestinal disorders. *Journal of Psychosomatic Research, 64*, 567-572.

Arroll, M. A., & Dancey, C. P. (2014). *Invisible illness: Coping with misunderstood conditions.* London: Sheldon Press.

Arroll, M. A., & Senoir, V. (2008). Individuals' experiences of chronic fatigue syndrome/ myalgic encephalomyelitis: An interpretative phenomenological analysis. *Psychology and Health, 23*(4), 443-458.

Beck, A. T., Steer, R. A., & Garbin, M. G. J. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Bennett, P., & Wilkinson, S. (1985). Comparison of psychological and medical treatment of the irritable bowel syndrome. *British Journal of Clinical Psychological, 24*, 215-216.

Blanchard, E. B. (2001*). Irritable bowel syndrome: Psychosocial assessment and treatment*. Washington, DC: American Psychological Association.

Blanchard, E. B. (2005). A critical review of cognitive, behavioural, and cognitive-behavioural therapies for irritable bowel syndrome. *Journal of Cognitive Psychotherapy: An International Quarterly, 19*(2), 101-123.

Blanchard, E. B., Keefer, L., Galovski, T. E., Taylor, A. E., & Turner, S. M. (2001). Gender differences in psychological distress among patients with irritable bowel syndrome. *Journal of Psychosomatic Research, 50*, 271-275.

Blanchard, E. B., Lackner, J. M., Jaccard, J., Rowell, D., Carosella, A. M., Powell, C., Sanders, K., Krasner, S., & Kuhn, E. (2008). The role of stress in symptom exacerbation among IBS patients. *Journal of Psychosomatic Research, 64*, 119-128.

Bor, R. (1993). Efficacy of HIV counselling. *Counselling Psychology Review, 8*(2), 7-9.

Borkovec, T. D., Robinson, E., Pruzinsky, T., & DePree, J. A. (1983). Preliminary exploration of worry: Some characteristics and processes. *Behaviour Research and Therapy, 21*, 9-16.

Brandt, L. J., Bjorkman, D., Fennerty, M. B., Locke, G., Olden, K., Peterson, W., Quigley, E., Schoenfeld, P., Schuster, M., & Talley, N. (2002). Systematic review on the management of irritable bowel syndrome in North America. *Amercan Journal of Gastroenterology, 97*, S7-26.

Camilleri, M., & Choi, M. G. (1997). Review article: Irritable Bowel Syndrome. *Alimentary Pharmacology and Therapeutics, 11*, 3-15.

Casement, P. (1985). *On learning from the patient*. London: Routledge.

Casiday, R. E., Hungin, A. P. S., Cornford, C. S., De Wit, N. J., & Blell, M. T. (2008). Patients' explanatory models for irritable bowel syndrome:

Symptoms and treatment more important that aetiology. *Family Practice, 26*, 40-47.

Chang, L. (2004). Epidemiology and quality of life in functional gastrointestinal disorders. *Alimentary Pharmacology Therapeutics, 20*(7), 31-39.

Charmaz, K. (1983). Loss of self: A fundamental form of suffering in the chronically ill. *Sociology of Health and Illness, 5*(2), 169-195.

Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review, 24*(3&4), 119-129.

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

Corney, R. (2003). Counselling psychology in primary care settings. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp. 401-418). London: Sage.

Coyle, A. (2007). Introduction to qualitative psychological research. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology.* (pp. 9-29). London: Sage.

Coyle, A. (2012). Discourse analysis. In G. M. Breakwell, J. A. Smith & D. B. Wright (Eds.)*, Research methods in psychology* (pp. 485-509). London: Sage.

Crane, R. (2009). *Mindfulness-based cognitive therapy*. East Sussex: Routledge.

Crane, C., & Martin, M. (2003). Illness schema and level of reported gastrointestinal symptoms in irritable bowel syndrome. *Cognitive Therapy and Research, 27*(2), 185-203.

Crossley, M. (2007). Narrative analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 131-144). London: Sage.

Dancey, C. P., Hutton-Young, S. A., Moye, S., & Devins, G. M. (2002). Perceived stigma, illness instrusiveness and quality of life in men and women with irritable bowel syndrome. *Psychology, Health & Medicine, 7*(4), 381-395.

Dancey, C. P., & Rutter, C. L. (2005). *Take control: Insights into irritable bowel syndrome*. Shrewsbury, Shropshire: TFM Publishing Ltd.

Dancey, C. P., Taghavi, M., & Fox, R. J. (1998). The relationship between daily stress and symptoms of irritable bowel: A time-series approach. *Journal of Psychosomatic Research, 44*, 537-545.

Dayes, J. E. (2011). Myalgic encephalomyelitis/ chronic fatigue syndrome: A discussion of cognitive behavioural therapy, mindfulness, and mindfulness-based cognitive therapy. *Counselling Psychology Review, 26*(2), 70-75.

Devins, G. M., Edworthy, S. M., Paul, L. C., Mandin, H., Seland, T. P., & Klein, G. M. (1993). Illness intrusiveness and depression symptoms over the adult years: Is there a differential impact across chronic conditions? *Canadian Journal of Behavioural Science, 25*(3), 400-413.

Dickson, A., Knutssen, C., & Flowers, P. (2008). 'That was my old life; it's almost like a past-life now': Identity crisis, loss and adjustment amongst people living with chronic fatigue syndrome. *Psychology and Health, 23*(4), 459-476.

Division of Counselling Psychology (2005). *Professional practice guidelines*. Leicester, Leicestershire: British Psychological Society. Retrieved 28

June 2013, from: www.bps.co.uk/publications/policy-guide-lines/practice-guidelines-policy-documents/practice-guidelines-poli

Drews, A., & Hazlett-Stevens, H. (2008). Relationships between irritable bowel syndrome, generalized anxiety disorder, and worry-related constructs. *International Journal of Clinical and Health Psychology, 8*(2), 429-436.

Drossman, D. A. (1995). Diagnosing and treating patients with refractory functional gastrointestinal disorders. *Annals of Internal Medicine, 113*, 828-833.

Drossman, D. A. (1996). Presidential address: Gastrointestinal illness and the biopsychosocial model. *Journal of Clinical Gastroenterology, 22*, 252-254.

Drossman, D. A. (2006). The functional gastrointestinal disorders and the Rome III process. *Gastroenterology, 130*, 1377-1390.

Drossman, D. A., Corazziari, E., Talley, N. J., Thompson, G. W., & Whitehead, W. E. (2000). *Rome II. The functional gastrointestinal disorders. Diagnosis, pathophysiology and treatment: A multinational consensus.* McLean, VA: Degnon Associates.

Drossman, D. A., Creed, F. H., Olden, K. W., Svedlund, J., Toner, B. B., & Whitehead, W. E. (1999). Psychosocial aspects of the functional gastrointestinal disorders. *Gut, 45*(2), 1125-1130.

Drossman, D. A., McKee, D. C., Sandler, R. S., Mitchell, C. M., Cramer, E. M., & Lowman, B. C. (1988). Psychosocial factors in the irritable bowel syndrome: A multivariate study of patients and non-patients with irritable bowel syndrome. *Gastroenterology, 95*, 701-708.

Eatough, V. (2012). Introduction to qualitative methods. In G. M. Breakwell, J. A. Smith & D. B. Wright (Eds.)*, Research methods in psychology* (pp. 321-341). London: Sage.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenology analysis. In C. Willis & W. Stainton-Rogers (Eds.)*, The sage handbook of qualitative research in psychology* (pp. 179-194). London: Sage.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129-136.

Etherington, K. (2004). Research methods: Reflexivities - roots, meanings, dilemmas. *Counselling and Psychotherapy Research, 4*, 46-47.

Farndale, R., & Roberts, L. (2011). Long-term impact of irritable bowel syndrome: A qualitative study. *Primary Health Care Research & Development, 12*, 52-67.

Freeston, M. H., Rheaume, J., Letarte, H., Dugus, M. J., & Ladouceur, R. (1994). Why do people worry? *Personality and Individual Differences, 17*(6), 791-802.

Galovski, T. E., & Blanchard, E. B. (1999). The treatment of irritable bowel syndrome with hypnotherapy. *Applied Psychophysiology and Biofeedback, 23*, 219-232.

Garland, E. L., Gaylord, S. A., Palsson, O., Faurot, K., Mann, J. D., & Whitehead, W. E. (2012). Therapeutic mechanisms of a mindfulness-based treatment for IBS: Effects on visceral sensitivity, catastrophizing, and affective processing of pain sensations. *Journal of Behavioural Medicine, 35*, 591-602.

Gholamrezael, A., Ardestani, S. K., & Emani, M. H. (2006). Where does hypnotherapy stand in the management of irritable bowel syndrome? A

systematic review. *Journal of Alternative and Complementary Medicine, 12*, 517-527.

Gilbert, P. (1998). Shame and humiliation in the treatment of complex cases. In N. Tarrier, A. Wells & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioural therapy approach* (pp. 241-271). Chichester, West Sussex: John Wiley & Sons Ltd.

Gomez, L. (1997). *An introduction to object relations.* London: Free Association books.

Good, G. E., Thomson, D. A., & Brathwaite, A. D. (2005). Men and therapy: Critical concepts, theoretical frameworks and research recommendations. *Journal of Clinical Psychology*, *61*(6), 699-711.

Greene, B., & Blanchard, E. B. (1994). Cognitive therapy for irritable bowel syndrome. *Journal of Consulting and Clinical Psychology, 62*, 576-582.

Guthrie, E., Creed, F., Dawson, D., & Tomenson, B. (1991). A controlled trial of psychological treatment for the irritable bowel syndrome. *Gastroenterology, 100*, 450-457.

Guthrie, E., Moorey, J., Margison, R., Barker, H., Palmer, S., McGrath, G., Tomenson, B., & Creed, F. (1999). Cost-effectiveness of brief psychodynamic interpersonal therapy in high utilizers of psychiatric services. *Archives of General Psychiatry, 56*, 519-526.

Harris, G., & Larsen, D. (2008). High-risk behaviours following an HIV diagnosis. *Counselling Psychology Review, 23*(3), 48-68.

Heap, M., & Aravind, K. K. (2002). *Hartland's medical and dental hypnosis* (4th ed.). London: Churchill Livingston/ Harcourt Health Sciences.

Heitkemper, M., & Jarret, M. (2008). Irritable bowel syndrome: Does gender matter. *Journal of Psychosomatic Research, 64*, 583-587.

Hellier, M. D., Sanderson, J. D., Morris, A. I., Elias, E., & De Caestecker, J. (2006). *Care of patients with gastrointestinal disorders in the United Kingdom: A strategy for the future.* British Society of Gastroenterology: UK.

Hession, N. (2010). The counselling psychologist working in the context of pain. In M. Milton (Ed.), *Therapy and beyond* (pp. 195-211). Chichester, West Sussex: John Wiley & Sons Ltd.

Hicks, C. (2010). Counselling psychology contributions to understanding sexuality. In M. Milton (Ed.), *Therapy and beyond* (pp. 243-258). Chichester, West Sussex: John Wiley & Sons Ltd.

Horwitz, B. J., & Fisher, R. S. (2001). The irritable bowel syndrome. *New England Medical Journal, 344*(24), 1846-1850.

Hunt, M. G., Milonova, M., & Moshier, S. (2009). Catastrophizing the consequences of gastrointestinal symptoms in irritable bowel syndrome. *Journal of Cognitive Psychotherapy: An International Quarterly, 23*(2), 160-173.

Hyphantis, T., Gutherie, E., Tomenson, B., & Creed, F. (2009). Psychodynamic interpersonal therapy and improvement in interpersonal difficulties in people with severe irritable bowel syndrome. *Pain, 145*, 196-203.

Jacobs, M. (2004). *Psychodynamic counselling in action* (3rd ed.). London: Sage.

Jones, M. P., Keefer, L., Bratten, J., Taft, T. H., Crowell, M. D., Levy, R., & Palsson, O. (2009). Development and initial validation of a measure of

perceived stigma in irritable bowel syndrome. *Psychology, Health & Medicine, 14*(3), 367-374.

Kasket, E. (2013). The counselling psychologist researcher. In G. Davey (Ed.), *Applied psychology, student companion site*. Chichester, West Sussex: BPS Blackwell. Retrieved July 13, 2013, from http://bcs.wiley.com/hebcs/Books?action=mininav&bcsId=6483&itemId=1444331213&assetId=297219&resourceId =29364&newwindow=true

Keefer, L., Sanders, K., Sykes, M. A., Blanchard, E. B., Lackner, J. M., & Krasner, S. (2005). Towards a better understanding of anxiety in irritable bowel syndrome: A preliminary look at worry and intolerance of uncertainty. *Journal of Cognitive Psychotherapy: An International Quarterly, 19*(2), 163-172.

Kennedy, A., Robinson, A., & Rogers, A. (2003). Incorporating patients' views and experiences of life with IBS in the development of an evidence based self-help guidebook. *Patient Education and Counselling, 50*, 303-310.

Kouimtsidis, C., Reynolds, M., Drummond, C., Davis, P., & Tarrier, N. (2007). *Cognitive-behavioural therapy in the treatment of addiction: A treatment planner for clinicians*. Chichester, West Sussex: John Wiley & Sons Ltd.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

Lackner, J. M. (2005). No brain, no gain: The role of cognitive processes in irritable bowel syndrome. *Journal of Cognitive Psychotherapy: An International Quarterly, 19*(2), 125-136.

Lackner, J. M., Gellman, R., Gudleski, G., Sanders, K., Krasner, S., Katz, L., & Blanchard, E. B. (2005). Dysfunctional attitudes, gender and

psychopathology as predictors of pain affect in patients with irritable bowel syndrome. *Journal of Cognitive Psychotherapy: An International Quarterly, 19*(2), 151-161.

Lackner, J. M., & Gurtman, M. B. (2004). Patterns of interpersonal problems in irritable bowel syndrome patients: A circumspect analysis. *Journal of Psychosomatic Research, 58*, 522-532.

Lackner, J. M., & Gurtman, M. B. (2005). Pain catastrophizing and interpersonal problems: A circumplex analysis of the communal coping model. *Pain, 110*, 597-604.

Lackner, J. M., Mesmer, C., Morley, S., Dowser, C., & Hamilton, S. (2004). Psychological treatments for irritable bowel syndrome: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology, 72*(6), 1100-1113.

Lackner, J. M., & Quigley, B. M. (2004). Pain catastrophizing mediates the relationship between worry and pain suffering in patients with irritable bowel syndrome. *Behaviour Research and Therapy, 43*, 943-957.

Lacy, B. E., & Lee, R. D. (2005). Irritable bowel syndrome: A syndrome in evolution. *Journal of Clinical Gastroenterology, 39*, 230–242.

Lee, N. (2009). *Achieving your professional doctorate: A handbook.* Maidenhead, Berkshire: Open University Press.

Lewis, H. B. (1987). Introduction: Shame – the sleeper in psychopathology. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 1-28). Hillsdale, NJ: Erlbaum.

Ljotsson, B., Andreewitch, S., Hedman, E., Ruck, C., Andersson, G., & Lindefors, N. (2010). Exposure and mindfulness based therapy for

irritable bowel syndrome: An open pilot study. *Journal of Behaviour Therapy and Experimental Psychiatry, 41*, 185-190.

Looper, K. J., & Kirmayer, L. J. (2004). Perceived stigma in functional somatic syndromes and comparable medical conditions. *Journal of Psychosomatic Research, 57*, 373-378.

Luscombe, F. A. (2000). Health-related quality of life and associated psychosocial factors in irritable bowel syndrome: A review. *Quality of Life Research, 9*, 161-176.

Lydiard, R. B. (1992). Anxiety and irritable bowel syndrome. *Psychiatric Annals, 22*, 612-618.

Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology: Research and Practice, 34*, 123-131.

Manning, A. P., Thompson, W. G., Heaton, K. W., & Morris, A. F. (1978). Towards positive diagnosis of the irritable bowel. *British Medical Journal, 2*(6138), 653-654.

Mayer, E. A., Naliboff, B., Lee, O. Munakata, J., & Chang, L. (1999). *Aliment Pharmacology Therapeutics, 13*, 65-69.

McDougall, J. (1989). *Theatres of the body: A psychoanalytic approach to psychosomatic illness*. London: Norton & Company Ltd.

McKelley, R. A. (2007). Men's resistance to seeking help: Using individual psychology to understand counselling-reluctant men. *The Journal of Individual Psychology, 63*(1), 48-58.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy* (2nd ed.). London: Sage.

Mease, P. (2005). Fibromyalgia syndrome: Review of clinical presentation, pathogenesis, outcome measures and treatment. *Journal of Rheumatology, 32*, 6-21.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the penn state worry questionnaire. *Behaviour Research and Therapy, 28*(6), 487-495.

Moss-Morris, R., McAlpine, L. Didsbury, L.P., & Spence, M. J. (2010). A randomized controlled trial of a cognitive behavioural therapy-based self-management intervention for irritable bowel syndrome in primary care. *Psychological Medicine, 40*, 85-94.

Muscatello, M. R. A., Bruno, A., Pandolfo, G., Mico, U., Stilo, S., Scaffidi, M., Consolo, P., Tortora, A., Pallio, S., Giacobbe, G., Familiari, L., & Zoccali, R. (2010). Depression, anxiety and anger in subtypes of irritable bowel syndrome patients. *Journal of Clinical Psychology in Medical Settings, 17*, 64-70.

Musial, F., Hauser, W., Langhorst, J., Dobos, G., & Enck, P. (2008). Psychophysiology of visceral pain in IBS and health. *Journal of Psychosomatic Research, 64*, 589-597.

Naliboff, B. D., Frese, M. P., & Rapgay, L. (2008). Mind/Body psychological treatments for irritable bowel syndrome. *Evidence Based Complementary and Alternative Medicine, 5*(1), 41-50.

National Institute for Health and Clinical Excellence (2008). *Irritable bowel syndrome in adults.* London: NICE. Retrieved August 3, 2011, from: http://www.nice.org.uk/nicemedia/live/11927/39622/39622.pdf

Neal, K. R., Hebden, J., & Spiller, R. (1997). Prevalence of gastrointestinal symptoms six months after bacterial gastroenteritis and risk factors for

development of the irritable bowel syndrome: postal survey of patients. *British Medical Journal, 314*, 779-782.

Neff, D. E., & Blanchard, E. B. (1987). A multi-component treatment for irritable bowel syndrome. *Behaviour Therapy, 18*, 70-83.

O'Neil, J. M., Good, G. E., & Holmes, S. (1995). Fifteen years of theory and research on men's gender role conflict: New paradigms for empirical research. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 164-206). New York: Basic Books

Orlans, V. (2013). The nature and scope of counselling psychology. In G. Davey (Ed.), *Applied Psychology, Student Companion Site*. Chichester, West Sussex: BPS Blackwell. Retrieved July 13, 2013, from http://bcs.wiley.com/hebcs/Books?action=mininav&bcsId=6483&itemId=1444331213&assetId=297216&resourceId=29364&newwindow=true

Papadopoulos, L., & Bor, R. (1995). Counselling psychology in primary health care: A review. *Counselling Psychology Quarterly, 8*(4), 291-304.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology.* London: Routledge.

Patel, S. M., Stason, W. B., Legedza, A., Ock, S. M., Kaptchuk, T. J., Convoy, L. Canenguez, K., Park, K., Kelly, E., Jacobson, E., Kerr, C. E., & Lembo, A. J. (2005). The placebo effect in irritable bowel syndrome trials: A meta-analysis. *Neurogastroenterology Motility, 17*, 332-340.

Payne, S. (2007). Grounded theory. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology.* (pp. 65-86). London: Sage.

Payne, A., & Blanchard, E. B. (1995). A controlled comparison of cognitive therapy and self-help support groups in the treatment of irritable bowel syndrome. *Journal of Consulting and Clinical Psychology, 63*, 779-786.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.)*, Doing qualitative analysis in psychology* (pp. 245-273). Hove, East Sussex: Psychology Press.

Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.), *Therapy and beyond* (pp. 41-55). Chichester, West Sussex: John Wiley & Sons Ltd.

Reid, K., Flowers, P., & Larkin. M. (2005). Exploring lived experience. *The psychologist, 18*(1), 20-23.

Riedl, A., Schmidtmann, M., Stengel, A., Goebel, M., Wisser, A., Klapp, B. F., & Monnikes., H. (2008). Somatic comorbidities of irritable bowel syndrome: A systematic analysis. *Journal of Psychosomatic Research, 64*, 573-582.

Rizq, R., & Target, M. (2008). 'The power of being seen': An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *British Journal of Guidance and Counselling, 36*(2), 131-153.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.*), Analyizing qualitative data* (pp. 173-194). London: Routledge.

Rodham, K., Rance, N., & Blake, D. (2010). A qualitative exploration of carers' and patients' experiences of fibromyalgia: One illness, different perspectives. *Musculoskeletal Care, 8*, 68-77.

Salkovskis, P. M. (1989). Somatic problems. In K. Hawton, P. M. Salkovskis, J. Kirk & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: A practical guide* (pp. 235-276). New York: Oxford University Press.

Shaw, R. (2010). Interpretative phenomenology analysis. In M. A. Forrester (Ed.)*, Doing qualitative research in psychology: A practical guide* (pp. 177-201). London: Sage.

Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods* (3rd ed.). London: Sage.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35-50). London: Sage.

Smith, J. A., & Eatough, V. (2012). Interpretative phenomenology analysis. In G. M. Breakwell, J. A. Smith & D. B. Wright (Eds.)*, Research methods in psychology* (pp. 439-459). London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 53-80). London: Sage.

Speilberger, C. D. (1983). *Manual for the state-trait anxiety inventory – STAI (form y)*. Palo Alto, CA: Consulting Psychologists Press.

Spence, M., & Moss-Morris, R. (2007). The cognitive behavioural model of irritable bowel syndrome: A prospective investigation of gastroenteritis patients. *Gut, 56*(8), 1066-1071.

Spiller, R., Aziz, Q., Creed, F., Emmanuel, A., Houghton, L., Hungin, P., Jones, R., Kumar, D., Rubin, G., Trudgill, N., & Whorwell, P. (2007). *Gut, 56*, 1170-1798.

Stalmeisters, D. (2012). Towards a schema level understanding of myalgic encephalomyelitis/ chronic fatigue syndrome: A grounded theory approach. *Counselling Psychology Review, 27*(3), 29-39.

Stanley, L., & Wise, S. (1993). *Breaking out again: Feminist ontology and epistemology.* London: Routledge.

Stenner, P. H. D., Dancey, C. P., & Watts, S. (2000). The understanding of their illness amongst people with irritable bowel syndrome: A 'q' methodological study. *Social Science & Medicine, 51*, 439-452.

Storey, L. (2007). Doing interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology.* (pp. 51-64). London: Sage.

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

Svetlund, J., Sjodin, I., Ottosson, J. O., & Dotevall, G. (1983). Controlled study of psychotherapy in irritable bowel syndrome. *The Lancet,* 589-592.

Sykes, M. A., Blanchard, E. B., Lackner, J., Keefer, L., & Krasner, S. (2003). Psychopathology in irritable bowel syndrome: Support for a psychophysiological model. *Journal of Behavioural Medicine, 26*(4), 361-372.

Taft, T. H., Riehl, M. E., Dowjotas, K. L., & Keefer, L. (2014). Moving beyond perceptions: Internalized stigma in the irritable bowel syndrome. *Neurogastroenterology and Motility, 26*, 1026-1035.

Talley, N. J., Fett, S. L., Zinsmeister, A. R., & Melton, L. J. (1994). Gastrointestinal tract symptoms and self-reported abuse: A population based study. *Gastroenterology, 107*, 1040-1049.

Thompson, W. G., Creed, F., Drossman, D. A., Heaton, K. W., & Mazzacca, G (1992). Functional bowel disease and functional abdominal pain. *Gastroenterology International, 5*, 75-91.

Thompson, W. G., Longstreth, G. F., Drossman, D. A., Heaton, K. W., Irvine, E. J., & Muller-Lissner, S. A. (1999). Functional bowel disorders and functional abdominal pain. *Gut, 45*, 1143-1147.

Toner, B. B. (1994). Cognitive-behavioural treatment of functional somatic syndromes: Integrating gender issues. *Cognitive and Behavioural Practice, 1*, 157-178.

Toner, B. B., Segal, Z. V., Emmott, S. D., & Myran, D. (2000). *Cognitive-behavioural treatment of irritable bowel syndrome: The brain-gut connection*. New York: The Guildford Press.

Toner, B. B., Segal, Z. V., Emmott, S., Myran, D., Ali, A., DiGasbarro, I., & Stuckless, N. (1998). Cognitive-behavioural group therapy for patients with irritable bowel syndrome. *International Journal of Group Psychotherapy, 38*, 215-243.

Van Duerzen, E., & Adams, M. (2011). *Skills in existential counselling and psychotherapy.* London: Sage.

Van Dulmen, A. M., Fennis, J. F. M., & Bleijenberg, G. (1996). Cognitive-behavioural group therapy for irritable bowel syndrome. Effects and long-term follow-up. *Psychosomatic Medicine, 58*, 508-514.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide.* Chichester, West Sussex: Wiley

Wexler, D. (2009). *Men in therapy: New approaches for effective treatment.* New York: Norton.

Wexler, D. (2010). Shame-O-Phobia: Why men fear therapy? *Psychotherapy Networker.* Retrieved January 12th, 2015, from http://www.psychotherapynetworker.org/component/content/article/215-2010-may-june/824-shame-o-phobia.

White (2009). Big boys really don't cry: Considering men's reluctance to engage in counselling. *Counselling psychology Review, 24*(3&4), 2-8.

Whorwell, P. J. (2008). Hypnotherapy for irritable bowel syndrome: The response of colonic and non-colonic symptoms. *Journal of Psychosomatic Research, 64*, 621-623.

Whorwell, P. J., Prior, A., & Faragher, E. B. (1984). Controlled trial of hypnotherapy in the treatment of severe refractory irritable bowel syndrome. *The Lancet, 2*, 1232-1234.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). New York: Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). New York: Open University Press.

Wilson, K. G., Sandoz, E. K., & Kitchens, J. (2010). The valued living questionnaire: Defining and measuring valued action within a behavioural framework. *The Psychological Record, 60*, 249-272.

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

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 235-251). London: Sage.

Zigmond, A. S., & Snaith, R. P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavia, 67*, 361-370.