An Exploration of
Counselling and Psychotherapy as a Form of Learning,
with Particular Reference to People with a Facial Difference.

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Abstract

The aim of this study is to open up a conversation on how counselling and psychotherapy can be positioned in relation to teaching and learning. “Is therapy a form of learning for people with a facial difference?” is the question that will be explored. The underpinning ethos of the study is an emphasis on the place of humanness in the research process.

From the researcher’s ‘interpretative lens’ a paradigm is developed to situate this study’s research activity. Meaning emerges in the in-between and known to those involved (ontological perspective); knowing is achieved through a relationship with another, it is an interactional subjective activity (epistemological perspective), meaning is generated through a reflexive and dialectical process (methodological perspective).

To guide the research process, a methodological framework is created that is cognisant with the research paradigm. The framework comprises of two cycles of interpretation and supports the notion of a multiplicity of meanings. The research method of heuristics generates data for analysis. This method through the second cycle of interpretation is expanded to incorporate a post-heuristic perspective; where there is a shift from the modernist self at the centre of the meaning making process, to a postmodernist de-centred self that is ‘subject to’.

Seventeen people shared their experience of either providing therapy for people with a facial difference, or their experience or opinions of therapy for people with a facial difference (this latter group included people who live with someone with a facial difference). The findings provided evidence of how previous learning experiences can create distortions in meaning making perspectives; distortions that are barriers to learning from experience, for they provide a template for the evaluation of experience. Therapy provides an opportunity for the uncovering and working through of distortions to enable a return to learning from experience. For the person to experience their experience. Facial difference pre-therapy is a label that can define a person, post-therapy there is recognition of how the label does not need to define the person; there is a return to learning from experience.

In conclusion a model is developed to enable others to open further conversations on therapy as a means to learning. A model premised on Levinas’ ethical relationship and Buber’s ‘I-It’ and ‘I-Thou’ relationship. Therapy as a means to learning can represent a transition from an ‘I-It’ (non-reflective). To an ‘I-Thou’ (reflective). To a responsibility to the other relationship (pre-reflective), and each transition offers the potential to return to learning from experience; to be more open to experience of the other.
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For my children from whom I have learnt so much.
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Chapter One

Introduction to the Study
An Exploration of counselling and psychotherapy as a form of learning,
with particular reference to people with a facial difference

Introduction
The aim of this chapter is to provide an overview of the study. Firstly the aim and background of the study will be stated, followed by definitions of the terms ‘counselling and psychotherapy’, ‘learning’ and ‘facial difference’. Next, the underpinning ethos of the study will be stated, followed by the key theoretical concepts and perspectives that inform the selection of a research paradigm to guide this study. The development of a methodological framework to be tested out in this investigation is discussed next, followed by a discussion of the selected research method heuristics. An overview of the findings that emerged will be stated followed by a discussion of the limitations of the study. A summary of the thesis layout concludes this chapter.

1. Aim and background to the study
The overall aim of this study is to open up a conversation about how counselling and psychotherapy can be positioned as a form of learning. A process that encompasses both teaching and learning, with a propensity for a return to learning from experience (Loewenthal 1999). Intrinsic to the development of this conversation is an exploration of how to study this phenomenon, to explicate a methodological framework to guide the investigation. A framework that emanates from the underpinning ethos of the study, notably a return to privileging humanness as opposed to science and technology. The framework will inform the research design and method, which then guides the investigation and culminates in the generation of a model. A model that may assist practitioners to discern the learning activities inherent to their psychotherapeutic practice; there is thus the potentiality to open up further conversations about psychotherapy as an educational process. Prior to saying more about the study, the researcher will provide some background information that was influential in bringing this study to fruition.

This study evolved from previous research by the researcher (Rose 1997), that identified the lived experience of people with cleft lips (this study employed a heuristic approach as it allows for the researcher to have direct experience of the phenomenon of the study). The conclusion drawn, was that there was a need for counselling/psychotherapy service to be made available to this client group as part of the team approach to care. An area identified for further study was the need to explore the potential merits of such a service, for both service users and providers. This recommendation provided the impetus for this study, and a successful application was made to the
Economic and Social Research Council (ESRC) to fund it. The topic area can be located in the following ESRC research themes, Lifespan, Lifestyles and Health (Theme 8), and Social Inclusion and Exclusion (Theme 9, ESRC 1997). Where the intention is to gain a greater understanding of people's life experiences and the implications for health, and the processes of how some individuals are included or excluded from society. It is hoped that through this study, the exploration and opening up of a conversation about counselling and psychotherapy as a form of learning for people with a facial difference, that a response can be made to these processes.

As the aim of the study is to open up a conversation on developing a way of looking at counselling and psychotherapy as a form of learning, a definition of the terms counselling and psychotherapy, and learning are provided next. As the focus is on people with facial difference, this term will also be defined.

2. Definitions of key terms

Prior to operationalising the key terms of 'counselling and psychotherapy', 'learning' and 'facial difference' there is a need to state the parameters of the study. The practice of counselling and psychotherapy can involve working with individuals, couples, families and groups, the focus of this study is on individual counselling and psychotherapy, and the client group are people with a facial difference.

2.1 Counselling and psychotherapy

The terms counselling and psychotherapy can be used interchangeably (Dryden and Feltham 1992, British Association for Counselling and Psychotherapy 2001), however there are others who like to make a distinction (Clarkson 1994, Corey 1991). The term psychotherapy or therapy will be adopted in this study, and the people engaged in its practice as the therapist and the client.

Psychotherapy is a process usually involving two people, one the therapist the other the client; the client seeks out the therapist to assist them with perceived difficulties in living and relating to others (Laing 1990). Therapy is about 'alleviating emotional pain and distress' (Greenberg and Safran 1987:vii). Ryecroft (1968) defines psychotherapy as any form of talking cure; and Freud is identified as the instigator of the 'talking cure' (Breuer and Freud 1895). Dialogue is the central activity of psychotherapy, and as such a requirement of the therapist is 'the ability to listen to another, the capacity to attend to another human being' (Heaton 1998:42). Through this attending the therapeutic alliance/relationship is developed; and according to Laplanche and Pontalis (1988) psychotherapy is about the effective utilisation of the therapist/patient relationship. The potential outcome of therapy is a change in perspective, emanating from 'learning, learning and relearning' (Strupp 1979:130).
The focus of this study will be on the ‘talking’ aspect of therapy; as opposed to which theoretical framework should be employed, and as such the researcher endorses the view: ‘The simple act of giving voice to one’s worries and concerns is itself therapeutic’ (Howe 1993:141). Psychotherapy is a treatment which, is not confined to any one particular group of people; in essence it is applicable for all of humankind. However, this study will focus on people with a facial difference, and how the therapy is a form of learning. Although the client group is specific, the aspect of learning emerging through therapy is generic.

2.2 Learning

‘Learning may be defined as the process of making new or revised interpretation of the meaning of an experience which guides subsequent understanding, appreciation and action’ (Mezirow 1990:1). As such the potentiality for education or teaching/learning experiences are infinite; when it is acknowledged that all experience is the ‘raw material’ of learning (Usher et al 1997). The term lifelong learning encompasses this concept (Williamson 1998, Barnett 1994). Human learning takes place in a context and is a reflexive activity (Jarvis et al 1998). The context of learning for this study is the practice of therapy, it is learning that is focused on personal knowing.

The theories of learning which inform this inquiry are student-centred (Rogers 1983), which acknowledges that adults learn best when motivated and when the subject is of interest to them, and their previous learning is recognised. The learner is active in the learning process, and the ‘teacher’ is a facilitator of the learning process; in essence the learner is learning how to learn. Learning that emerges from this form of teaching and learning is referred to as ‘significant learning’. Transformative learning (Mezirow 1990) is learning that arises from the process of critical reflection. Through this process, previous distortions in learning can be recognised, challenged and transformed; new meanings can emerge. Emotional learning is gaining recognition, there are claims that it enhances decision making, and personal relationships (Weisberg 2000). There is a focus on intentional psychological change (Quigley and Barrett 1999). Williams and Bendlow (1998) suggest that emotions within the scientific domain are viewed as being private and irrational and historically as being feminine. However, with the postmodern challenge, there has been a (re)opening of desire and reason; emotions are ‘embodied modes of being which involve active engagement with the world and an intimate connection with both self and culture’ (Williams and Bendelow 1998:xvi) [original emphasis].

It is suggested here that these three forms of learning in the context of therapy, are not mutually exclusive but are interdependent. Significant, transformative and emotional learning are intrinsic components of the teaching and learning milieu created within the therapeutic relationship. The term teaching is subsumed under the term learning, and is not included in the title for there is an
unwitting connection with the term teaching and traditional education, whereby the teacher (or in the case of therapy the therapist) is the one who imparts knowledge to the student (the client), this is at odds with the concepts of learning identified here, and with the practice of therapy.

2.3 Facial difference

According to Bradbury (1996) there are three broad categories of facial disfigurement, congenital, traumatic and disease processes. Whereas, Hughes (1991) suggests that there are two main categories, the 'disfigured' that have acquired the condition since birth, and the 'deformed', those who were born with the condition. Whether the condition has been acquired since birth or been present since birth, does not appear to affect significantly how a person copes with this difference in appearance (Robinson 1997a, Pruzinsky 1992). The purpose of this study is not to differentiate between the origin of the disfigurement, but to focus on the 'psychological' affects. The term facial disfigurement has been determined by some to have negative connotations, the term 'visibly different' was preferred by Lansdown et al (1997). The term facial difference (Charkins 1996, Elks 1990) will be used in this, because the research participant's frequently used the word 'different' to describe themselves.

3. Underpinning Ethos of the Study

The privileging of humanness over science and technology underpins this study. The concept of Plato's therapeia, appears pertinent as 'Plato perceived that education required the revolutionising of the entire mind. Plato's paideusis, or educational discipline, is literally a therapeia' (Cushman 1957:xxi) [original emphasis]. Plato recognised that central to knowledge was wisdom, which is not solely dependent on intelligence and the gathering of facts but also dependent on the ethical. Knowledge/cognition could be achieved through dialectical inquiry, whereby there was both the discovery and the acquisition of knowledge. Wisdom was also dependent on the three cardinal virtues of courage, temperance and justice (Cushman 1957); justice is concerned with a preference for the good. Therefore, knowledge without consideration of the implication of the good is not worthwhile, as it does not relate to the good of the state. As such, 'the enigma of Platonic wisdom, both its attainment and definition, is that there is no possibility of the one (knowledge) without the goal of the other (virtue)' (Cushman 1957:295). In the time since Plato, there has been a subordination of humanness (the ability to be in relationship with others) by science and technology. Descartes postulated that the mind and body are two separate entities; the Cartesian split. Credence was given to the mind over the body, with man's striving to know more about the world and in his quest for the knowable/definable truth to order the chaos he was thrown into. The science and technological explosion of the twentieth century firmly placed it as the dominant discourse.
Education became focused or was built around the notion of teaching students knowable facts. Science and technology reigned supreme. Students would be judged on their ability to technologicalise, to learn how to do things, to accumulate facts under the remit of science; a knowable truth (Leicester 2000, Usher et al 1997). The learning to think ones thoughts was substituted, in the name of science and technology and the grand narratives: Education was in essence soulless. Plato recognised the importance of the dialectical; the ability to discuss with another, to question, to engage in conversation, to argue: ‘It has the capacity to conduct the mind of inquirers from erroneous opinions to the threshold of valid insight and knowledge’ (Cushman 1957:295). Plato also alluded to how if this dialectic is written there is a deadening, it is in the dialogue with another that self-knowledge can flourish. Buber (1965) suggests that if the dialectical is written it is inscribed with a different meaning, one that takes away from the real relationship.

Thus it could be said that the development of wisdom is not taken from reading books, no amount of intelligence can equate with wisdom. For it is dependent on the dialectic, which involves ‘the art of learning to look’ (Faulconer and Williams 1990:21). Whereas, Goldberg (1998:215) suggests that it is a ‘to and fro exchange of information’. The practice of dialectic is dependent on a relationship, for Madison (1988) it is between mind and body, and Faulconer and Williams (1990:20) draw on Socrates, and the claim that result of the dialectic does not belong to either one (the student) or the other (teacher) rather it is a “gift”. As such it emerges in the in-between. Wisdom/virtue is something that is about being, about being in relation to another. And as such should take the primary position in education. An education that places science and technology first takes away from the development of wisdom. For the technical is all about structuring our thoughts, that there is a known reality, a reality that is the same for all, it is a fixed entity. Technical knowledge is about repeatability (Usher et al 1997), that if known procedures are followed, a set result or a predictable result ensues.

In the researcher’s view, the following questions can be posed, what of the ability to think our own thoughts? To put valence to our own experience? Or is our experience a taken-for-granted notion, that somehow we will all experience the same, we will all arrive at the same conclusion (this is the technical remit), but what if we do not? What if our experience is outside the parameters that is currently known? How do we cope with this disjuncture? That our experience is not like others? Are we different? Are we the same? Primacy to the technical, is about a reduction to sameness; when in essence putting humanness first would be a return to a celebration of difference. Where to be different does not equate to being less than, but is as acceptable: To be different does not necessarily lead to marginalisation.
For Friedman (1989:57) therapeia is a form of ‘service or attendance’ or ‘medical or surgical treatment or cure’. Whereas (Geddes 1994:41) refers to therapeia as the ‘talking cure’. Loewenthal (1999:277) puts forward another view, that it is about ‘meeting’ and that ‘Therapeia is the therapy of the soul’. Herein lies the difference between science, which seeks to name and know, Friedman (1989:69) suggests that one aspect of technological thinking, is ‘a commitment to bringing into being a moment in the future, which is already known’. There is as such an element of predictability, whereas, a privileging of humanness is about being with, and being open to the possibilities, that may emerge. It’s about being in a ‘not knowing’ position. However, for some it would appear that this is difficult to practise, for example Roomy (1984) advocates that his programme based on notions of therapeia involved offering rehabilitation training in adult living, but he places boundaries on the outcome of the programme, that people following the programme will have an increased sense of self-sufficiency and be ready for discharge into the community. However, for it to be therapeia there would need to be as Loewenthal (1999:278) suggests that therapy as therapeia would be ‘awakening thought’. How can this be achieved? How can we be with another and remain open, and to not impose closure? These issues will form a continuing thread through the study.

It is argued here that therapeia is the main purpose of education, an education that places science and technology secondary to being human; and recognises the fundamental prerequisite to learning, is the ability to learn from experience. When there is an inability to learn from experience, there is a need for psychotherapy to enable a return to learning from experience (Loewenthal 1999). The therapeutic relationship represents a learning milieu; the very practice of psychotherapy is therefore a form of learning. The term therapeutic education could be used to denote this concept, however, there could be a confusion with the current use of this term, which implies that it is about teaching through intervention programmes (see Jacquemet et al 1998, Cohler and Zimmerman 1997); where there is an emphasis on ensuring repeatability, and as such it is in direct opposition to the central tenet of this discussion. The term therapeia would be more suitable; however it is recognised that this term was originally intended to represent the education of society. Whereas, the use here would be to that of the individual, and as such represents a microcosmic perspective of therapeia.

4. Key theoretical concepts and perspectives
Within the field of researching personal experience, there is a need for the researcher to identify their intentionality; how their experiences informs the subject that they study, and the need for ‘keeping the researcher’s eye on matters’ (Clandinin and Connelly 1994:416). Denzin (1997) also appears to support this issue, for he suggests that the qualitative researcher needs to identify what they bring to the text and how this informs their interpretation. There is as such a need for the
researcher to make known their interpretative lens; their previous learning experiences that inform their way of looking at a subject. The researcher's previous learning experiences that inform this study are phenomenology and the exploration of the 'lived experience'; hermeneutical interpretation as a way of knowing; psychoanalytic theory and the implications of the unconscious for knowing; postmodernism and the questioning of a definitive 'truth'; rather there are 'multiple truths', meaning is created in the moment; feminism and the inclusion of the minority voice; the ethical relationship of responsibility to the other, based on the work of Levinas. An overview of each of these theories/concepts follows, and will be explored further in chapter three.

4.1 Phenomenology
Phenomenology provides a descriptive way at looking at the lived experience; the philosophy Husserl is accredited with developing this approach. As this inquiry is about determining whether counselling/psychotherapy is a form of learning, there is need to elicit the lived experience of those involved, the therapist and client; thus a phenomenological approach is applicable.

Phenomenology is 'concerned with the relationship between the reality which exists outside our minds (objective reality) and the variety of thoughts each of us may have about reality (subjectivity) (Spinelli 1989:28). It is also described as the study of 'essences'; and that it is about describing not putting meaning to an experience (Spinelli 1989, Merleau-Ponty 1962). For Husserl, subjectivity and objectivity exist only in relation to one another (Kearney and Rainwater 1996). Husserl's interest was 'things in themselves -- a rejection of science' (Merleau-Ponty 1962:80); hence the interest for this study.

There appears to be an element of the postmodern in both Merleau-Ponty's and Husserl's view of phenomenology; Merleau-Ponty (1962:80) states 'to seek the essence of the perception is to declare that perception is, not presumed true, but defined as access to truth'. Whereas, Husserl (1935:8) states: 'No line of knowledge, no single truth may be absolutized and isolated'. As such, there is no one definitive truth all that can be achieved is a description of it 'as it is' or 'as it was'.

4.2 Hermeneutics
Hermeneutics is a method of interpretation, how we make sense of how experience, and as such aspects of it may be helpful in researching the question posed by this inquiry. The philosopher Gadamer identified hermeneutics as a distinct branch of phenomenology. For Gadamer, understanding must be 'historically and linguistically mediated' (Kearney and Rainwater 1996:109).
A key element in hermeneutics is interpretation, how we make sense of our experience. Fundamental to knowing is pre-understanding, which is historically located, and evolves from our prejudices, our presuppositions about an object. Gadamer draws on the work of Heidegger, and states: ‘Our task is to reconnect the objective world of technology, which the sciences place at our disposal and discretion, with those fundamental orders of our being that neither arbitrary nor manipulated by us, but rather demand our respect’ (Gadamer 1976:111). He is also suspicious of method, seeing it as a kind of substitution for understanding. For him there is always a tension between truth and method, and as such understanding is always in a state of becoming. He also rejects the term ‘scientific rigour’, as it is impossible to totally eliminate the subjective. He makes reference to the hermeneutical circle, which is ontological, it is neither subjective nor objective, but constantly being formed. As such the meaning that is created in the in-between cannot be fixed, for there is the potential for it to be in a process of emergence, the explication of the in-betweenness is dependent on reflection.

4.3 Psychoanalytic theory
There are according to Bateman and Holmes (1995:17) three areas of psychoanalytic study, which reflect the work of Freud; ‘the development of the mind and the influence of early experience on adult mental states; the nature and role of unconscious mental phenomena; and the theory and practice of psychoanalytic treatment, particularly transference and countertransference’. Psychoanalytic theory provides a framework for meaning making which recognises the influence of the unconscious, and how this impacts on relationships with others, and how we make sense of a situation. The recounting of meaning making is difficult to elaborate for another, for it will always be contaminated or enriched by the unconscious. An approach to research that embraces subjectivity, would acknowledge how the ‘unconscious is considered a fundamental aspect of human experience, without which meanings cannot be explored’ (Walsh 1996:360) and thus has the potential to enrich meaning making. Whereas, an objectified stance to research would be to see the unconscious as either not important, or at the very least a contaminating influence, to be negated in the name of scientific rigour (Walsh 1996).

4.4 Postmodernism
This is a concept, which is difficult to define, but a perspective that acknowledges that there is not one definitive meaning but multiple meanings, and the meaning generated is dependent on the context and the people. Meaning as such is created in the in-between; between the two interlocutors involved; meaning is created in the moment, and can be re-created with each encounter. Language is the medium for communicating meaning, however, ‘words are useful to use because we can use them to simplify and ‘freeze’ the chaos and complexities of our surroundings, but that is all they can do’ (Robinson 1999:17). But how do we communicate our
experience to the other if we are limited by the words/language used? And if the text is open to multiple interpretations, then how to represent the multiplicity of meanings generated by this study? A deconstruction of the text offers a way; Parker (1999:2) draws on the work of Derrida and states:

'Deconstruction is unravelling works through a kind of anti-method which resists definition and prescription, for it is looking at how a 'problem' is produced the way it is rather than wanting to pin it down and say this is what it really is' [original emphasis].

In a way it is about revealing hidden truths, and there is a need to be open to the process of critical inquiry and reflection. In relation to the focus of this inquiry, there is a need to determine the meaning created 'in-between' the client and therapist.

4.5 Feminism
Within the research community, the voice of feminism is a perspective that allows for the minority voice to speak (Stanley and Wise 1979, Rheinharz 1993). Feminism, is 'the analysis of old knowledge and the source of new knowledge: it makes you think,' (Stanely 1997:1). Rheinhartz (1992) is keen to point out that feminism is not a research method, rather it is a perspective, and there is a need to use multiple research methods, and to address the reader. Whereas Lather (1991) suggests there is a need to invite the reader into the text, and that the text should represent multiple voices, relying on quotes, for the reader to determine/locate for themselves how the researcher develops their argument. From a postmodern feminist perspective, there is a 'sensitivity to differences and plurality of interpretations of human experience' (Nicholson 1995:83).

Feminism offers a return to emotions; and as Goldenberg (1993:13) comments in her book *Resurrecting the Body*, the mechanised society produced a 'deadness' due to 'the progressive dissolution of the social, physical context for human emotions – from the dissolution of our human bodies'. The upsurge in the interest in emotional learning can be partially attributed to feminism (Williams and Benedelow 1999). It could be said that a return to emotions as a relevant way of knowing offers the potential for an awakening from this 'deadness'.

The client group that are the focus of this inquiry, are people with facial difference, as such they represent a minority voice, and the inclusion of a feminist perspective acknowledges the inherent difficulty in re-presenting the voice of the other.

4.6 Ethics
An issue that surrounds and involves moral decisions is the domain of ethics. The philosopher Nietzsche is the 'thinker who most radically challenged traditional moral thinking and placed human development at the centre of a value creating system of thought' (Thompson 1994:131).
Whereas, Gans (1997), suggests that our ethical position stems from 'responsible relatedness'; and as such it is based on the Levinasian point of view of putting the Other first. As such ethics is a 'regard for other others that becomes a part of our sense of ourselves' (Levine 1999:73).

According to Kearney and Rainwater (1996:112) the philosopher Levinas focused on the 'priority of 'otherness', a radical alterity that demands our ethical response'; also he raised the question of 'examining the lived experience without presuppositions'. But what are the implications of this for research? Can we meet with another without presuppositions? These questions are fundamental to this research, which focuses on the lived experience of giving and receiving therapy. In relation to the activity of therapy, the meeting of two people; Loewenthal (1996:380) states: 'we should be concerned with justice on a case by case basis, for real justice cannot be appropriated or territorialized, instead, as with one's clients, one has to be just in the moment with another'. A challenge for this study is the representation of this 'moment with another' the meeting of the therapist and the client, and the meeting of the researcher with the research participant.

All theories and perspectives appear to support the notion that meaning is not a universal given, a fixed entity, rather it is an ongoing process. We each create our own meaning from experience and are influenced by previous experiences. There is also a questioning of the privileging of science and technology.

5. Research Paradigm

Research is an activity that involves generating knowledge, and a research paradigm 'represents a worldview that defines, for its holder, the nature of the "world", the individual's place in it, and the range of possible relationships to that world and its parts' (Guba and Lincoln 1994:107) [original emphasis]. Within the research community, it is generally considered that there are two main research paradigms, positivistic (privileging science and technology) and post-positivistic (privileging humanness) both of which will enable the researcher to address the questions that they pose. As this study is premised on a return to the primacy of humanness, the post-positivistic paradigm will inform this study.

Each paradigm is composed of three interdependent components ontological (what is there that can be known), epistemological (relationship between knower and what can be known) and methodological (how to find out about the assumptions made about what can be known) (Guba and Lincoln 1994). Following a review of the current paradigms within the overarching term of post-positivistic, the researcher develops a research paradigm drawing on aspects of critical theory and constructivism to guide this study, a paradigm that is more cognisant with her 'world-view'.
An overview of this research paradigm is provided, and it will be further explored in chapter three. The ontological perspective is relativist, meaning emerges in the in-between. The epistemological perspective is that knowing is subjective, that it is apprehended through relationships with others, as such it is an interactional subjective phenomenon. There is a blurring of the ontological and epistemological perspectives, for with the recognition that meaning emerges in the in-between, and dependent on the two interlocutors involved, there is the possibility of meanings being multiple. The methodological perspective is dialectical and reflexive; it is through this back and forth process that the multiplicity of meanings can emerge. Meanings are not fixed; rather there is the potential for re-presenting the interactional subjective, situated meanings that emerge in the in-between.

6. Developing a methodological framework to be tested out in this study

Qualitative research can be ‘an interactive and transformational process in which the researcher seeks to learn about interpret life experiences’ (Sword 1999:270). This activity involves a relationship between the researcher and the researched; and as such there is the ethical responsibility to this relationship and of the meaning created in the in-between (Fine 1998). According to Levinas (1989) an ethical relationship is centred on notions of putting the other first. As such it ‘disrupts knowing with a higher call, a responsibility to the other’ (Cohen 1986:5). It is suggested here that there is a need for the researcher to be mindful of what is happening in the in-between.

In the research paradigm developed for this study, the meanings generated from and through an interactional subjective process are co-created between the people involved, and the emerging meaning/knowledge belongs neither to one nor the other. Rather it is created in the in-between, and it is not an entity that can be rationalised, it is just there, in the moment. Therefore the framework, will need to support the notion of meaning created in the in-between: In-between the researcher and the research subject (data generation), the researcher and the data (data analysis), the researcher and the text (research report).

The framework (discussed more fully in chapter three) comprises nine stages: (1) Pre-understanding: the interpretative lens of the researcher – theories and perspectives and experience of the phenomena of the inquiry, these inform the research question; (2) which informs the research design and method; (3) which informs the data generation, which emerges in-between the researcher and research participant; (4) data analysis – emerges in-between the researcher and the data; (5) from the back and forth process between the data generated and the analysis a primary construction is created, which represents the researchers understanding of the phenomena of the inquiry; (6) this informs the pre-understanding of the next construction, the researcher revisits the
primary construction, and identifies what might have been left out, as such there is a questioning of the meaning generated; there is a second cycle of interpretation, (7) a secondary construction is the outcome of this process, it emerges in-between the researcher and the text; (8) this creates further understanding of the phenomena, that provides pre-understanding for the next step (9) which is a critique of the research process. This framework will be tested out in the investigation that forms part of the exploration of therapy as a form of learning. There is a need to select a method to inform the research process.

7. Method
To explore the question posed ‘Is counselling and psychotherapy a form of learning for people with a facial difference?’ the researcher chose to elicit the ‘lived experience’ of people involved in the therapeutic process, therapists (with experience of working with people with a facial difference) and clients (with a facial difference). To elicit additional information on what may precipitate the need for therapy, people with a facial difference who had not had therapy, and those with living someone with a facial difference (who may or may not have had the experience of therapy), would be invited to share their views on the place of therapy for people this client group. The data generated analysed to identify learning processes intrinsic to the process of therapy, and distortions in learning that may precipitate the need for therapy.

The methodological framework will be applied to Moustakas’ (1990) heuristic research method (the selection of this method will be discussed in chapter four, and chapter five provides a detailed account of the method in process). The central tenet of this approach is the explication of the lived experience of the phenomena under investigation, and as such it is generally regarded to fall within the field of phenomenology (Moustakas 1994, Patton 1990). However, it is suggested here that although the central premise is on description, and the reliance on using the research participant’s words, there is ultimately an element of interpretation, which is hermeneutical, and such this method is a phenomenological hermeneutic investigation. The second cycle of interpretation, and the critique of the research process required by the methodological framework employed provides an opportunity for heuristics to be expanded to a post-heuristic approach to research.

8. Findings
The presentation of findings from the first cycle of interpretation is found in chapter six (the guidelines of the heuristic method are followed). Initially themes are presented within the two areas of focus of the study. The first area is the experience of giving and receiving therapy (three themes emerged, reasons for seeking therapy, the therapeutic experience, and the outcome of therapy). The second area, experiences that may precipitate the need for therapy comprised of two
main groups, parents (two themes emerged, reactions to giving birth to a baby with a facial difference, and ongoing concerns); and people with a facial difference (four themes emerged, stories about their birth, reactions from others, reactions to others, and effects of difference).

There was evidence of significant learning, and the changes correlated with Cell (1984:vi) view, and were in relation to a change ‘in behaviour, in interpretation, in autonomy or creativity’. It is suggested here that significant learning is an overarching term for the learning that is intrinsic to therapy; both transformative and emotional learning are subsumed within the term. Transformative learning is a reflexive process, that encompasses uncovering and working through distortions in previous learning (Mezirow 1990); distortions are barriers to learning (Williamson 1998, Boud and Walker 1993, Claxton 1984). Previous learned responses to a situation are not just within the cognitive domain; there is also an affective domain, (Bouton et al 2001, Quigley and Barrett 1999). There is such an element of emotional learning involved in the process of exploring barriers to learning; feelings are articulated in language.

Following on from the description of the themes, a composite depiction that is representative of the phenomenon as experienced by the group of research participants is provided. An exemplary portrait that focuses on one person’s experience of therapy follows this. It is in these two sections that the conversation of therapy as a form of learning is developed further. A creative synthesis concludes the findings, and this is re-presentation of the researcher’s understanding of the phenomenon that has emerged through the process of the investigation. There was recognition of how previous learning experiences can influence a person’s ability to learn from experience. There was sense pre-therapy that facial difference defined the person, therapy challenged this perspective, and distortions that created this template were worked through, post-therapy the person was more open to the possibility of experiencing their own experience. Facial difference need not define the person. Through the learning processes intrinsic to psychotherapy, there was the potentiality to return to learning from experience; therapy can be seen to be a reparative discourse.

The discussion of these findings is found in chapter seven. The understanding gained in chapters six and seven form the pre-understanding of the next cycle of interpretation required by the methodological framework employed. This culminates in a secondary construction, which is found in chapter eight. The researcher deconstructed the two concepts that emerged from the creative synthesis, ‘facial difference does not need to define the person’ and ‘psychotherapy is a reparative discourse to return to learning from experience’. From this conversation, the concept of therapy as therapeia was explored, and this is premised on the ethical relationship as advocated by
Levinas, Gans (1997:30) refers to this relationship in therapy as 'responsible relatedness' and this is the term used here.

A model is developed to enable others to open further conversations on therapy as a means to learning. A model premised on the Levinasian ethical relationship and Bubers' (1965) 'I-It' and 'I-Thou' relationship. A relationship that may be helpful when exploring notions of responsibility to the other (Greenwood et al 2001). Therapy as a means of learning can represent a transition from an 'I-It' to an 'I-Thou' relationship, to a 'responsible relatedness' relationship, with each transition offering the potential to return to learning from experience; to be more open to experience of the other.

9. Limitations of the study
The empirical part of the study was limited by the parameters imposed; one-to-one therapy as opposed to family therapy, couples, and/or therapeutic groups. The focus is on people with a facial difference, this is not to say that therapy as a means to learning is only applicable to this client group, rather this is this study's emphasis.

In the field of facial difference, although it is recognised that the origin of the facial difference does not appear to effect a person’s psychological response (Bradbury 1996, Pruzinsky 1992, MacGregor 1984). It should be noted that this study is limited to people who have a congenital form of facial difference, predominantly those with a cleft lip and/or palate, the most common form of congenital facial difference (Leonard et al 1991). Potential confounding variables are identified, however, they are not isolated, and the focus is on the lived experience. This focus represents another limitation for there is as such a reliance on anecdotal evidence of therapy as a form of learning, as opposed to the presentation of case study material i.e. of a therapy session.

To conclude this study, a model is developed to enable practitioners to develop further conversations on therapy as a meanings to learning. This model has not been tested out in psychotherapeutic practice, for it is presented here as work in progress.

10. Thesis layout
The thesis comprises of ten chapters, the first providing an introduction to the study. Chapter two focuses on the three literature reviews, counselling/psychotherapy, learning, and facial difference. In summary there is a discussion of how the literature reviews inform the research question, and culminates in the development of working definitions of the three forms of learning that are considered to be intrinsic to the process of therapy.
Chapter three is on developing a methodological framework. Initially there is a discussion on research and the making of a case for how a research paradigm needs to be informed by the researcher’s interpretative lens. This paradigm informs the methodological framework developed to guide the research process. The discussions are premised on how with a privileging of humanness, there is an increasing recognition of the impact of the researcher on the study, and the tensions involved in re-presenting the other. Chapter four is a discussion on the selection of a research method to structure the generation of, and analysis of, data. Chapter five is how the selected method of heuristics was employed by the researcher to generate and analyse data.

Chapters six, seven and eight contain discussions on the findings of the study. Initially, chapter six contains the primary construction, the understanding gained through the first cycle of interpretation of the methodological framework. The findings are presented as per the heuristic method, the themes that emerged from the individual depictions, a composite depiction that represents the groups experience, an exemplary portrait that captures the lived experience of one person. A creative synthesis concludes the presentation of findings, and is a representation of the researcher’s understanding of the phenomenon following the four stages of data analysis. Chapter seven contains a discussion of these findings (the headings of chapter six are used to structure this discussion) and comments are supported by the three literature reviews. Chapter eight is the secondary construction, the understanding gained during the second cycle of interpretation of the methodological framework. Two phrases from the creative synthesis were deconstructed, ‘facial difference need not define the person’ and ‘psychotherapy as a reparative discourse to return to learning from experience’. From this discussion it was determined that therapy is a means to learning. A model is developed to enable further conversations to be developed on psychotherapy as a means to learning; a return to learning from experience.

Chapter nine is a critique of the research process and comprises of a discussion on the research design and method, data generation and analysis, and the primary and secondary constructions. Overall there was a view that the methodological framework had assisted with the privileging of humanness, however it is recognised that there are many tensions involved in this process. One way of working with these tensions is for the researcher to make transparent the choices made during the research process. Chapter ten provides a summary of, and implications of the investigation, and suggestions for further study, together with an identification of the researcher’s personal learning.

Conclusion
The question posed by this study is counselling/psychotherapy a form of learning for people with a facial difference? The key terms were defined, counselling and psychotherapy, and in this study
either the term psychotherapy or therapy will be used. Three learning theories/perspectives that are premised on personal knowing inform this study, significant, transformative and emotional learning. Facial difference is a generic non-pejorative term, irrespective of the nature or origin of the facial disfigurement.

The underpinning ethos of the study is the privileging of humanness as opposed to science and technology. Science and technology are premised on repeatability, certainty and 'sameness', whereas, humanness is premised on unpredictability, uncertainty and 'difference'. The implications for research are the need for the researcher to make known how they make sense of or interpret their world; to share their interpretative lens. The six theories/perspectives that inform the researcher's interpretative lens were briefly introduced. From this it is possible to determine a research paradigm that correlates with this lens. A research paradigm was developed for this study, and from this a methodological framework was created that will be tested out in this research investigation.

The method chosen for the generation and analysis of data is heuristics, however, with the second cycle of interpretation required by the methodological framework, the method is expanded and is post-heuristic. The findings of the study support that therapy can be seen to be a means to learning for people with a facial difference. A model for looking at therapy as therapeia was developed to enable further conversations on therapy as a means to learning, to be initiated.

The next chapter, contains the three literature reviews and the implications for the research question.
Chapter Two

Literature Reviews

Introduction
The aim of this chapter is to review the literature pertinent to the research question: Is counselling/psychotherapy a form of learning for people with facial difference? Thus there are three reviews, counselling and psychotherapy, learning and facial difference. The first section provides a discussion on counselling and psychotherapy as learning, (as referred to in chapter one, the term psychotherapy or therapy will be used as a generic term for counselling and psychotherapy). The therapeutic relationship unites all therapeutic approaches, and this will be explored next. Followed by an overview of the research implications for assessing the efficacy of therapy, a summary of the discussion concludes this section.

The review on learning focuses on learning theories and perspectives that may inform therapy as a form of learning, firstly the concept of lifelong learning will be introduced, followed by a discussion of student-centred learning with an emphasis on significant learning. Transformative learning and emotional learning are also considered to be learning approaches that may inform the discussion as they too emphasise learning as a personal phenomenon; learning as a process. Potential barriers to learning are explored, and a discussion of how the learning approaches have the potential to inform the research question concludes this section. The review on facial difference focuses initially on an exploration of the concept of facial difference, followed by a review of the literature with reference to counselling and psychotherapy. A discussion of previous research methods and designs is provided, and the implications for the research question concludes this section.

A discussion of how the three literatures inform the research question is provided, and in conclusion, it is believed that significant learning, transformative learning and emotional learning are forms of learning intrinsic to the practice of therapy; and the potential outcome is a return to learning from experience.

1. Literature review: Counselling and Psychotherapy
The review will firstly focus on counselling and psychotherapy as a form of learning, followed by a discussion of the therapeutic relationship. How the efficacy of psychotherapy is measured is briefly discussed, and a summary of the discussion concludes this section.
1.1 Counselling and Psychotherapy as form of learning

A review on the term learning brought up a limited number of references. The terms unlearning (Albee 1999, Elliott 1995, Gross and Fugstein 1992, Olders 1989, Bruno 1974, van de Veer 1974) and relearning (Traux and Carkhuff 1965, Meerloo 1958, Walker 1957, Ennesis 1951, Mackinnon 1950, Hunt 1948) were used in connection with learning. Whereas, Rogers (1961) and Bernstein (1992) focused solely on the concept of learning. The focus of the unlearning was either in relation to previous ‘inappropriate’ learning (Elliott 1995, van de Veer 1974), or working through (Gross and Fugstein 1992), or emotions (Albee 1999). Relearning was either in relation to behavioural or emotional competencies for the client (Hunt 1948), and the art of listening for therapists (Drus 2000).

It appears that relearning was the term of preference before the seventies, to then be replaced by unlearning. The term unlearning implies that there has been some failure to learn correctly, therefore there is a need to ‘undo’. Whereas, relearning implies that there is need for a refresher course as the learning has become forgotten, therefore there is a need to ‘redo’. In his definition of psychotherapy, Hunt (1948:68) favours relearning, he states:

‘The goal of psychotherapy is to make uncomfortable people more comfortable and to make them more self-sufficient socially and emotionally. In any successful psychotherapy there must be relearning of the behavioral or emotional variety’.

Whereas, there is a combining of the terms by Strupp (1979:130) for he states:

‘Psychotherapy of all varieties is made up of learning, unlearning and relearning experiences that can be mediated in different ways and that the task of the future is to spell out the conditions that promote or impede such learning’.

Rogers (1967) suggests that the whole process is a learning one, learning about oneself. Whereas, it can be learning in an interpersonal context (Strupp 1986); learning new skills (Brammer et al 1993); learning new meanings (Gergen and Kaye 1992). Gordon (1999:10) appears to be in agreement that therapy is a learning process, but suggests that ‘therapy is in part a learning about the language of emotions, not in some sense of being instructed or told’ but that it is about the ‘exploration of meaning’. It could be said that therapy is emotional work, for therapy is about getting in touch with emotions (Hazler and Barwick 2001, Goncalves and Machado 2000, Rice and Greenberg 1991, Greenberg and Safran 1987, Orlinsky and Howard 1986).

Therapy is also considered to be a ‘kind of work on the self’ (Kegan 1994:235); ‘an instrument for self-understanding’ (Fromm 1994:46); to be more aware of self and others (Spinelli 1994); to increase an individuals ‘freedom of choice and responsibility in the conduct of his life’ (Szasz 1990:172). Whereas, Greenberg and Safran (1987:vii) suggest that the client who enters therapy usually has a problem with emotions, ‘all psychotherapy deals in one way or another with alleviating emotional pain and distress’. They also suggest that it is through the therapeutic
relationship that emotional restructuring can take place. The link between all therapeutic approaches is the therapeutic relationship (McLeod 1998), and this will be explored next.

1.2 Therapeutic relationship

This alliance or the therapeutic relationship is fundamentally about ‘two people talking together’ (Fromm 1994:121). There is a view that the therapeutic relationship and therapeutic process are intertwined. Bugental (1990:189) suggests that ‘Psychotherapy is the process of two people struggling with the issues of being alive in this world at this time’. Whereas, Zeig and Munnion (1990:14) suggest that the ‘process is idiosyncratic and determined by the interaction of the patient’s and therapist’s preconceived positions’ [original emphasis]. This perspective appears to take into consideration that each person in the therapeutic relationship has their autobiographical details which they bring to the encounter; the therapist their theoretical training and life experiences, and the client that which is troubling them.

Holmes (2000:452) appears to support this view, for he states: ‘Psychotherapy’s unique contribution is that it provides a language with which to talk and think about relationships’ [original emphasis]. It would appear that this relationship is linked with the outcome of therapy, for according to Parry and Richardson (1996:71) ‘Clinical effectiveness of therapy depends on the patients ability to engage in a therapeutic alliance and the skill of the therapist’. Margison (2001:180) supports this view and states: ‘The only robust predictor of outcome is the therapeutic alliance early on in the therapy’.

However, it is difficult to measure the outcome of therapy, as the meaning that emerges in the therapeutic relationship does not belong to either the client or the therapist, rather it is what emerges in the in-between; it is a shared understanding. Symmington (1986:17) states of this phenomena: ‘Truth does not exist as some external idea, as Plato thought, but as a reality that exists in between: in between two persons seeking it, in between psychoanalysis, sociology, psychology, economics and religion’ [original emphasis]. He also suggests that when this ‘truth’ emerges there is a change in both the client and the therapist.

For Guidano (1991:62) the meaning and therefore the change that occurs in the process of therapy is based on emotions, and that the therapeutic relationship is crucial, for it is ‘a real, living, interaction that is, one in which cognitive and emotional aspects are continuously intertwined, its emotional aspects produce a facilitating effect for the assimilation of new data or reframing existing ones’ [original emphasis]. It could be said that within this definition there are elements of unlearning, relearning and learning. Izard (1991:281) refers to how change in the realm of emotions is more about ‘insight’ and ‘restructuring’; and ‘the role of emotions in psychotherapy depends in part on the
therapist's conception of emotions'. Safran and Greenberg (1991:11) appear to be in agreement when they suggest that it is the quality of therapeutic relationship that provides a medium for 'the exploration and synthesis of new emotional experience'.

Freud defined his therapy as the talking cure (Breuer and Freud 1895); and as such then central to it, are the narratives the clients tell in the process (Goncalves and Machado 2000, Legg 1998, Papadopoulos and Byng-Hall 1997, Pilgrim 1997, Gergen and Kaye 1992, Howard 1990, McLeod 1997). It is argued that narrative therapy is a component of any type of therapy (McLeod 1998, Papadopoulos and Byng-Hall 1997), and it is suggested here that a fundamental precept of the therapeutic relationship is the narrative of the client. According to McLeod (1998:159) 'narrative approaches to counselling have gained a popularity over the past decade, and many counsellors are beginning to employ narrative techniques in their work'.

Narrative therapy, is 'a way of working that tries not to privilege specific models, theories or taken-for-granted assumptions about human nature, and remains curious and questioning about how people construct their lives and tell their life stories' (Speedy 2000:361). Therapy provides an opportunity for the individual to tell their story and for new meaning to emerge (Speedy 2000, McLeod 1998, Howard 1990). Holmes (2000:457) is in agreement and states: 'psychotherapists are people who are trained to tune into different narrative styles – both their own and those of their patients – and to identify inauthenticity, defensiveness, incoherence, evasion and all the other aspects of distorted or falsified stories, and to help their clients to move towards a self-authorship and personal authority that has the ring of truth'.

Thus it would appear that when defining psychotherapy, there is an inherent supposition that the process involves telling one's personal story, and through the communication of this with the therapist and the subsequent development of the therapeutic relationship, there is the propensity for the generation of new meaning. Learning is an integral part of the process. It would also, seem essential when considering the practice of psychotherapy, there is a need to question the efficacy of such a practice.

1.3 Effectiveness of therapy

A major issue regarding psychotherapy is, is it effective? A question that has been researched since the 1920's (May 1992). On the one hand, all therapeutic approaches can claim to have some success (Eaton 1998:422), and that this 'depends largely on the personal qualities and skills therapists bring to therapy'. On the other hand, Freedheim (1992) suggests that of research undertaken to determine the effect of psychotherapy, there is a 50- 75% success rate. Whereas, Masson (1988:287) suggests that it is a myth to believe that 'all therapy helps, regardless of the theoretical orientation of the
Roth and Fonagy (1996) advise caution, as the difficulty in researching such a complex phenomenon may impact on the ensuing results.

Researching psychotherapy is very challenging, (Parry 2000, McLeod 2000, Parry and Richardson 1996, Garfield 1992). There is recognition of how quantifiable studies are more suited to measuring the outcome of psychotherapy and qualitative studies for the process of psychotherapy (Turpin 2001, McLeod 2000); there is an increasing recognition that a combination of the two would be more illuminative of the effectiveness of psychotherapy (McLeod 2000, Pilgrim 1997, Parry and Richardson 1996). This combining of methods comes under the umbrella term of pluralism; and there is a need for the link between client benefit and empirical data to be made explicit (Norcross and Freedheim 1992). Whereas, Pilgrim (1997:22) suggests that if therapy is a form of 'situated social practice' it 'can only be understood within a qualitative framework but equally it can only be justified by posing quantitative questions' [original emphasis].

Another facet to be considered of research in psychotherapy is that, research findings mean different things to different people (Roth and Fonagy 1996); and there is a need to identify and state the nature of evidence that will be used to evaluate psychotherapy (Tantam 2001). Evidence-based health care is about the providers of a service, being able to demonstrate that the service provided is based on reasoned decisions; and as such the service is effective (Richardson 2001, Rustin 2001, Barkham and Mellor-Clark 2000, Parry and Robinson 1996, Roth and Fonagy 1996); and that there is constant review in light of further evidence (Mace and Moorey 2001). A key issue to support evidence-based practice is the quality of the practitioners, and this is in part determined by the quality of the training provision (Mace and Moorey 2001, Tantam and van Deurzen 1999, Roth and Fonagy 1996). Parry and Richardson (1996:71) acknowledge that 'the multi-disciplinary nature of all types of psychotherapy provision creates a complex situation for training, qualifications and regulation of practice'.

The model of training that was founded on the psychoanalytic approach, has elements of didactic course work, supervised treatment of patients, and personal therapy (Binder 1999, Abram 1992); these encompass the three elements required for either registration with United Kingdom Council for Psychotherapist, or accreditation with the British Association for Counselling and Psychotherapy. Whereas, Charles-Edwards et al (1989:402) identify four components of training 'theory, skill practice, counselling under supervision, personal development activities, including the experience of being a client'. The discussion of theory and its application to practice should ideally be supported by research evidence (McLeod 1998), he also suggests that training is an area that is under represented in the field of research. Training should not be a one off exercise, but should continue throughout the therapist's professional working life (Nel 1996, Clarkson 1994).
1.4 Summary
Therapy is a multi-faceted phenomenon, people seek therapy when they are having problems with living and relating and fundamental to this is how they feel, emotions are at the heart of psychotherapy. Through the therapeutic relationship the client explores how they make sense of their experience, this exploration incorporates both behavioural and emotional components as they are mutually interdependent. Through the process of therapy, the client unlearns unhelpful ways of responding, and learns new ways of responding. Therapy as such is a learning process that involves elements of unlearning and relearning.

The efficacy of therapy is difficult to research for the identification of the element of change is difficult to isolate, studies have therefore tended to focus on outcome measures that can be recorded. The process of therapy is more difficult to elicit, for there are a multiplicity of factors involved. An area that is of considerable importance is the quality of the therapeutic relationship, and this is dependent on the therapist’s ability to provide an environment where the client is able to tell their story, and to be open to what emerges in the in-between. The ability to do this is dependent on the training and supervision received, and their commitment to ongoing professional development.

2. Literature review: Learning
The aim of this section is to review learning theories/approaches that may inform the discussion of psychotherapy as a form of learning. Initially lifelong learning will be defined as it appears a pertinent starting place for the exploration of learning as appropriate to psychotherapy. The premise of this study is to place humanness primary to science and technology and that psychotherapy is a form of learning that enables a return to learning from experience. The exploration of learning theories/perspective therefore needs to encompass learning from experience. With this caveat in mind, the following three theories will be discussed, student-centred learning, transformative learning and emotional learning. Barriers to and distortions to learning from experience will then be discussed, and a consideration of how these approaches to learning have the potential to inform the research question, concludes this section.

2.1 Lifelong Learning
There is a view that education encompasses the whole person, and the sense they make out of their experience, as experience is part of living, then so is learning a life-long process (Holford and Jarvis 2000, Jarvis et al 1998, Barnett 1994, Cell 1984, Rogers 1961); ‘learning is continuous, it builds on lived experience’ (Williamson 1998:21). Both Barnett (1994) and Williamson (1998) refer to the concept of Habermas’ life-world, to describe how socialisation and learning takes place in the community. These processes are continuous and synonymous with life itself; it is about people’s life stories and how they confer meaning. Habermas (1968:102) suggests that the learning process is
initiated into the communication system of a social life-world by means of self-formative processes'. It is communicative learning about understanding meaning, as opposed to instrumental learning which is about learning 'how to do' (Mezirow 1990). A key aspect is the need for reflective knowing, and Barnett (1994:112) coined the phrase 'meta-learning' which is 'a willingness to critically examine one's own learning'. Williamson (1998:173) acknowledges that for some people the insight required for this type of learning 'is almost impossible; they require the help of therapy'.

The potentially for learning is infinite when it is acknowledged that all experience is the raw material of learning (Usher et al 1997). Also, there is not a definitive state of knowing to be achieved, rather it is about being open to experience, to not place foreclosure due to having 'been there before'; learning is not the arrival at a particular destination, it is an ongoing journey (Jarvis 1997, Drew 1993).

2.2 Student-Centred Learning

Rogers (1983) wrote his seminal text on his theory of learning: Freedom to Learn for the 80's, his central premise was the concept of self-directed (or person-centred) learning, whereby student's take responsibility for his or her own learning process. The programme of study is not all about the content, but it is also about learning how to learn: 'Traditional education and person-centred education may be thought of as two poles of a continuum' (Rogers 1994:209). There are also two types of learning, the traditional knowledge acquisition of the curriculum, and 'significant learning' which, he defines as:

'learning which makes a difference in the individuals behaviour, in the course of action he chooses in the future, in his attitudes and in his personality, it is a pervasive learning which is not just an accretion of knowledge, but which interpenetrates with every portion of his existence'. (Rogers 1994:209).

Rogers (1967:305) stated: 'I see the facilitation of learning as the aim of education, the way in which we might develop the learner, the way in which we can learn to live as individuals in process'. He then goes on to define three qualities of the facilitator of learning, (i) a realness; that the facilitator is genuine and not hiding behind a mask or façade; (ii) an acceptance of the learner, and trusting that the student is able to learn; (iii) empathic understanding. He does acknowledge that these findings were first discovered in the field of psychotherapy, but that there is evidence in the classroom as well.

Rogers then elaborates on the 'ideal' attitudes of the facilitator, which are most helpful in this learning relationship, these are, (i) a 'puzzlement' to know self, this implies that the facilitator is also struggling with their quest to know themselves; (ii) a trust in the human organism, that the organism has a propensity to self-actualise; (iii) the ability to live with the uncertainty of discovery, that prior to the facilitative experience the facilitator does not know the outcome for the student or
for themselves. Rogers style of facilitation was for the occurrence of significant learning, learning that made a difference to an individual.

2.3 Transformative Learning

Making sense of learning is mediated by reflection, there is a need to be open to critically reflect on experience and the emergent learning (Mezirow 1990). He defines critical reflection as ‘challenging the validity of presuppositions in prior learning’ [original emphasis], and states:

‘By far the most significant learning experiences in adulthood involve critical self-reflection – reassessing the way we have posed problems and reassessing our own orientation to perceiving, knowing, believing, feeling and active’ (Mezirow 1990:12).

Like Rogers, he uses the word significant to emphasise how the importance of this learning is personal to the student/individual. Mezirow in contrast to Rogers calls ‘significant learning experiences’ transformative learning, and how this ‘perspective transformation may be individual, as in psychotherapy’ (Mezirow 1990:14). It is about gaining an ‘empowered sense of self and new connection with others’ (Christopher et al 2001:134). There is according to Randall (1996) a therapeutic component to transformative learning.

Mezirow (1990) refers to how we confer meaning on a situation or experience, and makes the distinction between meaning schemes and perspectives. Schemes involve the ‘if then, cause and effect’ of a situation, whereas, perspectives involve the assumptions made about past experience, and how they impact on current interpretation of a situation or experience. As such meaning schemes can be generalised, whereas, meaning perspectives are individual, they ‘involve criteria for making value judgements and belief systems’ (Mezirow 1990:2-3).

He also acknowledged how distortions in meaning can impact on the ability to learn from experience, and identifies three main forms of distortion in meaning perspective, epistemic, sociocultural and psychic. The epistemic field focuses on the nature and use of knowledge, and he highlights five points that contribute to this form of distortion. (i) The ideal, that everything has a correct solution, and the quest is to find the right expert to help us; (ii) reification, that somehow the situation is beyond human control, e.g. homelessness, famine; (iii) use of prescriptive knowledge to judge a situation, e.g. human development and the attainment of milestones; (iv) taking abstraction as though it were an existing object, e.g. interpreting reality concretely; (v) verification of what is apprehended by empirical means. All of the five points appear to be about accepting the status quo rather than to question and stay with the uncertainty of not knowing, that it is preferable to fit everything into a predetermined category or box.
The sociocultural distortions, focus primarily on power and social relationships; and there are two main issues; (i) self-fulfilling prophecy, which is ‘based on a mistaken premise in the first place, such a belief becomes a distorted meaning perspective’ (Mezirow 1990:16). There is the likelihood that what is feared happening will happen, because unconsciously the person engineers it, so that they can keep the distortion in place. (ii) ideology, which ‘is a form of prereflective consciousness, which does not question the validity of existing social norms and resists critique of presupposition’ (Mezirow 1990:16).

The psychic distortions, focus on ‘presuppositions generating unwarranted anxiety that impedes taking action’ (Mezirow 1990:16). He suggests that overcoming these psychological distortions require ‘skilled adult counsellors and educators as well as by therapists’. It is suggested here that all three distortions, place the individual in a fixed position, and that there is an inability to learn from experience, to experience their own experience.

2.4 Emotional Learning

Social and emotional learning is gaining momentum in the popular press, because emotional intelligence has been linked with success in life (Mayer and Cobb 2000). Whereas, Ellison (2001) posits that emotions have an impact on learning and that the upsurge in the interest of ‘emotions’ is partly due to the feminist movement. In contrast to this Goleman (1995:xii) attributes the interest to the ability to scientifically measure emotional intelligence; and suggests that emotional intelligence includes ‘self-control, zeal and persistence, and the ability to motivate oneself’. He also suggests that ethics and morality stem from ones ‘emotional competence’.

Emotional learning is attributed to conditioning principles, they are a response to cognitive and behavioural learned responses (Bouton et al 2000); emotional learning is linked to previous experience (Quigley and Barrett 1999). The empirical aspect of emotions, is emotional intelligence, scientists can now measure the amount of emotional brain activity (see Goleman 1995). Whereas social and emotional learning appears to place primacy to humanness; Yins (2001:441) defines social and emotional learning as ‘knowledge and skills that children acquire through social and emotional related education... that help them recognize and manage emotions, engage in responsible decision making, and establish positive relationships’.

In their handbook on emotional intelligence, Bar-On and Parker (2000: xii) posit that emotional intelligence is not a new concept, but that it has been around for most of the twentieth century, and comment on the related concepts being ‘alexithymia, levels of emotional awareness, emotional competence, openness to experience, practical intelligence, psychological mindedness, social competence and social intelligence’. In this explication it would seem that emotional learning
embraces what it is to be human; for it appears to focus on subjective experiences. In the literature
on ‘emotional learning’ there are numerous articles on how emotional learning is linked with either
behavioural and learning difficulties and that programmes have been developed to enhance
2000) contributions were unique in that he acknowledged how early experiences of feeling insecure
can impact on learning; he based his opinions from his work as a psychodynamic therapist working
with adolescents with learning, emotional and behavioural problems.

The recognition of how early learning experiences may contribute to the need for emotional learning
implies that these experiences may act as barriers or distortions to learning, and it is suggested here
that this aspect correlates with transformative learning.

2.5 Barriers and distortions to learning

It is acknowledged that some students will have difficulty in learning due to some form of barrier or
Previous experience of learning may remain as a template for all future learning experiences,
alternatively they may have a distorted image of themselves which has been handed down by others
(Rogers 1951). Williamson (1998:23) states:

‘Many people remain trapped within ascriptive images of themselves which have been built
up for them and which are imposed by others. Lacking the means to question this they remain
confined with narrow assumptions of their lives’ [original emphasis].

It could be that this image of the self is a barrier to learning, or that this distortion of self-perception
is due to ‘an emotional impairment which has occluded the learners capacity to learn anew’ (Boud
and Walker 1993:82). Whereas, Mezirow (1990:7) identifies that when experiencing ‘is too strange
or threatening to the way we think and learn, we tend to block it out and resort to psychological
defence mechanisms to provide a more compatible interpretation.’ Claxton (1984:146) shares this
view, and identifies four beliefs (competent, consistent, control, comfortable) that can hinder
learning, and states:

‘any learning situation that threatens to make me incompetent, inconsistent, out of control,
and uncomfortable appears to be a threat to me – to my survival as the person I think I am or
hope I am or ought to be. When one of these triggers is pulled, learning is resisted, regardless
of what the learning is about.’

Thus it would appear that psychological forces impinge on our ability to learn, they represent
barriers to learning from experience. Another term that is used in relation to distortions, is that of
‘dysfunctional learning’ which ‘principally stems from obstacles we encounter in our struggle to be
a significant person’ (Cell 1984:3). He suggests that dysfunctional learning is a defence about
anxiety, and he draws on the existential theologian Tillich and the psychotherapist Sullivan to
support his view. He then posits that the aim of learning is to be significant and to cope with
meaningless and powerlessness.

For learning to be optimised there is a need for the recognition of, and working with barriers (Boud
and Walker 1993). They propose a four stage framework; (i) acknowledge the existence of the
barrier, (ii) identify them, (iii) how they operate – critical reflection is important for this explication,
(iv) work with them, which has the potential for being confrontational and transformative. Claxton
(1984: 171) proposes another model and he poses the question ‘What are the circumstances that
facilitate relearning to learn and encourage openness to experience?’ His answer concerns the
provision of ‘therapeutic contexts’ which he suggests are not just related to therapists, that educators
can provide the necessary support to learners to confront and challenge their beliefs. Whereas, the
other viewpoint is that if the barriers/distortions are too firmly entrenched then there is the need to
refer to a therapist (Boud and Walker 1993, Mezirow 1990). Possibly the referral to a therapist is
about how there is a need to explore the unconscious processes that underpin the barriers to learning
from experience.

2.6 Summary
The concept of lifelong learning embraces the notion that the potential for learning is ongoing
throughout life; learning is a personal phenomenon and premised on experience. The focus on all the
three forms of learning (significant, transformative, emotional) is that the potential outcome is for
the individual to have an increased knowledge about self and how they learn from experience; it is
learning that is significant to the person. Learning that has a value for the person, and ‘value like
beauty is to be found in the experience of the beholder – it is always subjective and social’ (Jarvis

The implications of previous learning experiences are considered to be influential in how a person
approaches and responds to learning opportunities. Distortions in previous learning may be barriers
to future learning. It is suggested here that these distortions and barriers have the potential to close
down on learning from experience, and as such impact on a person’s ability to experience their own
experience.

3. Literature review: Facial Difference
The term ‘facial difference’ is used in preference to ‘facial disfigurement’, as it is considered to be
less pejorative. Initially the concept of facial difference will be explored, from this it is concluded
that society is influential in determining what is acceptable appearance, and those who differ from
the norm are defined as ‘different’. This is followed by a review of the literature with reference to
counselling and psychotherapy. From this it is concluded that the presence of a facial difference
does impact on a person's psychological well-being, and that counselling/psychotherapy is increasingly recognised as being a component of the treatment and rehabilitation programmes offered. A discussion of previous research methods and designs is provided; overall, there has been a preference for quantitative studies, and there have been a limited number of studies that report on the experience of living with a facial difference and/or the experience of therapy. A summary of the review concludes this section.

3.1 The concept of facial difference

Prior to discussing the literature reviewed, there is a need to locate the reader with the concept of 'facial disfigurement'. According to Bradbury (1996) there are three broad categories of disfigurement: congenital, traumatic, and disease process. Whereas, Hughes (1991) suggests that there are two main categories, the 'disfigured' that have acquired the condition since birth, and the 'deformed', those who were born with the condition. Whether the condition has been acquired since birth or been present since birth, does not appear to affect significantly how a person copes with this difference in appearance (Bull and Rumsey 1988, MacGregor 1984). The purpose of this study is not to differentiate between the origin of the facial difference, but to explore the experience of having a face that does not conform to the norm. A norm that is both culturally and self defined (Partridge 1997, Elks 1990).

To talk of facial difference is to focus on the concept of 'face', and Lerner (1996:303) suggests that 'Goffman furnished social psychology with the notion of face'. In his view "face" is the assessable public image of the self that results from social interaction. Facial appearance is deemed to be important, for it is the first thing we see when we meet with another and when we communicate the focus is usually on the face (Bull and Rumsey 1988). According to McNeill (1998:4) 'It [the face] is the centre of our flesh. It is also the showcase of the self, instantly displaying our age, sex and race, our health and mood. It marks us as individuals'. This notion of individuality appears to be a fundamental concept when exploring the impact of facial appearance; identity is invested in appearance. 'Not only is the face judged to be extremely important by persons in making evaluative judgements about other person, but human beings are particularly discerning in noting and evaluating even slight differences from the prevailing norm or "ideal"' (Elks 1990:37).

How a person creates an image of themselves 'comes not in our meeting with ourselves but with other persons and with the image of the human that we acquire through such meetings' (Friedman 1992:6). Also that 'image and beauty are marketing tools portraying a particular "supermodel" as the desired "look", diminishing the value of individuals who deviate from the face or form of the moment' (McGrouther 1997:991). As such what is beautiful is good (Dion et al 1972) whereas, Webb (1987:110) states: 'physical beauty brings a person more of the good things in life'. She also
acknowledges that beauty can not be defined in a once and for all statement; it is a subjective phenomenon.

Society is responsible for defining what is acceptable in the normality stakes regarding appearance (Solomon 1998, Partridge 1997, Rumsey 1997, Hughes 1991, Bull and Rumsey 1988). 'The beauty-is-good stereotype is a strong and general phenomena' (Eagley et al 1991:109). Whereas, Hatfield and Sprecher (1986) suggest that beauty is good, but that the inference is context specific, and as such there is a need to challenge society's norms. However, the notion of beauty equating with goodness and success is being challenged (Eagly et al 1991, Feingold 1992, Jackson et al 1995:108).

But how do we define the look? How and what becomes the dominant voice? Can we ever embrace the postmodern phrase ‘celebration of difference’? Kearney (1988:1) states in the opening of his book, *In the Wake of Imagination*: ‘Everywhere we turn today we are surrounded by images’. He traces the philosophy of imagination through the ages; and suggests that in today’s postmodern society, ‘the real and imaginary have become almost impossible to distinguish’ (Kearney 1988:2). Like beauty, reality is in the eye of the beholder (Woolley 1992), and, he states: ‘what better way of expressing your individualism than by creating your own, individual reality? Empowered by the personal computer, liberated by virtual reality, the individual becomes the God of his or her own universe’ (Woolley 1992:9). It is suggested here that therapy can provide a learning milieu for the person struggling with their ‘difference’; to re-create their story by challenging their perception of reality. Rather than being empowered by the personal computer; interaction via the inter-face, they will be empowered by the ‘face-to-face’ encounter with another.

### 3.2 Counselling and Psychotherapy

An initial search on counselling/psychotherapy for people with facial difference revealed a limited number of articles. The most frequently referred to form of therapy was cognitive behavioural therapy, generally it was perceived as being goal oriented and short term (Turner et al 1998, Heinberg et al 1997, Bradbury 1996, Rosen et al 1995, Cash 1990). Psychoanalytic psychotherapy was recommended for long-term work, and provided the opportunity for the individual to explore their thoughts and feelings about their ‘disfigurement’ (Miliora 1998, Niederland 1975). Whereas, two studies drew on more than one approach; Hughes (1991:497-8) concluded his study on *The Social Consequences of Facial Disfigurement*, by proposing a counselling model ‘drawing on social work, deviance and psychodynamic theories’. A study by Newell (1998) *Facial Disfigurement and Avoidance: A Cognitive Behavioural Approach* developed a fear avoidant model which he combined with social skills training. Whereas, Bennett and Stanton (1993) suggest that it is difficult to identify
which therapeutic approach to use without first defining the psychological implications of having a facial disfigurement.

There was overall recognition that therapy was required for this group, although the reasons or area of focus, for therapeutic intervention varied. Some ranged from how counselling is an intervention that can be helpful for people coming to terms with a facial difference (Bradbury 1996, 1997), or that it should be combined with social interaction skills (Kent and Keohane 2001, Turner et al 1998). According to Heinberg et al (1997) there is a need for therapy when a person repeatedly requests further surgery. Both Rosen et al (1995) and Cash (1990) focus on people’s dissatisfaction with their body image, and how therapy can enhance both an individuals’ sense of well being, and the perception of their body.

The potential merits of providing therapy were on the whole not stated, rather it was implied that it would be helpful. Whereas, the two psychoanalytic case studies by Miliora (1998), and Neiderland (1975), did provide more detailed information on the therapeutic alliance. Through therapy these patient’s explored their thoughts and feelings about their difference, and as a result of therapy there was an apparent change in their behaviour. Both comment on the subjective nature of how the patient perceived their difference (both had facial birthmarks), and that the anomaly represented a narcissistic injury; therapy offered the client the opportunity to work through the early childhood traumas.

Several authors commented on who should provide the intervention, Robert et al (1997:53) suggest that ‘any and all burn care professionals can be called to serve as psychotherapeutic agents’. They identify how the professional listening to the patient’s story can create a therapeutic dialogue, and this experience serves to normalise experience. Whereas, Ye (1998) suggested that there is an increased need for doctors to provide emotional support. Pruzinsky (1988:2) refers to medical psychotherapy as being a ‘hybrid discipline composed of many sub-disciplines’ and he includes nurses, psychologists and doctors in his list of professional that could provide therapeutic interventions. It was assumed that the reader would know the nature of these ‘therapeutic interventions’, and an area that was not commented on was the training required. One person commented on the knowledge and skills required; Bronheim (1994) highlighted the need for the therapist to have a familiarity with medical treatments and body image issues. He also stated that there was a need for the therapist to open up a discussion on losses ‘otherwise a form of pseudo therapy with both patient and psychiatrist struggling at an impasse’ (Bronheim 1994:117) [original emphasis]. Whereas, Edwards (1997) suggests that counselling is not effective when the practitioner presents the client with their pre-formed answers to what they presumed the problems to be.
There was also concern expressed about the need to consider the limitations of counselling with this client group. Bronheim (1994:117) suggests that psychotherapy following head and neck surgery, will not be effective if the person is still concerned with 'serious physical concerns'. Also, Edgerton et al's (1991:606) study on patients undergoing reconstructive surgery comments on how 'psychiatric counselling yields minimal rehabilitation. The sense of deformity remains' [original emphasis]. They also suggest that the deformity is a disease, and suggest that patients undergoing aesthetic reconstructive surgery would benefit from a combination of psychological assessment, intervention and surgery. Referring to working with dermatological patients, van Moffaert (1992) suggests the need for an eclectic approach, one that combines medical and psychotherapeutic interventions.

An area that was referred to, or alluded to was, who would be the people who were more likely to have problems coming to terms with a newly acquired difference, or living with a facial difference, and who would therefore, be more likely to require therapy. One area of focus was whether there was a correlation between the size of the 'difference' and the degree of psychological trauma encountered. A common held belief was that the 'bigger' the difference, the greater the trauma suffered. Robinson (1997a:102) states: 'Common-sense tells us that disfigurement will bring in its train a host of psychological problems'. However, she then goes on to say that 'common-sense' is an enemy of truth. And she suggests that 'a mild disfigurement can carry a greater psychological burden than a more severe one'. This view is supported by Pruzinsky's (1997:372) study, he concluded that 'very small deformities can be associated with a very intense desire for surgery and an overwhelming negative psychological response'. MacGregor (1984:91) states that there is 'no proportional relationship between disfigurement and the amount of psychic distress it engenders'.

Another issue that was discussed was people's perception of their difference; both Pruzinsky and Bradbury share the view that there is no correlation between subjective and objective experience of reality. Pruzinsky (1997) suggests that people's subjective opinion of their 'disfigurement' influence their psychological well being. Whereas, Bradbury (1997:366) states: 'There is no linear relationship between the degree of disfigurement and subjective feelings of distress'. Pruzinsky (1992:582) states 'Each patient will respond to the stress of having a facial deformity in his or her own individual manner'. It is suggested here that the individuality is a key phrase when considering the implications of living with a facial difference, for it is not possible to legislate how it may effect someone.

Overall counselling and psychotherapy was recognised as being helpful to this client group, it was also recognised as being an area 'where an appropriate therapeutic response is currently inadequately defined, described or delivered' (Newell 1998:311). There was however, support for
counselling being an integral component of care (Rose and Loewenthal 1998, Turner et al 1998, Partridge 1997a, Rose 1997). McGrouther (1997:991) is in agreement and suggests that as therapy becomes a more accepted as part of the treatment package; ‘The challenge is now to audit and scientifically evaluate the various forms of counselling and to lobby politicians to ensure that resources are made available’. The next section focuses on a review of the research methods employed in the studies reviewed.

3.3 Review of research methods and designs
The majority of the studies reviewed relating to ‘facial difference’ relied on some form of standardised measurement tool to assess an individual’s psychological functioning. For example, Klassen et al (1998:380) used the Derriford scale, which had been ‘developed specifically for use with plastic surgery patients”. In Kent and Keohan’s (2001) study with dermatological patients the following scales were used HADS (Hospital Anxiety Depression Scale), DLQI (Dermatology Life Quality Index) and FNE (Brief Fear of Negative Evaluation Scale). In Heinberg et al (1997) study, the following scales were used, psychosocial adjustment to illness scale, a self report scale (PAISS-SR) covering the following topics, relationships, social environment, sexual relationship, psychological distress. Also the Beck Depression Inventory (BDI) which is a 21 item multiple choice measure, and the Millon Clinical Multiaxial Inventory II (MCMI II) which is a 175 item likert scale questionnaire. A study by Robert et al (1997), used an ISC (incomplete sentences for children), which is a psychological assessment tool. The results were then subjected to a content analysis, and from this five major themes emerged on the issues that caused people concern when coming to terms with facial difference. These were preoccupation with health, the struggle for internal acceptance, reconstruction of one's life map, changing relationships and redefining the world. In Edgerton et al’s (1991:607) the one hundred participants were subjected to a ‘formal battery of psychometric assessments’.

From the qualitative domain, there were four studies, two psychoanalytic case studies (Miliora 1998, Neiderland 1975); two phenomenological studies reporting on peoples experience of living with a facial difference (Rose 1997, Cavicchioli 1994). There was a difference in how the data was generated in the phenomenological studies, Cavicchioli (1994:64) asked participants to give their response to a pre-planned interview schedule, e.g. ‘what does it mean to you to be facially disfigured? What do you think it means to other people?’ Whereas, the participants in the heuristic inquiry (Rose 1997) were asked to share their experience of living with a cleft, their responses were not constrained by a pre-determined questionnaire emanating from the researcher’s frame of reference. It is suggested here that these two studies represent opposing ends of the continuum of qualitative research; in the first study the researcher is responsible for determining the categories
that emerged from the study, in the second, the themes emerged from the research participant's responses.

Some studies combined both quantitative and qualitative elements. Both Hughes (1991) and Newell (1998) combined the use of a range of standardised tools (similar to those referred to above) together with a structured interview.

In relation to studies conducted, in the field of facial difference, there were questions raised about the research methods; Solomon (1998:271) suggests that 'there is a lack of systematic methodology, which has deterred many researcher from investigating the effects of facial distinction'. Robinson (1997a:104) comments on the disparity of research findings and cites 'small unrepresentative samples that are often reported and the non-standardised measures frequently used'. Suggesting that larger sample sizes would provide a more accurate statistical analysis. Whereas, Rose and Loewenthal (1998) suggest that the emphasis on quantitative methods, has detracted from the 'lived experience' of the researched group. It is suggested here, that it is difficult to rely on quantitative data at the exclusion of qualitative data, as this has the potentiality of engendering results that speak more from the researcher's frame of reference rather than the researched.

For example in Hughes (1991) study; seventy-one patients who had undergone disfiguring facial surgery for head and neck cancer, were interviewed to elicit how the surgery had impacted on their social contacts. However, the 'interview' comprised the interviewer eliciting comments to a questionnaire; in other words the respondents responses were coded as to their best fit to a pre-determined category. It is argued here, that the use of these forms of collecting data, whilst providing an insight into how people with facial difference are coping, or have coped, and the responses have enabled researchers to determine the likely effect of facial difference for the individual and their (re)integration into society. The findings are more dependent on the researchers perception of the likely difficulties encountered, for they developed the questionnaires. What if a respondent's experience did not fit with the predetermined categories? Would it be a case of best fit? Or would their responses be disregarded? A research method, which allows for the voice of the researched to be heard is required, but can we ever hear the story of the other, or will it always be filtered through our own experience? These questions inform the discussion on developing a methodological framework to guide this study (see chapter three).

3.4 Summary
A facial difference may present itself at birth (congenital) or be acquired later in life (trauma or disease processes). There appears to be no correlation between the cause and the size of the facial difference to the level of psychological distress experienced. Counselling/psychotherapy is viewed
by some to be helpful, however, the exact nature of what is helpful is not explicated; although, it is recognised that it should be an integral component of the care package offered to people with a facial difference. The research studies in this field were predominantly quantitative; there was as such a privileging of science and technology over humanness.

4.0 The literature reviews and the research question
Subjective experience lies at the heart of the three reviews; learning is premised on the ability of humans to learn (Bergevin 1967), it is thus a life long process. The learner accessing lifelong learning is seen to be self-directing, knowing what it is that they need to know, and that previous learning is acknowledged (Knowles 1984, Rogers 1983). The teacher can be seen to be a facilitator; facilitating the learning process (Heron 1989). As a consequence the learner is actively engaged in the learning process. This contrasts with the traditional style of teaching whereby the teacher was seen as the expert, who imparted knowledge to the learners, there was an element of repeatability in the performance of the teacher, and the learner was a passive recipient in the exchange of information. With the change from ‘teaching’ to ‘facilitating’ there is the potential for a return to placing humanness prior to science and technology. For the ‘teacher’ is not able to state beforehand what it is that the learner will learn in any given learning situation. Rather there is openness to the possibility of each learner, taking from the learning situation that which they need to enhance their understanding, and in the process learning how to learn.

The relationship between learner and facilitator is an influential factor in the learning process, a process that places the learning from experience as a key component, and in this activity reflection is a fundamental requirement (Jarvis 1997, Mezirow 1990). The learner through the reflective process is able to see the content of learning from different perspectives, and in this process further learning may be identified. There is an openness to the experience of learning, that learning does not necessarily equate with learning a once and for all ‘answer’ rather that this ‘answer’ can be modified/expanded/ altered in light of further experiences which may create a change in perspective to the initial learning.

It is suggested here that a corollary can be drawn with therapy, for the client seeks out therapy of their own volition (Bond 1993), they are in a sense self-directing, acknowledging that they are experiencing problems in their day to day life. Problems which according to Greenberg and Safran (1987) can be said to be premised on some difficulty in coping with emotions. The therapeutic relationship provides an environment that may be conducive for the person to explore their current difficulties, to tell their story. The therapist has an openness to what will happen in the therapeutic session (see Gordon 1999, Lomas 1999, Rogers 1961). The learning that emanates through therapy
can not be predicted, nor does it represent the attainment of the correct answer, it is about the person finding a language for their emotions (Goncalves and Machado 2000, Gordon 1999).

The resolution of difficulties to learning from experience requires the ability to reflect on previous learning experiences with a facilitator so that the ‘blocks’ to learning can be uncovered (Boud et al 1993); as such it requires a form of unlearning (Drew 1993). It is acknowledged in the field of education that some distortions may be so firmly entrenched that they may require psychotherapy (Mezirow 1990); therefore psychotherapy may be helpful to the process of learning. But is psychotherapy only a ‘last resort’ when the educators are having difficulties with encouraging students to learn, or when there is a lack of educational achievement? Or is it that psychotherapy is a form of learning within field of lifelong learning?

It is generally considered that all the theories of counselling and psychotherapy are a derivative of Freud’s theory of psychoanalysis, in some cases a derivative of the derivative, and thus appear to be far removed from Freud. However, in tracing the origins of a particular theory, there is a link albeit a tenuous one. This factor is important in determining whether therapy is a form of teaching and learning. For Freud recognised that the treatment he was offering was a form of education:

‘The work of overcoming resistances is the essential function of analytic treatment; the patient has to accomplish it and the doctor makes this possible for him with the help of suggestion operating in an educative sense. For that reason psychoanalytic treatment has justly been described as a kind of after-education’ (Freud 1917:504) [original emphasis].

The term after-education implies that following the primary educational experience, there was a need for further education to work with the resistances that emanated from it. It is suggested here that resistances represent distortions in learning, and that after-education can equate with today’s term of lifelong learning. Thus Freud anticipated the concept of lifelong learning, whereby learning extends beyond mandatory education. That the resistances arising from early experience, can impact on how future experience is interpreted, for there can be an expectation that experience is a repeatable phenomenon. Whereas, according to the psychoanalyst Bion (1962:64) who was interested in learning from experience, suggests that ‘no experience exactly matches a past experience’. To expect experience to be replicated exactly is representative of an inability to learn from experience. Therapy provides an opportunity to relearn, or to unlearn, from this it can be said that therapy provides an opportunity to return to learning from experience (Loewenthal 1999).

Psychoanalytic theory has influenced the philosophers Gadamer and Habermas both suggesting that it has a place in the interpretation of experience. Habermas (1963:77) viewed psychoanalysis as a form of emancipation as it offers the experience of ‘critical insight into relationships of power, the objectivity of which has as its source solely that relationships have not been seen through’. Habermas developed a theory of communicative action; socialisation is fundamentally an interactive
process stemming from the lifeworld, the culture in which the individual is situated, and the communicative networks within the lifeworld. Reflection is central to communicative action, and comprises of two aspects, 'subjective reflection on what makes it possible for him or her to perform certain actions, and to a more critical insight into the distortions built into these and other processes' (Outwaithe 1996:115). It is suggested here that it is these distortions that are subject to transformation through the process of psychoanalysis. Mezirow is influenced by the work of Habermas, and refers to his theory of reflective learning as transformative or emancipatory learning.

Gadamer (1967:41) suggests that 'hermeneutical reflection plays a fundamental role in psychoanalysis', and he draws on the work of Habermas and how his reference to psychoanalysis, is that it is a form of understanding, which is dependent on reflection and logic. Also that psychotherapy is about 'completing an interrupted process of education into a full history'. He does not develop the theme of the nature of the 'interruption' to the process of education, but it could be that some form of trauma has resulted in the inability to learn from experience (Loewenthal and Snell 1998). Gadamer refers to the influence of Lacan and his linguistic interpretation of psychoanalysis, to support his view that language is fundamental to both his hermeneutical theory and the practice of psychotherapy. He states 'in psychotherapy hermeneutics and the circle of language that is closed in dialogue are central' (Gadamer 1967:41). It is suggested here that the closure of the circle is at odds with the open circle of hermeneutics; and the completion of a process of education, is not compatible with the concept of lifelong learning.

Whereas, Loewenthal's (1999) view is cognisant with lifelong learning, when he suggests that therapy can assist with an interrupted process of education, the potential outcome is a return to learning from experience. Suggesting that learning from experience is what constitutes education. Within the sphere of lifelong learning, it is about learning how to learn, and as such therapy is an activity which enables people to learn how to learn; to experience their own experience.

It is suggested here, that the concept of lifelong learning is a key aspect for viewing psychotherapy as a form of learning. The National Adult Learning Survey (1998) cited by Alridge and Lavender (2000:?) identified the following category under the heading of non-taught learning: 'Deliberately trying to improve one's self-knowledge about anything or teach yourself a skill without taking part in a taught course'. Therefore, counselling and psychotherapy can be included in this category, for people seek out therapy, when they are experiencing difficulties in day to day living, and through the therapeutic relationship, there is an opportunity to learn about oneself, relationships with others, and how sense is made out of experience. The relationship provides an opportunity to tell ones personal life story, to speak of thoughts and feelings, to reflect on experience, and to make changes.

A cycle that is complimentary to Merizows reflective learning cycle, where transformative learning
is the potential outcome. The exploration of feelings is an element of emotional learning, learning that can inform relationships with others and enhance decision making. The change that emanates through the therapeutic process is personal; it is learning that makes a difference to a person, it is therefore significant learning. Thus counselling and psychotherapy provide an opportunity for learning; transformative learning, emotional learning and significant learning. Learning that has the propensity to return to learning from experience.

Counselling and psychotherapy are a recognised form of health treatment, particularly in the field of mental well being. For a study on *The Impact of Learning on Health* (Alridge and Lavender 2000) identified how learning can lead to an increase in mental well being. The general benefits were seen to encompass an increase in self-esteem and self-awareness, and the unanticipated benefits also included issues of personal discovery about self and others, for some this was encompassed under the umbrella term of ‘general sense of well being’. The physical health benefits also related to feeling ‘mentally better’.

It is suggested here that learning provides an opportunity to enhance an individuals’ health; learning and health are thus seen as inter-related concepts. Learning facilitates a change in the experience of physical and mental well being, and this could be attributed to seeing their situation from a different perspective, a return to learning from experience. In the Department of Health’s (1998) document *Our Healthier Nation* there is reference to the need to look at how learning can influence the workforce’s health. As such the view put forward here supports the intention of how learning and health are increasingly being recognised as inter-related concepts.

The concept of lifelong learning opens up the number of activities that can be embraced under the ‘umbrella’ of learning; the learner is an active participant in the process, and change is the potential outcome. Psychotherapy is a process whereby the client is an active participant, and change is the potential outcome. With the widening of the scope of learning activities, psychotherapy can be aligned with the non-taught learning category of adult learning. With learning now being recognised as having an impact on health, there is further opportunity for psychotherapy, which is comes under the umbrella term of health treatment, to be aligned with learning. Thus, lifelong learning and psychotherapy can be seen to be mutually interdependent terms.

The potential for a return to learning from experience in therapy is not restricted to people with a facial difference (this is the particular focus of this study). The potential is open to any one who is not able to learn from experience, due to previous distortions in experiences, experiences that influence a person sense of emotional well being.
The literature review on facial difference, highlights that an area of difficulty is in relation to how appearance can have implications on a person’s ability to cope in everyday situations. Therapy is seen to be an helpful in assisting people cope with their and others reactions to their facial difference. Therapy may also be combined with social skills training, or be separate to it. Bull and Rumsey (1988) comment on how social skills training is about learning how to cope. It is suggested here that therapy may also be a form of learning to enable a return to learning from experience.

Conclusion
Psychotherapy can be seen as a form of learning, within the field of lifelong learning. There are commonalities in the process of therapy and self-directed learning, the client/learner is an active participant, the therapist/facilitator provides an environment conducive to learning, the client/learners previous experience is acknowledge. Both processes involve reflection on experience, and the potential outcome is change, a change that can be health related. A change that is related to the ability to learn from experience, where learning is a personal process.

From the review of the literature the working definitions of the three forms of learning that are considered here to be intrinsic to the process of psychotherapy are as follows:-

(i) Significant learning is learning that makes a difference to how a person perceives their current situation.

(ii) Transformative learning, is a questioning of previous learning, and through this reflexive process distortions in meaning making perspectives are recognised; the learning that emanates from this process results in a change in perspective.

(iii) Emotional learning involves an exploration of personal emotions, developing a language to speak of feelings and how these inform relationships with others.

It is suggested here that the three forms of learning are mutually interdependent and intertwined, each contributing to the possibility of a return to learning from experience; for a person to experience their own experience.

Therapeia is the term adopted here to encompass the concept of psychotherapy as a form of learning a concept that includes significant, transformative and emotional learning as defined above. The term teaching is subsumed under the term learning and is not contained in the heading, to avoid any confusion that the therapist takes on the role of a traditional teacher, whereby the teacher imparts knowledge to the student, an activity that is at odds with the nature of psychotherapy. Therapeia is learning that privileges humanness, it is learning that can not be taught, but is apprehended through relational processes.
The relational process of psychotherapy provides an opportunity for the creation of a learning milieu that may encompass significant, transformative and emotional learning; the potential outcome is for the client to experience their own experience – to return to learning from experience. The client group chosen to demonstrate the teaching and learning aspects of psychotherapy are people who have a facial difference.

The difficulty is how to research learning that emanates through the therapeutic relationship. For both therapy and learning are difficult concepts to grasp, how does the researcher attempt to grasp the ungraspable? How can the voice of person’s subjective experience of the phenomena be heard? This difficulty is explored in the next chapter, which focuses on the development of a methodological framework to enable the opening up of a conversation, focused on the question posed by this study: Is counselling and psychotherapy a form of learning for people with a facial difference?
Chapter Three

Developing a Methodological Framework

Introduction
The aim of this chapter is to discuss the process of developing a methodological framework for selecting a research method to explore the research question posed: Is counselling/psychotherapy a form of learning for people with a facial difference? The initial discussion provides a definition of research, an activity that generates new knowledge. In this study it is the knowledge on how to look at psychotherapy as a form of learning. Methodology is one component of a research paradigm, and as such it is not possible to develop a methodological framework without considering the other components, as they are interdependent (Guba and Lincoln 1994). Therefore a discussion of a research paradigm is provided.

A paradigm 'represents a worldview that defines, for its holder, the nature of the “world”, the individual’s place in it, and the range of possible relationships to that world and its parts' (Guba and Lincoln 1994:107) [original emphasis]. In this study, the research paradigm supports the privileging of humanness as opposed to science and technology. There is a move away from technique and the detached researcher, to a recognition that the researcher influences the meaning(s) generated through the research process. The researcher is involved in the study, is part of the study; subsequently there is a need to explicate for the reader what they bring to the study, to share their interpretative lens. The researcher discusses the theories and perspectives that inform her interpretative lens. These are phenomenology, hermeneutics, psychoanalytic theory, postmodernism, feminism and ethics. Each is introduced, and a discussion of how they inform research concludes this section.

The next section explores the development of a research paradigm for this study. To choose a predetermined paradigm, would not correlate with the reason given for eliciting the interpretative lens of the researcher, i.e. it informs the research paradigm. Rather than use a ‘best fit’ paradigm, a paradigm will be developed from the current paradigms; thus supporting the notion that the construction of knowledge is personal. The final section outlines the methodological framework developed for, and to be tested out in this study.

1. Research
Research is considered by Wilson and Hutchinson (1991) to be about developing knowledge, in relation to this study it is knowledge on psychotherapy as form of learning. But what is knowledge? The concept of knowledge has a long history as a philosophical inquiry, and it is a term used in
everyday speech (Berger and Luckman 1966). Philosophy is 'a special department of speculative knowledge' (Ayer 1946:64), and the philosopher, as an analyst is concerned about the way in which we speak about things. According to Foucault knowledge is about 'reason' and as such he asks the question: 'How is it that the human subject took itself as the object of possible knowledge' (Merquoir 1991:11). This is a question that is difficult to answer, for on the one hand 'virtually everyone has the capacity to "construct" knowledge' and on the other hand the traditional perspective on knowledge creation was that 'only a few people have possessed the power to decree which knowledge will count for the culture and which will not' (Kramarae and Spender 1993:4). Legitimacy of knowledge has implications ultimately for what constitutes 'knowledge' and once conferred with the term knowledge, it becomes a universal property. Polyani (1966:170) challenged the view of reproducibility of the truth claims of knowledge, suggesting that if this were the case then 'all the great pioneering achievements of our history would not be knowledge'. He appears to be suggesting that there is an irreducible element to knowing.

Martin (1990) draws on the work of Polyani, to support his view that there are two kinds of knowledge, explicit – that which can be put into words, and tacit – that which cannot. He also suggests that 'what we like to call the "real world" is to some extent "constructed" by the human psyche' (Martin 1990:148). Whereas, Peters (1995:33) suggests that knowing is 'simply a set of contingent social practices, as a right, by current standards, to believe'. This view was also put forward by Berger and Luckman (1966:15) when they stated 'the sociology of knowledge is concerned with the analysis of the social construction of reality' [original emphasis]. As such knowledge is 'the outcome or consequence of human activity, knowledge is a human construction, never certifiable as ultimately true but problematic and ever changing' (Guba 1990:26) [original emphasis].

There are, according to Lyotard (1984) two functions of knowledge, research and the transmission of learning. If research is about the development of knowledge, it raises the question of 'what is knowledge?' Knowledge is not a 'thing' it is a construction, a concept, objective knowledge as a given is therefore an illusion. For there is always a link with the person whose awareness it was, and this was Kant’s contribution to knowledge, that you can not separate knowledge from the knower (Applebaum 1995). If research is a function of knowledge, and knowledge the outcome of research it appears to be a 'chicken and egg' situation – for which comes first? This could also be said about the second function of knowledge – the transmission of learning. For learning is associated with the transmission of knowledge (Jarvis 1997), as such the terms learning and knowledge could be said to be synonymous. Cohen (1986:9) posits that all knowledge is self-knowledge and that outside of it 'there is an abyss chaos – for there is no truth – that is the myth which knowledge is founded on'.
This definition appears to encompass the inherent difficulty in defining knowledge and as such knowledge is an enigma, as is research.

The move from modernism to postmodernism opened up a conversation about how knowledge can be located or situated within a context (Lyotard 1984). The implications for research is that there is no ‘fixed’ reality rather it is constructed in the moment. But how can this ‘moment’ be captured and shared with others? How can the learning experiences of therapy be explored so that this situated knowledge becomes knowledge available for others? It could be that the knowledge generated through this investigation, could be represented as a model, offering a way of looking at therapy as a form of learning. A model that may enable therapists and clients to begin to open up further conversations about how their experience of therapy may be seen to be a form of learning; learning that offers the potential to return to learning from experience. A starting point to this exploration is to situate the study within a research paradigm.

1.1 Research paradigm

A paradigm is considered by Guba and Lincoln (1994) to be composed of three interdependent elements: epistemology (the relationship between what can be known and the knower), ontology (what is the form and nature of reality), and methodology (how we gain knowledge). The discussion will initially be in relation to research in general, followed by the implications for this study.

‘Paradigm issues are crucial; no inquirer we maintain, ought to go about the business of inquiry without being clear about just what paradigm informs and guides his or her approach’ (Guba and Lincoln 1994: 116). This view is also supported by Schwandt (1994:118) who suggests that there is a need to be conversant with the notions of being and knowing which guide a study, to enable the researcher to construct an account of the phenomena of a study which is more of a ‘construction of the constructions of the actors one studies’. To focus exclusively on the methods is to focus on the techniques for gathering and analysing data (Alvesson and Sköldberg 2000), and as such this can mask the relationship between the method and the inquiry process. It is suggested here that the emphasis on method is to give primacy to science and technology. Whereby, there is a primacy to the technical prowess of the researcher, rather than the human element of that which they bring to the study, e.g. the sense they make out of the data, the guiding principles that underpin and inform the sense they make out the data. It is suggested here, that making known the underpinning ontological and epistemological foundations, which inform(s) the methodology and ultimately the methods of an inquiry, bring the researcher’s impact on the study more to the foreground, and as such make visible the human element in the meaning making process.
Within the research community, it is generally considered that there are two main research paradigms, quantitative and qualitative or the positivistic and post-positivistic both of which will enable the researcher to address the questions that they pose. A commonality between the two is that both are founded on the concept of a knowing subject (Prior 1997). Descartes has been acknowledged as the founder of the quantitative domain, and Kant the source of the qualitative domain (Hamilton 1998). The positivistic paradigm was the only one for some four hundred years, the essential principle is that there is a known reality, which can be accessed through scientific inquiry. Through procedures of validity, reliability and objectivity, the researcher can get close to the ‘truth’. A researcher can increase the validity of a study by selecting instruments, which measure what they are designed for (Davis 1995, Black 1993, Bryman 1988); and how the selected tests can be carried out with some degree of sameness is related to the reliability of a study (Bryman 1988). As such the quantitative studies of the positivistic paradigm are recognised as providing ‘hard’ evidence, due to the reliance on scales and measures (Guba and Lincoln 1994, Reinharz 1993). The influence of the researcher on the study is negated due to objective nature of scientific rigour, therefore the relationship between the researcher and researched, is not acknowledged.

The post-positivists viewpoint challenged the notion of a knowable reality, recognising that reality could not be fully known, but that methods could be developed to ensure ‘objectivity’, reality could then be apprehended under certain conditions, as such an objectified ‘truth’ could be elicited. Research conducted under this paradigm is known as qualitative, and it can be ‘an interactive and transformation process in which the researcher seeks to learn about, and to interpret life experiences’ (Sword 1999:270). Whereas, Letourneau and Allen (1999:623) define post-positivistic as ‘the search for ‘warranted assertability’ as opposed to ‘truth’. They also acknowledge that there is not one ‘ideal’ method, they all have limitations. Qualitative research is a process, it involves ‘theory, method, and analysis, and ontology, epistemology and methodology’ (Denzin and Lincoln 1998:23). According to McLeod (1994:79): ‘The fundamental of a qualitative investigation is to uncover and illuminate what things mean to people’. As such there is a reliance on ‘verbal data to build upon descriptions or explanations of a particular phenomenon’ (Lynch 1996:114). Unlike quantitative studies it does not involve ‘measurement or statistical technique’ (McLeod 1994:76).

The concept of validity is challenged within this paradigm for there is a shift from objective knowing to subjective knowing; that meaning is created through the relationship with the researcher and the phenomenon of the study, the self of the researcher is recognised in the process (Heron 1981, Reason 1981). An apparent conundrum is presented by Reason (1981:245) who suggests that to gain understanding of what is going on for an individual in an identified situation, requires the researcher to ‘get into the ‘world-taken-for-granted’ perspective of those involved; yet at the same time as ‘getting into’ the experience the researcher needs to be able to maintain a perspective on it’.
As such the researcher obtains/creates an objectified subjective view on a situation, and it is suggested here that the knowledge claims of the positivistic views exert an influence on what constitutes knowing, in the post-positivistic paradigm.

As further developments have taken place within the post-positivistic paradigm, the issue of the objectified subjective stance of the researcher is challenged, and new terms have emerged, to challenge and/or replace the positivistic term of validity; verisimilitude (the ability to reproduce the real) (Denzin and Lincoln 1994); credibility (consistency between data collection and analysis) (Thorne 1997). Also the explication of the researchers experience of the phenomenon of the study is said to further increase the credibility of a study (McLeod 1994, Reason and Rowan 1981). Kincheloe and McLaren (1994:152) include credibility as one aspect of ‘trustworthiness’ the other aspect is ‘anticipatory accommodation’ which draws on the work of Piaget and the ability ‘to reshape cognitive structures to accommodate unique aspects of what they perceive in new concepts’. Whereas, Sword (1999) suggests the location of the researchers self in the study increases the legitimacy of findings. Lather (1991) identifies five forms of validity which she considers are more applicable to research of a more qualitative genre: reflexive (challenging the text for its own validity); ironic (deconstruction of the reproductions and simulations that structure the real); neopragmatic (challenge the power of the researcher as the one who knows); rhizomatic (presentation in the text of multiple voices) and situated (the text as a representation of the minority voice). It is suggested here that these developments have arisen in response to the main criticism of research conducted in this paradigm that it is ‘subjective and unscientific’ (Morse 1994:24), or ‘soft’ (Guba and Lincoln 1994, Reinhart 1993).

Although quantitative and qualitative research have been presented here as separate entities, studies can draw on both paradigms, usually by cross checking findings from qualitative studies with quantitative methods (Bourner 1996, Patton 1990), as such this is a form of triangulation (Deacon et al 1998). The preference for one paradigm over the other is based on the researchers underpinning theoretical orientation; and there usually is a tendency to prefer one to the other. The following quote by Stevens (1995:85-6) appears to encapsulate this phenomenon:

‘The trouble is that researchers become so attached to their own orientation, and so hostile to those who adopt another, that they forget they are all partially sighted observers examining different aspects of the same elephant in the dark, each believing that the particular bit of trunk, foot or tail they are grasping represents the whole beast’.

It is suggested here, that quantitative research has given primacy to science and technology and that qualitative research begins to address the gulf between science and technology on the one hand, and humanness on the other hand. Therefore qualitative research will be explored further, as it is cognisant with the underpinning ethos of this study.
Denzin and Lincoln (1998, 1994) outline five 'moments' within qualitative research, and how the role of the researcher has changed within each epoch, and it is suggested here, that each epoch represents a movement away from the purely scientific towards humanness. The first moment the 'traditional period' was from the 1900's to 1939, validity, reliability and objectivity were supreme components, and the other was seen as being 'strange' or 'foreign'. In this epoch, ethnography was the predominant method of study. The next moment 'the modernist phase' (1945 – 1970), there was a formalising of qualitative methods, and the recognition of the researcher as a participant observer, the interpretative theories of ethnomethodology, phenomenology, critical theory and feminism flourished.

The third moment 'blurred genres' (1970 – 1986) there was a blurring of how best to interpret the phenomenon of a study, and an increasing recognition of the authors' presence in the text. Also there was broad range of methods and strategies to conduct a qualitative inquiry, e.g. symbolic interactionism, constructivisim, naturalistic inquiry, semiotics, structuralism, feminism, deconstruction, poststructuralism. The fourth moment 'the crisis of representation' (1986-1993), there was recognition of the minimal difference between writing and fieldwork. Reflexivity called into question issues such as gender, class, race and how best to represent the voice of the other. The next moment, the present, is a 'double crisis' of both representation and legitimisation. The lived experience is 'created in the social text written by the researcher, this is the representation crisis' (Denzin and Lincoln 1994:11). The legitimisation crisis focuses on issues of validity, generalisability and reliability.

In relation to this study, one way of looking at psychotherapy, as a form of learning is to speak with people who have experienced therapy and elicit the learning that has taken place. From this a model may be developed to assist others to look at psychotherapy as a form of learning. The crisis of representation is how to create a text that is mindful of the many tensions inherent when representing the voice of the other. In accepting the premise that knowledge is socially constructed, and linked with personal awareness, it is difficult to write a text that is representative of those who shared their experience of learning emanating from therapy. Also, can generalisations be made? For in the creation of a model there is a form of generalising; with different people the context changes and with it the meaning changes.

In accepting the premise that knowledge is a personal construction, then the construction of the phenomenon of learning experiences in therapy undergoes numerous re-constructions. For example, the meaning of the phenomenon [learning experiences in therapy] is situated within the therapeutic environment, the meeting of a therapist and a client. This meaning is then situated within the research meeting, a researcher with a research participant. From this meeting the researcher creates a
report (research text) that is representative of her or his understanding of the phenomenon and from this creates/generates a model to provide others with a way for opening up conversations on, psychotherapy as a form of learning. This text is then available to unknown readers who will make their own construction of the phenomenon. There is thus a transformation of the original construction of the meaning generated during a study, and through this process the contextual knowledge developed between the therapist and the client has the potential to become available for others.

The crisis of legitimisation focuses on the acceptance of this piece of research by the academic community. Does it meet with current standards for research? Can the standards be flexible to allow for creativity? There is the potentiality for creativity to be stifled by the demands of stakeholders and intended readership (Street 1998). Can it be different and acceptable? Can the postmodern ethos of multiple meanings be presented in such a way that is as acceptable as producing a piece of research from the modernist perspective? Can a report that is structured from a modernist stance, with chapters following a linear trajectory, to meet with the current acceptable standards of a research report, encompass a postmodern stance? A postmodern presentation would not follow a predictable linear trajectory, chapters or 'episodes' would emerge as the study progressed, and the style would be more conversational. Would this style be as acceptable?

In accepting the premise that the researcher is involved in the research process, not separate to, the theories and perspectives, which inform the researcher's way of knowing should be made explicit; as such there is a need for the researcher to share their interpretative lens. For this lens, informs the selection of an appropriate paradigm one that is cognisant with the ontological, epistemological and methodological beliefs, which ultimately inform(s) the question(s) posed and the research design to enable the answering of the question(s) posed.

2. Interpretative lens
A key factor in the elicitation of the interpretative lens, is the recognition of previous learning experiences. For the researcher, it was the undertaking of masters level studies and in the process being introduced to phenomenology and the exploration of the 'lived experience'; hermeneutic interpretation as a way of knowing, (the focus in both areas was on twentieth century philosophers); psychoanalytic theory and the role of the unconscious; postmodernism and the questioning of a definitive 'truth', rather there are 'multiple truths', meaning is created in the moment; feminism and the challenge of representing the minority voice; and the implication of the ethical relationship as posed by Levinas was also explored.
The researcher's knowledge of these theories and perspectives has been further developed during the course of this study; each theory and perspective will be explored, phenomenology, hermeneutics, psychoanalytic theory, postmodernism, feminism and ethics, followed by a discussion of their interrelatedness and how they inform the ontological, epistemological and methodological components of a research paradigm.

2.1 Phenomenology

Freidman (1964) credits Dilthey for suggesting that phenomenology is a distinct method of knowing; and Husserl for raising it from an approach to a philosophy and his motto was 'to things themselves', whereas, Heidegger (1967) acknowledges Husserl as being the instigator of phenomenology. A definition which encompasses both of these views is provided by Merleau-Ponty (1962:79) 'Phenomenology can be practised and identified as a manner or style of thinking, that it existed as a movement before arriving at complete awareness of itself as a philosophy' [original emphasis]. He also credits Hegel, Kirkegaard, Marx, Nietzsche and Freud as being influenced by phenomenology.

Husserl (1929:15) defines phenomenology as 'a new kind of descriptive method'. He suggests that there are two main strands to phenomenological reduction, firstly the ability to 'bracket' or provide 'epoche' to the describers own 'psychic sphere', and secondly the ability to describe the multiple appearances available to us. There is intentionally to our experience, and the act of phenomenological description is to identify the 'what' and the 'how' of any given experience. Husserl sees objectivity and subjectivity in relation to one another, and shares the view of Gadamer that it is not possible to separate them. Even though the scientist may claim to be able to be objective about the world, a view which stems for the Enlightenment project, this is, however not achievable as it is not possible to get away from humanness; the subjective element. 'Since Socrates, man has become a theme in his specifically human qualities, as a person, many within the spiritual life of the community' (Husserl 1935:9). He also postulates 'It is my conviction that intentional phenomenology has made of the spirit qua spirit for the first time a field of systematic experience and science and thus brought about the total reorientation of the task of knowledge' (Husserl 1935:13) [original emphasis]. It would thus appear that he is suggesting that science is not the only way of knowing, of increasing knowledge of the world; of existence.

According to Heidegger (1967:46) 'the meaning of phenomenological description as a method lies in interpretation' [original emphasis]. He also makes the claim for ontology to be situated within phenomenology. For Heidegger, the central tenet of his philosophy is Daesin or Being: 'the persons 'being there' in the world, thrown into a situation apart from which neither subject nor consciousness have any meaning' (Friedman 1964:70). As such: 'The task of ontology is to explain
Being itself and to make the Being of entities standout in full relief (Heidegger 1967:42). However, it is difficult to isolate the elements which contribute to this phenomena, for on the one hand, ‘the meaning of Being must already be available to us in some way (Heidegger 1967:27), and on the other hand, ‘no line of knowledge, no single truth may be absolutized and isolated’ (Husserl 1935:8). Which incorporates the notion of meaningless, or that meaning is created in the moment, and dependent on the perception of the perceiver; ‘I alone bring into being myself (and therefore into being in the only sense that the word can have for me)’ (Merleau-Ponty 1962:80).

The element of ‘truth’ as being in the moment is referred to by Merleau-Ponty (1962:80) as: ‘To seek the essence of perception is to declare that perception is, not presumed true, but defined as access to the truth’. Whereas, Husserl (1935:8) suggests: ‘No line of knowledge, no single truth may be absolutized and isolated’. It would seem that our perception, or our understanding of ‘life is only a constant approximation; that life reveals quite different sides to us according to the point of view from which we consider its course in time, is due to the nature of both understanding and life’ (Dilthey 1962:73). Thus it would appear difficult to define a particular way of being that is universal, rather it is context specific; and dependent on another: ‘Psychic life is accessible to us not only through self-experience but also through experience of others’ (Husserl 1929:17) [original emphasis]. As such, this experience of others and therefore of self, or ‘real living’ is to be ‘found not in the self but in the “between” – in “meeting” (Friedman 1964:71); and he suggests that the credit for this perspective lies in the work of Buber. It would seem that there is a need for an experience to be situated for meaning to emerge.

As a methodological conception, phenomenology ‘is all about things in themselves, and the need to get away from ‘technical devices’ (Heidegger 1967:43). It is about rejection of things being inscribed a recognised formula for the creation of a definitive meaning, and the acceptance of meaning being created in the moment. A central issue for this meaning making is reflection, for this allows us to grasp subjective experiences (Husserl 1929). The implications for research is about how there is a need for the researcher to bracket their experience of the phenomena in order to get as close as possible to the experience of the researched, and that the meaning is context specific.

2.2 Hermeneutics

A term introduced by Heidegger, and for Gadamer who is associated with this theory, it is that understanding is both ‘historically and linguistically mediated’ and that ‘there is always some pre-understanding or prejudice’ surrounding knowing, and this pre-understanding is an essential requisite for intentionally (Kearney and Rainwater 1996:109). Pre-understanding is the basis for all understanding; and it is constantly in the process of becoming; it is a cyclical process, pre-understanding is transformed into understanding, which then becomes the pre-understanding for the
next experience. Another term Gadamer refers to in relation to pre-understanding is prejudice, which he suggests are ‘biases of our openness to the world. They are simply conditions whereby we experience something — whereby what we encounter says something to us’ (Gadamer 1976:115). For interpretation to take place and a transformation of pre-understanding to understanding, there is a need to see through our prejudices ‘or tear away the pretences that hide reality’ (Gadamer 1989:32).

Gadamer appears to reject the Enlightenment project deeming it to be illusory; as such it could be said that he incorporates a postmodern perspective. He suggests that the overall aim of science is to objectify experience, and that as it ‘no longer contains any historical element’ it can therefore be reproduced (Gadamer 1989:346). For Gadamer, historicity is an important aspect of understanding, of meaning making; we draw on the past to recreate or make new meaning in the present. He states ‘experience stands in an orientation toward new experiences’ (Gadamer 1989:355). This represents the hermeneutical circle, a circle that can not be closed, for we are constantly having new experiences, which have the propensity for expanding our horizon of knowing; an aspect of this circle is reflexivity. Metaphorically, the horizon is made up of what we know and beyond is what we do not know; the ability to be open to new learning emerging from and through experience, represents an expansion in our horizon of knowing.

An interest in hermeneutics for Howard (1982:ix) is the continuing debate between the humanities and the sciences, and he poses the question ‘to what extent do the purposes and intentions of the individual affect the experience he has, and consequently the shape of his reality he apprehends, and consequently the knowledge he claims to acquire?’ This on the one hand appears to be a circuitous argument, and on the other hand commonsensical. He goes on to state:

‘Somehow our aspirations, wants, desires and interests are themselves hermeneutically, interpretative, active in the emergence of knowledge. Knowledge (or understanding) and interests (or purposes) are interwoven’ (Howard 1982:85).

Thus knowledge and interests are mutually interdependent; the potentiality for expanding our horizons of knowing is present, but there are necessary prerequisites, that of the need or the wish or the desire to know. In essence to be open to the new experience and the subsequent emergence of meaning/knowing/learning. An inherent part of this process is reflection, the ability to critically reflect (Gadamer 1976). If there is no reflection on experience, then the hermeneutical circle would in essence be responded to with old patterns of meaning making; previous experience would be the template for future experience. There would be no room for manoeuvre, metaphorically we would be wearing a straitjacket of our own making. With reflection, there is the possibility to experience new ways of meaning making to discover the infiniteness of experience.
As such Gadamer (1967:111) suggests that:

‘our task is to reconnect the objective world of technology which the sciences place at our disposal and discretion, with those fundamental orders of our being that are neither arbitrary nor manipulated by us, but rather demand our respect’.

It is suggested here that this reconnection is cognisant with the placing of humanness primary to science and technology. It is about the ability to think our own thoughts, to expand the horizons of our knowing, not in a previously thought out way, but with a willingness to be open to the experience.

Language has an importance for Gadamer (1966:3) he states: ‘the fundamental mode of operation of our being-in-the-world and the all embracing form of the constitution of the world’. And that it ‘is itself the game of interpretation that we are engaged in everyday’ (Gadamer 1989:32); also that it ‘is the single word, whose virtuality opens for us the infinity of discourse, of speaking with one another, of the freedom of “expressing oneself” and “letting oneself be expressed”’ (Gadamer 1989:549). He also acknowledges dialogue as the fundamental tool for knowing, either face-to-face or through the text; both provide the opportunity for interpretation and meaning making. Opportunities are everywhere: ‘I maintain that the hermeneutical problem is universal and basic for all interhuman experience, both of history and of the present moment, precisely because meaning can be experienced even when it is not actually intended’ (Gadamer 1967:32).

In relation to science methodology, Gadamer (1967:39) suggests that hermeneutics may help indirectly by ‘making transparently clear the guiding pre-understanding in the sciences and thereby open up new dimensions of questioning’. Questioning is central to research activities and he suggests that central to asking questions is the imagination: ‘imagination naturally has a hermeneutical function and severed the sense for what is questionable’ (Gadamer 1967:118). In essence we need to know what questions to ask to expand our horizon of knowing; it is suggested here that a sterile imagination may lead to a foreclosure on experience, a fertile imagination a propensity to the openness of experience. To encounter and embrace difference, rather than to a reduction to sameness in the name of academic rigour. According to Gadamer it is not possible to totally eliminate the subjective, the researcher does not enter the field as an object, they bring with them their particular viewpoint of culture, their prejudices, in essence their experience of the world; and ‘hermeneutical consciousness culminates not in methodological sureness of itself, but in the same readiness for experience that distinguishes the experienced man from the man captivated by dogma’ (Gadamer 1989:362).

Thus hermeneutics provides a way of looking at the creation of meaning, and how previous learning or understanding impacts and informs future meaning making. The expansion of the horizon of
knowing requires openness to experience, and a willingness to question and reflect upon that experience.

2.3 Psychoanalytic theory

Freud is identified as the founder of psychoanalysis; and he provides a theory of personality. His theory has been influential to society, and as such he is considered as powerful as Darwin and Marx. His concepts of the unconscious, repression and sexual desire are used in everyday language, as such his concepts are ‘accepted wisdom’ (Frosh 1999:1); also the theory can provide meaning in social life (Elliott 1999). Symmington (1986:39) makes the distinction that Freud did not discover the unconscious, as a concept it had been around for some two hundred years, what he did do was the exploration of ‘the laws and principles, which governed it’. There are three areas of psychoanalytic study; ‘the development of the mind and the influence of early experience on adult mental states; the nature and role of unconscious mental phenomena; and the theory and practice of psychoanalytic treatment, particularly transference and countertransference’ (Bateman and Holmes 1995: 17).

Freud outlines a theory for human development and how early childhood experiences impact on the adult’s behaviour. Analysis is aimed at uncovering repressed material, in making unconscious material conscious. Symmington (1986:44) describes the personality as ‘a mass of bits and psychoanalysis is concerned with binding them together. The external world as chaos mirrors the inner abyss’. As such psychoanalysis is about a search for meaning(s) which are not just confined to the individual, but also has implications for society in general (Elliott 1999, Frosh 1999).

To support of his theory of the unconscious, Freud (1915:574) states: ‘that at any given moment consciousness includes only a small content, so that the greater part that we call conscious knowledge must be in any case be for very considerable periods of time in a state of latency, that is to say, of being psychically unconscious’. However, the unconscious material can impact on our relationship with others, we transfer unconscious material from one experience to another. And the receiver of the transference can respond to the experience with his or her own transference, or counter-transference. Freud (1915:574) stated:

‘an analysis without transference is an impossibility. It must not be supposed, however, that transference is merely uncovered and isolated by analysis. It is a universal phenomena of the human mind, it decides the success of all medical influence, and in fact dominates the whole of each person’s relations to his human environment’.

‘What is peculiar to the unconscious as a psychical system is that it violently deforms, disfigures, or disguises meaning into something unrecognisable’ (Elliott 1999:21), and it suggested here that meaning is ‘slippery’ it is difficult to articulate the experience as it was, to get to the ‘real’ of an experience. This point is elaborated by Derrida (1998), for he makes reference to how Freud’s
conceptualisation of the omphalos (the navel) as a metaphor for how a dream can never be fully interpreted, due to the threads of the omphalos being so closely inter-twined, that they cannot be separated. As such, interpretation will always be found wanting; and deconstruction as a form of analysis, faces the same problem, for it is not possible to get to the thing itself; it will always be an approximation. He also states 'if there is any deconstruction it takes place (which I have said too often, and yet once again in psyche to dare repeat it again) as experience of the impossible' (Derrida 1998:55) [original emphasis].

Psychoanalytic theory provides a framework for meaning making which recognises the influence of the unconscious, and how this impacts on relationships with others, and how we make sense of a situation. The recounting of meaning making is difficult to elaborate for another, for it will always be contaminated or enriched by the unconscious. Possibly within the science and technology domain, the unconscious would be seen to contaminate the findings. Whereas, with a privileging of humanness, the unconscious would be seen to enrich the findings. It is suggested here that in the case of the report (research text), the interpretation made by the unknown reader, will also be subject to unconscious influences. Therefore getting to the ‘real’ will always be an approximation.

2.4 Postmodernism

Postmodernism is a concept that is difficult to define (Loewenthal 1996, Hinkson 1995), whereas, Potter (1996) suggests that to attempt to define it is contrary to the nature of it. However, it is defined in the Dictionary of Modern thought as:

‘amphorous body of developments and direction marked by eclecticism, pluriculturalism, and often a post-industrial, hi-tech frame of reference coupled with a sceptical view of technical progress’ (Bullock et al 1988:672).

Toynbee coined the term in the 1960’s (Peters 1995); however, both Peters and Kearney and Rainwater (1996) accredit the philosopher Nietzsche as being the first postmodernist, due to his style of questioning. Scepticism, appears to be an important aspect of postmodernism, it is about challenging previously held views stemming from the modernist paradigm, and the truth claims inherent in it. Postmodernism is noted for its questioning of the notion of a definitive truth and a known reality; it is therefore characterised by uncertainty (Pilgrim 2000, Robinson 1999, Ward 1997, Gergen and Kaye 1992, Kvale 1992). As such there can only be a partial view of reality (Cheek 1999), and therefore the meanings that emerge from within the postmodern paradigm, are also viewed with scepticism; for postmodernism is an ‘ongoing project to find new ways of looking at new times’ (Ward 1997:5).

Technical thought according to Gergen (1992) flourished within the modernist frame, and as such was deemed to have superseded values, with postmodernism, such truth claims of the ‘technical’ are
called into question. Lyotard (1984) explored how the concept of knowledge can be challenged/redefined within postmodernism. He argues that the privileged position of scientific knowledge is called into question, as it does not represent the whole field, and he makes the case for narrative knowing, which is more personal. The grand-narrative of knowledge is replaced, and knowledge becomes local (Lauzon 1998, Kvale 1992); there is an emphasis on practical knowledge (Kvale 1992, Shotter 1992) as such knowledge becomes context specific or situated (Gergen 1992, Polkinghorne 1992, Shotter 1992, Lather 1991). With modernism, scientific knowledge has been privileged, and the other ways of knowing marginalised; with postmodernism there is an opportunity for the marginalised terms to be privileged.

The French philosopher Derrida introduced the term deconstruction, and he questions the ‘meaning of meaning’ (Ward 1997:95). One aspect, is the focus on binary opposites, ‘how they are related, how one is central, natural and privileged the other repressed, and marginalised’ (Powell 1997:30). Derrida’s concept of deconstruction is about the constant interplay between the dominant and minority voice, for deconstruction temporarily privileges the minority voice. As such the minority voice then becomes the dominant one, and in the next cycle of deconstruction, it is relegated to the margins again. Meaning is not fixed, and in one respect it is not possible to eradicate binary opposites rather there is blurring of the boundaries; in essence they are mutually interdependent. In relation to research Derrida provides researchers with ‘a means for deconstructing objective truth or what is referred to as “the metaphysics of presence” (Kinchelow and McLaren 1994:140).

A slogan associated with postmodernism is the ‘death of the subject’ (Kvale 1992); or rather a decentering. Sarbin (1993:xxi) defines the postmodern self as:

‘the self is a ‘decentralised manyness’ of I positions that each have a voice and can tell their own stories about their respective me’s. The I moves in an imaginal landscape, from one position to another in such a way that dialogical relationships in a multivocal self become possible’ [original emphasis].

Thus the self, is not a monologicai concept, rather it is created in communion with others. Lyotard (1984:40) suggests that language is the medium of narratives, and states: ‘the social bond is linguistic but it is not woven with a single thread’. But language is found wanting for imagery cannot be fully captured in language (Myers 1969). For it appears an impossibility to translate thoughts, feelings, and experiences into words. According to Anderson (1996:65) ‘Every language is its own set of blueprints for constructing reality’ [original emphasis]. Within postmodernism there is recognition of how words can ‘fix’ an event, and as such there is a need to be playful with language and meaning making (Anderson 1996, Michael 1994).

The implications of postmodernism for research is that it ‘is not a mapping of some objective social reality; research involves co-constitution of the objects investigated, with a negotiation and
interaction with the very objects studied' (Gergen 1992:13). And that this has led to a focus on
discursive practices as opposed to methods, because the 'concept of truth and research as means to
truth are impugned' (Gergen 1992:25). Within this paradigm there is reliance on narrative,
hermeneutic and deconstructivist methods of investigation (Schuerich 1997, Kvale 1992, Løvlie

This perspective challenges the modernist claim to a known reality, rather it recognises how
meaning is created in the moment, and is dependent on the players involved. As such we are all
subject to; language is the best tool we have of explaining our experience, but it is found wanting.
There will always be a gap between an experience and the explanation of it, we know more than we
can tell.

2.5 Feminism

The work of de Beauvoir (1949) *The Second Sex*, 'has inspired many subsequent developments in
feminist theory, as well as shaping the gender critique within the discipline of philosophy itself;' (Kearney and Rainwater 1996:93). Phoca (1999:3) defines feminism as being: 'identified with a
desire for gender equality in a long intrinsic struggle which advocated change through social action'.
A feminist stance acknowledges diversity and with this diversity comes a questioning of the status
quo and the emergence of new meanings. This questioning stance (Arpad 1993) creates and gives
valence to plurality of meanings (Nicholson 1995, Kramarae and Spender 1993). Feminism as a
perspective questions the traditional scientific views of knowledge, as such this masculine
framework renders women invisible (Stanley 1997, Reinharz 1993). Also that within the male
orientated approaches, there is an emphasis of theory over experience (Stanley and Wise 1993).
There is also a tendency to treat women as objects; the feminist aim is to challenge this by
suggesting that women are also actors (Arpad 1993, Reinharz 1993, Stanley and Wise 1993). There
is a need for women to move from the subservient position assigned them by society, to a position,
which is in relation to the other sex (Irigaray 1993). A key notion here is that within the embracing
of diversity, is the recognition of difference, and how the feminist movement is more about human
difference and how this 'translates into social script' (Goldenberg 1990:61). Feminists have been
drawn to psychoanalytic theory, as a way of explaining gender biases (see Kristeva, Irigaray,
Goldenberg).

Postmodernism creates the potential for this minority voice to be heard. However, Nicholson (1995)
is critical of the emergence of postmodernism, and suggests it was a ploy to silence women. As
women were beginning to question the dominant male culture, metaphorically the 'goal posts' as to
what constitutes acceptable knowledge were moved, to embrace the concept of multiple truths. It
would seem that she wished to 'turn the tables', and create the feminine as *the* only voice and
metaphorically emasculate the other; as such she suggests feminists should reject postmodernism. Somehow there does not appear to be room for both perspectives, feminists who acknowledge both prefer the term postfeminism (Phoca 1999).

Within the research community, the voice of feminism, is a perspective that allows for the minority voice to speak (see Kitzinger and Wilkinson 1996). Walsh (1993) suggests that feminism is sceptical of all research methods, whereas, Stanley and Wise (1993:161) acknowledge that there is a need to value the self of the researcher; 'all research involves, as it's basis, an interaction, a relationship, between researcher and researched'. On the other hand, Reinharz (1992) is keen to point out that feminism is not a research method, rather it is a perspective, and there is a need to use multiple research methods. There is also a need to address the reader, whereas Lather (1991) suggests there is a need to invite the reader into the text, and that the text should represent multiple voices; relying on quotes, for the reader to determine/locate for themselves how the author develops their argument. Within the research framework/perspective of feminism is the recognition that there is a need for the person who is having the experience to be given a voice, rather than them being the stranger who is somehow not quite involved in the lived experience (Stanley 1997).

Feminism, is 'the analysis of old knowledge and the source of new knowledge: it makes you think,' (Stanley 1997:1). She goes on to talk about the 'borderlands' of this 'new knowledge':

'Here in the borderlands difference is often experienced neither as separation nor as silence, but rather as an interface expressed through the babble of voices speaking together, speaking past each other, in which some voices sound, resound, more than others, and in which echo connotes power. This interface is a frontier that sees the coming and going of peoples, the speaking and silencing of voice's, the casting of gazes which look but do not necessarily see. Around this frontier are gathered the differences of 'race', ethnicity, sexuality, gender, class, age, dis/ability, and more; and it is this frontier which constitutes the cultural space in which 'difference' becomes the point at which epistemological disputes surface around seismic linguistic and ideational shifts. The frontier provides 'the space between' for debate, contention, disagreement.'

Thus there is a need for the researcher to be aware of the concept of 'difference' and how this is culturally defined, and that the exploration of the 'borderlands' represent the challenge of representing the other. Ultimately to explore the language used to describe a situation, and to determine which 'voice' is being privileged and to question why.

2.6 Ethics

Nietzsche is the 'thinker who most radically challenged traditional moral thinking and placed human development at the centre of a value creating system of thought' (Thompson 1994:131). Whereas, Levinas, viewed traditional ethics as secondary to the primacy of the ethical relationship; he 'puts concern for the other at the centre of ethics' (Moran 2000:320). Levinas was influenced by phenomenology (Levinas and Kearney 1986, Moran 2000). As such he 'integrates
phenomenological ontology into dialogical thinking' (de Boer 1986:83). Whereas, Smith (1986:57) suggests that 'ethics is his optics' for understanding intersubjectivity. A key aspect of his work, was the relation to the other, and how it is founded on the ethical principle of putting the other first: to be responsible for the other (Peperzak 1993, Bernasconi 1988). In conversation with Kearney, Levinas states 'My ethical relationship of love for the other stems from the fact that the self cannot survive by itself alone, cannot find meaning within its own being-in-the-world, with the ontology of sameness' (Levinas and Kearney 1986:24). He goes on to say: 'Ethics redefines subjectivity as this heteronomous responsibility, in contrast to autonomous freedom' (Levinas and Kearney 1986:27).

The notion of the 'face' is an important concept, and how the face of the other calls me, to be responsible for him. Levinas (1982:85) states:

'You turn yourself toward the Other as toward an object when you see a nose, eyes, a forehead, a chin, and you can describe them. The best way of encountering the Other is not even to notice the color of his eyes! When one observes the color of the eyes one is not in social relationship with the Other'.

It appears that this responsibility transcends the physical aspect of the Other, rather it is about being with another, not noticing their physical attributes; and it is suggested here that this is a tall order in today's image conscious culture. But this possibly arises out of a rejection of the technical remit, whereby there is sameness, a reduction to the same, and it is this that Levinas questions. Rather than the totalising move of reduction to sameness, there is a need to be accepting of difference, and a willingness to be open to the infiniteness of possibility. Although the concept of 'face' is a metaphor for the personhood of the other (Moran 2000), there is a tendency to think of the face symbolising the other, for Reed (1986:81) states: 'I am responsible not because I cannot hide my face, but because the other person does not hide his'.

Another aspect is how difficult it is to 'capture' this responsibility for the Other, for in the event the 'saying' of this ethical response there is an aliveness. When recounting the event, the 'saying' becomes 'said' and as such there is a deadening. According to Smith (1986:61) 'Saying' belongs to the horizon of sociality that is incommensurable with the text of the 'said' but is its origin and presupposition'. As such the issue of the Other, is about a gap that cannot be bridged (de Boer 1986, Llewelyn 1988).

According to Kearney and Rainwater (1996:112) the philosopher Levinas focused on the 'priority of otherness', a radical alterity that demands our ethical response'; also he raised the question of 'examining the lived experience without presuppositions'. But what are the implications of this for research? Can we meet with another without presuppositions? These questions are fundamental to this research, which focuses on the lived experience of giving and receiving therapy. In relation to the activity of therapy, the meeting of two people; Loewenthal (1996:380) states: 'we should be
concerned with justice on a case by case basis, for real justice cannot be appropriated or territorialized, instead, as with one's clients, one has to be just in the moment with another'. However, researching this activity is difficult, for 'the other cannot be represented by me' (Moran 2000:337). Whereas, Cohen (1986:2) suggests that ethics disrupts knowledge and truth as 'epistemology and ethics only seem to distort one another unrecognisably'. He also suggests that ethics 'is the essentially nonencompassable context, the nonplace, the u-topia, within which knowing “takes place” (Cohen 1986:8). This represents a challenge for this study, how to elicit this 'moment with another' the meeting of the therapist and the client, and the meeting of the researcher with the research participant.

Gordon (1999) in his book *Face to Face: Therapy as Ethics*, makes reference to the influence of Levinas, and suggests the difficulty of the saying and the said, get in the way of representing what happens in therapy. He suggests that there is a gap created 'between what actually happens in a session and any attempt to record or reconstruct it afterwards' (Gordon 1999:60). It is suggested here that this gap is also found between the relationship between the researcher and the researched and how to re-present the event. Gordon (1999) develops his discussion further by suggesting that part of the role of therapist is 'responsibility to the other to allow for openness, formlessness, disorder' (Gordon 1999:62). In relation to research, it is suggested here that there is a need for the researcher to be 'open' to the experience of the other, rather than impose closure on the meeting by providing a set structure, by for example, a pre-determined questionnaire/interview schedule, but to be open to what emerges in the in-between.

The ethical relationship is about putting the Other first; and this is based on notions of difference rather than a reduction to sameness. This relationship has implications for the relationship created between the researcher and the researched. A challenge is how to minimalise the inevitable 'gap' when representing the 'saying' as 'said' that emerges in this activity.

2.7 How the theories and perspectives inform research

A commonality between the theories and perspectives discussed, is the search for meaning, and each has a particular take on how meaning is created; that meaning making is dependent on experience. Phenomenology emphasises the lived experience, and the need to describe the 'what' and the 'how' of the experience rather than to ascribe a fixed meaning. Hermeneutical interpretation, which has its roots in phenomenology, recognises how pre-understanding can provide prejudgements to experience and meaning making; as such there is closure to experience. The meaning derived from an experience is 'fixed' by the previous experience, and as such the 'horizons of knowing' remain unchanged. By adopting an openness to experience, and the ability to reflect on experience, there is the potential for a new understanding to be generated. An understanding which is not 'fixed' rather
that it has the potential for change/ modification in light of further experience, experience that provides further opportunities for expanding the horizons of knowing. Thus meaning making is never complete; it is always in a state of becoming.

Psychoanalytic theory provides a framework for meaning making/interpretation that is dependent on both conscious and unconscious elements. Previous experiences are stored in the unconscious and have the potential to impact on future experiences. As such these transferential issues are crucial to the meaning making process; when we confer meaning we do so from past experience, and as such it can be an illusion to ‘experience the experience’; for there is always something prior to, which shapes the interpretation of the experience. Being aware of how past experiences may inform future meanings, derived from experience, enhances the ability to experience the experience as ‘is now’, in preference to ‘as then’.

Postmodernism challenged the modernist tradition of a definitive truth being elicited; rather there is multiplicity of meanings. That meanings are construed in the moment and are dependent on the experiencer, the context, and the interaction with the other interlocutors involved. There is a recognition of how the experiencer is not at the centre of the meaning making process, rather that they are subject to; when we speak we do so from a particular position. Language is the medium for articulating this position, however, language is found wanting, for it is impossible to provide descriptions that mirror the reality of an experience. Also in the recounting of an experience, further experiences will have taken place, which have the potential for contaminating the account of the first experience. As such there is always a gap between the experience and recounting it to another, another gap is between the meaning conferred to the receiver of the account of the experience, and the meaning the receiver makes of the account. As such meaning is a slippery concept; it is difficult to grasp. And in this grasping there is a propensity to ascribe a fixed meaning.

A feminist perspective further develops the theme of the multiplicity of meaning by recognising that the language used to describe an experience is masculine, subsequently women’s experience is reduced to what can be spoken about in the male dominant discourse. As such there is a silencing of women’s voices. By bringing in the marginalised voice, there is the opportunity for the voice of the other to be heard. However, there is need to be mindful how this privileging of one voice over the other, is temporary, otherwise there is the potential for creating a reverse marginalisation, and a closure to difference. It is not one or the other, but rather that in difference each have a place; they are as good as, or as valid as. The challenge is how to represent the minority voice; a voice not just restricted to women, but to other oppressed groups e.g. races, disability, and social classes.
Our ethical responsibility to the other is based on not reducing all to the same, it is only in difference we can avoid totalising moves, and meet with the other, and subsequently to put the other first. It is also acknowledged that this meeting with another is in the moment, and attempts to convert the ‘saying’ into the ‘said’ represents an attempt to fix meaning on the meeting, that there will always be a gap between the meeting and attempts to represent it. It is difficult to represent the meaning making that emerges in the in-between.

All of the theories and perspectives support the view that ‘meaning making’ emanating from an experience is a continuous ongoing project, that there is not a definitive meaning or ‘truth’, rather ‘truth’ is in the moment. The elicitation of this meaning is dependent on the struggle over the interpretation and definition of the experience (Kincheloe and McLaren 1994:44).

This representation of experience is fundamental to the research process; ‘Experience is the only evidence’ (Laing 1967:16) [original emphasis]. All of the theories and perspectives discussed have implications for the research process. Phenomenology is concerned with the lived experience, and the need for the researcher to bracket their experience of the phenomenon, in an attempt to not provide foreclosure on the experience of the other. This is also recognised as fundamental to the ethical relationship posed by Levinas, who was influenced by phenomenology. There is the need for the researcher to come to the study without presupposition, so that in the meeting with the other, there is the potential for meaning to emerge in the in-between, between the researcher and the researched. Transferential issues as defined by psychoanalytic theory, give credence how the process of research is a subjective and relational activity.

The implications of hermeneutical interpretation for research is how interpretation is a cyclical process, one that is based on reflection; ‘reflection on a given pre-understanding brings before me something that otherwise happens behind my back’ (Gadamer 1967:38) [original emphasis]. This act expands the horizons of knowing, and opens up to new knowing/meaning making, rather than reducing what is being experienced to what is already known. It is also about questioning, and the ‘ability to see what is questionable’ (Gadamer 1976:13). There is a need for the researcher to be reflexive. Reflexivity is about being able to move beyond the level of straightforward interpretation (Woolgar 1988:16). He suggests that there are many varieties of reflexivity from ‘radical constitutive’ at one end of the continuum, to ‘benign introspection’ at the other. It is the former that is cognisant with the view that there is a not one definitive meaning, rather that meaning is an illusive concept, and it can only be grasped in the moment. Radical constitutive reflexivity involves a ‘back and forth process’ focusing on the interdependency between representation and the phenomenon. Inherent to this activity is the ability to question, to be open to the possibility of expanding the horizon of knowing.
Postmodernism challenges the scientific claims of modernism, and there is recognition of how the
grand-narratives of modernism are replaced with local or situated narratives of postmodernism, as
such knowledge is practical. Feminism also challenges scientific knowledge suggesting that it is a
technique that renders women invisible, there is a need to encompass diversity over sameness.
Experience is privileged over theory, and the research participants are involved in the research
process not as objects but as subjects; for the lived experience is their story. Both feminist and
postmodern perspective advocate the multiplicity of research methods, and the need for the text to
represent the multiple voices, and to address the reader, inviting them into the meaning making
process.

All the theories and perspectives discussed appear to be questioning the dominant voice of science,
and suggesting that there are other ways, ways which acknowledge that meaning is not a universal
given, a fixed entity, rather it is an ongoing process. We each create our own meaning from
experience and are influenced by previous experiences, and our ability to locate our experience in
language. There appears to be a recognition of the need to move away from the ‘technical’ remit of
science to embracing humanness.

To open up a conversation about a way of looking at psychotherapy as a form of learning, there is a
need to identify the research paradigm within which this conversation will be situated. A paradigm
that is developed from the current paradigms, for to choose a predetermined paradigm, would not
correlate with the reason given for eliciting the interpretative lens of the researcher, i.e. it (in)forms
the research paradigm. Rather than use a ‘best fit’ paradigm, a paradigm will be developed from the
current paradigms; thus supporting the notion that the construction of knowledge is personal.

3. A research paradigm for this study

To illustrate how the ontological, epistemological and methodological components integrate to form
a research paradigm, the four research paradigms of positivism, post-positivism, critical theory, and
constructivism as defined by Guba and Lincoln (1994) will be briefly explored. They suggest that
their definitions which are derived from the field of social sciences, are ‘tentative and subject to
further revision and reformulation’ (Guba and Lincoln 1994:109). Following on from the discussion
of these paradigms, the ontological, epistemological and methodological components of the research
paradigm developed for this study will be explored.

Positivism: The ontological perspective (what is there that can be known) is ‘realism’ whereby there
is a known reality, epistemologically (relationship between knower and what can be known), there is
a ‘dualist and objectivist’ perspective, whereby there is no relationship between the researcher and
the object/subject researched. Methodologically (how to find out whether what is thought to be known can be known) there is a reliance on quantitative techniques, the testing out of hypothesis and the controlling of variables which contaminate the findings. As previously stated this paradigm is not cognisant with the underpinning ethos of this study, the privileging of humanness in preference to science and technology.

Post-positivism: The ontological perspective is 'critical realism' whereby reality can only be partially known, epistemologically, there is a 'modified dualist and objectivist' stance, whereby there is recognition given to the relationship between the researcher and the researched, however it is objectified. Methodologically there is a reliance on 'modified experimental and manipulate', or qualitative techniques. As such positivism is the “received view” and post-positivism responds ‘in a limited way (that is, while remaining within essentially the same set of basic beliefs) to the most problematic criticism of positivism’ (Guba and Lincoln 1994:109). Post-positivism is an overarching term, whereby there is a privileging of humanness, there are however, varying degrees to this, in this category it is ‘in a limited way’; the next two paradigms embrace humanness to a greater extent. They are therefore considered to be more relevant to this study. Each paradigm will be defined followed by a discussion of how they inform the development of a paradigm for this study.

Critical Theory: The ontological perspective is ‘historical realism’ whereby there is a virtual historical reality, epistemologically there is a ‘transactional and subjectivist’ stance, whereby the researcher and the researcher are interactively linked, and the values of the researcher are influential. As such the findings are value mediated, and there is a blurring of the ontological and epistemological, for ‘what can be known is inextricably intertwined with the interaction between a particular investigator and a particular object or group’ (Guba and Lincoln 1994:110) [original emphasis]. Methodologically there is reliance on ‘dialogic and dialectical’ techniques, and the researchers views are transformed through the process. According to Kincheloe and McLaren (1994:157) ‘critical research traditions have arrived at the point where they recognize the claims to truth are always discursively situated and implicated in relations of power’; whereas, Olesen (1994:158) suggests that ‘interpretative human actions ... can be the focus of research’. As such, there is an increasing recognition of the scope of research, and how knowledge is local and situated.

Constructivism: The ontological perspective is ‘relativist’ whereby ‘realities are apprehendable in the form of multiple, intangible mental constructions’ (Guba and Lincoln 1994:110). As such reality is ‘local and specific’, however, there may be some commonality with others. The epistemological stance is the same as critical theory ‘transactional and subjectivist’ but there is a difference in that the findings are created as the investigation proceeds, there is also a merging of
ontological and epistemological perspectives. The resulting constructions 'are not more or less "true", in any absolute sense, but simply more or less informed and/or sophisticated' (Guba and Lincoln 1994: 111). Methodologically there is a reliance on 'hermeneutical and dialectical' techniques, and that 'individual constructions can be elicited and refined only through interaction between and among investigator and respondents' (Guba and Lincoln 1994:111) [original emphasis]. Constructivism is a branch of qualitative research, and recognition is given to how knowledge, in a relative sense, is created through formations of ever more constructions (Schwandt 1994). As such constructivists 'reconstruct the “world” at the only point at which it exists; in the minds of the constructors. It is the mind that is to be transformed, not the “real” world' (Guba 1990:27) [original emphasis].

Elements of critical theory and constructivism inform the paradigm that will guide this study, and this is now explored. The ontological perspective that informs the inquiry is relativist, and like the constructivist paradigm there is the recognition of how the meanings that are generated are multiple and intangible. However, there is a difference in that this meaning emerges in the in in-between, between the researcher and the research participant rather than through the process of the inquiry. The epistemological perspective is interactional subjective, that is meaning is generated through the relationship between the researcher and the research participant in the first instance, and then between the researcher and the data analysis, and between the researcher and the research report. Acknowledgement is given to how at each stage, there is the potential for an uncovering of the multiplicity of meanings generated in the inquiry, and the final report is a re-presentation of the multi-layering perspectives that inform the understanding of the phenomenon of the inquiry.

There is a blurring of the ontological and epistemological perspectives, whereby the ethical relationship developed between the researcher and research participant is founded on the ethical principle of recognising the alterity of the other; subjectivity is found in difference. The meaning that emerges in the in-between is in the moment and dependent on the interlocutors, and is thus context specific, or situated. This contrasts with the transactional subjectivist epistemological perspective of both critical theory and constructivism. There is however, a similarity in how both are interpreted due to the merging with the ontological perspective. Constructivism's ontological perspective is relativism, and as such meaning emerges through the process of the inquiry. Whereas, the ontological perspective of critical theory is historical realism, and how truth claims are discursively situated and dependent on power relations. The meaning generated is therefore interactively linked with the researcher's values.

The methodological perspective of the paradigm for this study is reflexive and dialectical. The dialectical component is shared with both constructivism and critical theory, whereby what is being
proposed is a systematic reasoning of the phenomenon of the inquiry. The reflexive component represents a generic term that incorporates the hermeneutical element of constructivism and the dialogical element of critical theory. In hermeneutics, meaning is generated in a back and forth processes, during which pre-understanding, or the presuppositions which informs the interpretative process, are transformed into understanding. This understanding then becomes the pre-understanding that informs the next interpretative process; there is thus the potential to expand the horizons of knowing infinitely. Meanings generated in a hermeneutical inquiry are developed and refined between researcher and research participant. However, within the interactional subjective perspective of the paradigm that informs this study, meaning emerges in the in-between, this in-between extends beyond between the researcher and the research participant, to the in-between the researcher and the data analysis, and the researcher and the research report; all three activities have the potential to generate a 'snapshot' of the multiplicity of meanings of the phenomenon, that are generated through the research process.

The research paradigm informs the methodological framework and provides a coherency to the research process in action; this will be explored next.

4. A methodological framework to be tested out in this study

The methodological framework provides a structure to guide the study. The use of the word 'structure' can be misleading, for it appears to be at odds with a study that embraces a postmodern perspective. However, the framework provides coherence to the development of a conversation on a way of looking at psychotherapy as a form of learning. The framework embraces the notion of multiple meanings, and is premised on the interpretative lens of the researcher and how this informs paradigm choices and the selection of the topic to be researched and the questions posed.

The topic for research in this study is to develop a way of looking at psychotherapy as a form of learning. The research question: Is therapy a form of learning for people with a facial difference? This question then informs the research design and method. The research design provides clarity of the purpose of the study and the question posed (Denzin and Lincoln 1998). The question is contextualised or situated in a field of experience. The method is a way of generating data to explore the question posed. The use of the word 'explore' as opposed to 'answer' supports the notion of a multiplicity of meanings, meaning making is infinite. To 'explore' suggests a process; to 'answer' suggests a definitive outcome. This view embraces the ontological perspective of relativism of the research paradigm of this study.

The meeting of the research participant and the researcher generates data for analysis. Thus the data is generated in the in-between, between the research participant and researcher. The meaning that
emerges is interactional subjective, for it is apprehended through dialogue, and this correlates with the epistemological perspective of the research paradigm of this study. This also correlates with the ontological perspective, for meaning is generated in the in-between and there is a propensity for multiple meanings to emerge.

The analysis of data involves a back and forth process, the researcher moves between the data and generation of new meaning. This reflexivity is an integral component of the research paradigm’s methodological perspective, as is the questioning, dialectical stance adopted throughout the research process. The construction of meaning (the findings) represents the meaning that emerges in the in-between, between the researcher and the data. To embrace the concept of multiple meanings the analysis of data does not stop with the construction. For this construction forms the pre-understanding of a further analysis of the construction, an activity which culminates in the creation of a secondary construction. This is premised on a deconstruction, whereby hidden meanings in the text are elicited (Howells 1999, Norris 1982). This construction emerges in-between the researcher and the text. This cycle of primary construction and secondary construction could be repeated infinitely. However, to meet with the aim of this study, to develop a model to open up further conversations on a way of looking at psychotherapy as a form of learning, there is a need to reach a conclusion, albeit a tentative one. Thus, the meaning that emerges from the secondary construction is an at-the-time understanding of the phenomenon; it is the pre-understanding that informs a critique of the research process. This critique supports the notion that meaning making is an ongoing process. As the critique involves each stage of the research process, information is generated on the testing out of the framework in practice.

To summarise, the methodological framework is process comprising of nine stages:

1. The interpretative lens of the researcher is made explicit.
2. The research question influences the research design, and there is a need for the researcher to identify the research field and the selection of an appropriate research method to guide the study.
3. The research method provides a framework for the generation of data, the meeting between the researcher and the research participant who has experience of the phenomenon of the study.
4. The research method also provides a structure for the analysis of the data.
5. The analysis of data culminates in a primary construction of the researchers understanding of the phenomena that has emerged from the data.
6. The meaning emerging from the primary construction forms the pre-understanding that informs a revisiting of the construction, to elicit the hidden meanings in the text.
7. A secondary construction of the meaning(s) generated in the inquiry is provided and there is recognition to the multiplicity of meanings inherent in the experience of the phenomenon.
8. This leads to an understanding of the phenomenon.

9. Which forms the pre-understanding of a revisiting of each stage of the research process: (a) research design and method, (b) data generation, (c) data analysis, (d) primary construction, (e) secondary construction, (f) understanding of the phenomena, and culminates in a critique of the research process. This supports the concept that meaning making is an ongoing process; that the meanings emerging from the inquiry are tentative.

Conclusion

The initial discussion provided a definition of research, followed by a discussion of research paradigms, and how they are comprised of three interdependent elements, ontology, epistemology and methodology. The two main paradigms of positivistic (quantitative) and post-positivistic (qualitative) were explored. Within the post-positivistic paradigm there has been over the past sixty years, a movement towards the increasing recognition of the relationship developed between the researcher and the researched, and the researcher and the sense made out of the emerging data, and the written report. As such there is an increasing recognition of the difficulties encountered when representing the other, and the need for the exploration of these tensions within the research process. There is recognition of how the positivistic paradigm gives primacy to science and technology and the post-positivistic paradigm a relegation of this, a return to humanness is fostered; and this supports the underpinning ethos of this study.

With the increasing recognition of the researchers' impact on the research process, there is a need for the researcher to elicit the interpretative lens they bring to the study. This informs the development of a research paradigm; the ontological perspective is relativist, the epistemological perspective is interactional subjective and the methodological perspective is dialectical and reflexive. The paradigm then informs the creation of a methodological framework that will be tested out in this study. The framework comprises of nine stages, and includes two cycles of interpretation. The first cycle culminates in the creation of a primary construction of the findings; this understanding forms the pre-understanding for the next cycle of interpretation, which culminates in the creation of a secondary construction. The understanding that emerges from this informs a critique of the research process.

The research paradigm informs the selection of a research method, a method to guide the research process, a process that is structured by the methodological framework. The next chapter focuses on the research design and the selection of a method to guide this study; to test out the methodological framework.
Chapter Four

Research design

Introduction

The aim of this chapter is to describe the research design and represents stage two of the methodological framework (the first stage—pre-understanding—the theories and perspectives that inform the study were discussed in chapter 3, section 2). A research design ‘involves a clear focus on the research question and the purpose of the study’ (Denzin and Lincoln 1998:28). The purpose of this study is to open a conversation, on a way of looking at psychotherapy as a form of learning. From this exploration the intention is to develop a model to enable practitioners to generate conversations on how psychotherapy can be positioned as a form of learning. The question for exploration; is counselling/psychotherapy a form of learning for people with a facial difference?

There are potentially at least three ways of generating data to explore this question, participants could be asked to share their experiences of learning in therapy, this could be achieved either by the researcher asking specific questions on different types of learning. Or they could be invited to talk about their learning experiences per se, without providing a framework to guide the discussion. Both of these approaches to a greater or lesser extent provide a predetermined structure that will enable the answering of the question posed by the researcher. There is an assumption made that the person will have learned through the experience of therapy, rather than the aim being to open up a conversation on the experience of therapy. To hear of the experience of therapy without imposing a pre-determined structure would be to ask people to share their lived experience of therapy. From this, learning experiences may be elicited; learning that emanates within the field. This third way of generating data is more in keeping with the underpinning ethos of this study, a privileging of humanness; an openness to the experience of the other.

The design of the study is influenced by the research question, initially there is a need to contextualise the question, to define the parameters of the research field. This will firstly be achieved by focusing on the macro perspective which defines the general focus of the research question; the therapeutic relationship, and then secondly focusing on the micro perspective, which is the specific focus of the research question; facial difference. As such the macro view is the ‘what’ and the micro view is the ‘who’ of the study.

Once the research field has been defined, there is need to select an appropriate research method to guide the research process, a process that involves data generation, analysis and discussion, and
culminates in the research report. Again there is a requirement that the method is cognisant with the underpinning ethos of the study. The section on the selection of a research method, commences with a discussion on how the research paradigm informs the selection of a research method, followed by an exploration of the following methods that may guide this study: grounded theory, heuristics, case study and discourse analysis. A discussion of why the heuristic method was chosen concludes this chapter.

1. The research field
The research field represents the parameters of the question. Whereby the macro perspective is the general focus of the research question, that is counselling/ psychotherapy as a form of learning. The area of interest is the therapeutic relationship, which is dependent on the meeting of a therapist and a client, and that the potential outcome of this meeting is learning. The micro perspective is the specific focus of the research question; people with a facial difference. Thus the client should have a facial difference, and the therapist have experience of working with someone with a facial difference. It is suggested here that the researcher needs to extrapolate both aspects of the research field to enable the selection of an appropriate method, to guide the research process, which culminates in an exploration of the question posed.

1.1 Macro perspective
The area of interest is the therapeutic relationship, which is dependent on the meeting of a therapist with a client. The client brings to the therapeutic relationship, their current difficulties in living and relating. They bring to the relationship their experience of living with others in a family unit, and of living in a community. The therapist brings with them to the therapeutic relationship, training and supervision experiences in providing therapy; this may also include their own experience of personal therapy. They will also have their life experiences of living in a family unit and a community, which have the potential to inform the therapeutic relationship. Together, the therapist and client create a working alliance, a therapeutic relationship (see Horvath and Greenberg 1994).

The meeting of the client and therapist, and the ensuing therapeutic relationship, creates a potential learning community. This learning milieu is a form of situated learning whereby, the situation or the context is the therapeutic relationship, created by the meeting of the client and the therapist. Within this ‘learning community’, there is the potential for recognising the barriers to learning from experience. Learning from experience is a fundamental requisite to learning, whereby an individual is able to experience their own experience. The recognition of the barriers to learning that emanate from distortions in previous learning experiences may be explored and the potential outcome is a return to learning from experience. Although the focus within this learning community is the client, there is the potential for the therapist to learn from the client, this learning is usually covert, whereas
the clients learning is usually overt and worked through in the here and now with the therapist. Whereas, the therapists learning may be worked through either in supervision, or in their own therapy, or their own reflective processing. For learning to take place within the therapeutic relationship there is a need for both the therapist and the client to be open to the experience of the other.

The learning community created by the meeting of the client and the therapist is situated within the lifeworld. The term lifeworld (Lebenswelt) was first used by Husserl, to describe the world as is, the given. Accordingly he suggests that all researchers have at the basis of any inquiry the lifeworld, ‘it is always presupposed as the ground, as the field work upon which alone his questions, his methods of thoughts make sense’ (Husserl 1935:11).

Habermas developed the concept of the lifeworld, by suggesting that a common language within the lifeworld enables an individual to participate, to communicate, and to interact with others. Also that identity is created through interactions, and as such there is the potential for the boundary of a particular lifeworld to be expanded, experience affords the opportunity to expand understanding, and thus expand the knowable aspects of the lifeworld available to consciousness. Thus the therapeutic relationship has the potential for expanding understanding and the sense made from experiences that emanate from within the lifeworld. Habermas, also recognises that within the lifeworld, experiences and meanings are not fixed: ‘Even collective identities dance back and forth in the flux of interpretations, and are actually more suited to the image of a fragile network than that of a stable centre of self-reflection’ (Habermas 1985: 358). Thus supporting the notion that meaning is context specific and dependent on the interlocutors involved; in the context of the therapeutic relationship it is the meaning that emerges in-between the meeting of the therapist and the client.

1.2 Micro perspective

The micro perspective is the specific focus of the research question, facial difference. From the micro perspective the client will bring to therapy their experience of having a facial difference, and some degree of difficulty in living with this difference that has precipitated the need for therapy. The therapist will have experience of working with clients with a facial difference. Within the relationship, the client is able to explore their thoughts and feelings, beliefs and attitudes regarding their facial difference and how it impacts on their relationships with others. The number of people with a facial difference who have accessed therapy is unknown, and to provide another perspective, the term ‘client’ is enlarged to include people who have an opinion on therapy. Also, rather than limiting it to those with a facial difference, those living with a person with a facial difference are also included, these people may or may not have had therapy. Again the intention is to provide an
additional perspective, to further elicit the specific context of the lived experience of facial difference and the potential need for therapy as a form of learning.

There are four different groups of research participant, the first two groups are therapists and clients. The therapist will have experience of working with people with a facial difference. The intention is to exclude other experiences of providing therapy, and thereby to keep the focus on those clients who have a facial difference. The client will have a facial difference, and has experienced a therapeutic relationship. Both of these groups have direct experience of the lived experience of therapy. Whereas the next two groups do not, they have been included in the study to provide additional information that may further illuminate the question posed; to generate data on what may precipitate the need for therapy as a form of learning. The first group are people with a facial difference who have not had therapy but have an opinion on therapy either for themselves or for others with a facial difference. The next group is people who live with someone with a facial difference. The analysis of the data generated by the participants should enable learning experiences to be highlighted, together with an understanding of the issues that may precipitate the need for therapy as a form of learning. From this, a model may be developed to enable others to explore psychotherapy as a form of learning; to open up further conversations.

There are many aspects of the lifeworld that may inform the research participants lived experience. The intention here is to not isolate these confounding variables but to acknowledge the possibility of how they contribute and influence how a person perceives their experience; their take on reality.

The variables identified, are ones that the researcher is currently aware of, from the literature reviews and her own experience. Each will be briefly mentioned, and links made with the relevant literature. Age, this would appear to effect how a person perceives their situation, according to Bradbury (1996) a mid-life crisis may trigger concerns about appearance related issues, for the person with a facial difference it may awaken previously not thought through aspects of their difference, for example ‘why me?’ Class, according to Rumsey (1997:94) the ability to pay for surgical and orthodontic treatment is expensive and with the cutting back by NHS providers on non-functional surgery (e.g. cosmetic surgery) creates a situation whereby ‘further discrimination between the rich and the poor’ for those with a facial difference. Linked with this is financial security, as this may effect a person’s ability to pay for surgery, or therapy. Culture, a culture defines beauty and acceptability, some cultures shun those with a facial difference (Rumsey 1997), whereas, the Asian culture perceive facial difference as ‘fate’ or ‘Karma’ and those with the difference are expected to bear it stoically (Partridge 1997). Furthermore, Rumsey (1997) cites Strauss (1985) who highlights that the impact of culture and societal values is an uninvestigated area in the field of congenital anomalies. Education, it is recognised that for some the level of
educational attainment may effect their resilience when coping with facial difference (Coles-Gale 2000, Robinson 1997a). Occupation, the presence of a facial difference can have implications for work opportunities (Stevenage and Mckay 1999). Gender, there is a commonly held view that women worry more about appearance than men (Solomon 1998, Woolfe 1990). Race, a study by Solomon (1998) highlighted the lack of literature available on black women's experience of burn injury, and likened the experience to 'being on an island by myself'. There are potentially many more, but at this stage they are unknown.

2. Research methods

This section contains a discussion of the research methods that were considered for guiding this study, to develop a conversation on how to look at psychotherapy as a form of learning. Initially the lived experience of therapy will be elicited and from this, learning that is intrinsic to the therapeutic process will be identified. This understanding then informs the development of a model to look at psychotherapy as a form of learning, this has the potential of opening up further conversations with unknown others.

The method needs to correlate with the ethos of the research paradigm. The methodological perspective is reflexive and dialectical and the ontological perspective is that meaning emerges in the in-between. It is created by the two interlocutors involved, and can only be apprehended by them in the moment, can only ever be known fully to them, as such meanings are multiple and intangible. The epistemological perspective is that knowing is subjective, that it is apprehended through communion with others as such it is an interactional subjective phenomenon. The methodological, ontological and epistemological perspectives are interdependent.

One the one hand, within the research paradigm developed for this study, it would seem that to represent what happens between the researcher and the research participant is an impossibility, particularly if it is only known to those involved. Yet on the other hand, the researcher can re-tell their perception of the experience to an unknown other (the reader of the research report), and that this re-telling can be authenticated in several ways, initially by conferring with the research participants that the data generated captures their experience. When creating the research report the researcher can reveal the inherent difficulties in re-presenting the 'saying' (where the saying is what happened between the researcher and the research participant, in the re-telling it is translated into the 'said'); that the report is a testament of the meaning that emerged between the researcher and the research participant (an interactional subjective activity). By conducting a secondary construction of the primary construction which forms the pre-understanding of the next cycle of interpretation, the researcher demonstrates that meanings are multiple and tangible, and recognition is given to the
fundamental concept of reflexivity. Fundamental, for without it there would be no recognition of how meanings are multiple, or that the generation and interpretation of data is a human activity.

To select a method, that is mindful of these factors can be difficult, for on the one hand a method is an anathema when there is an attempt to foster an openness to experience, the very use of the terms ‘method’ and ‘framework’ appear to imply a closure. However, on the other hand, the use of a method can provide coherence to data generation and analysis, thereby creating a degree of certainty in the midst of uncertainty.

From the plethora of methods available, the focus on hermeneutical and phenomenological approaches is appropriate; for research is all about ascribing meaning to a phenomenon. A phenomenon that is already partly known to the researcher and this constitutes their pre-understanding, through the process of conducting the research process new understanding emerges. The researcher through the process of description and interpretation re-presents their newly acquired understanding of the phenomenon for others. Both of these activities draw on the theories of hermeneutics and phenomenology. These theories were explored in chapter three, section two, as they inform the researchers interpretative lens; the explication of this lens is the first stage of the methodological framework that guides this study.

Methods that incorporate these theories are viewed as potential methods and another factor to be considered is the research design, and the need for the method to embrace the ethos of capturing the ‘lived experience’. For it is believed that explication of this will provide hitherto unknown information on the experience of therapy, and from this elicitation it may be possible to discern the learning activities inherent within the therapeutic relationship; as such to make overt the current covert aspect of therapy. From this a model may be developed to enable practitioners to open up conversations about their own practice; it offers a way of looking at psychotherapy as a form of learning.

The researcher whilst acknowledging that there are many approaches and methods to guide the research process, has focused on the following; grounded theory (Glaser and Strauss 1967) is said to incorporate elements of both hermeneutics and phenomenology, so it will be explored as a possible method to guide this study. Heuristics is an approach that lies under the umbrella term of phenomenology (Moustakas 1994); therefore it too will be explored. The case study method, can be representative of both quantitative and qualitative approaches (Yin 1994), there are descriptive elements, and as such it could be said that it is informed by hermeneutic and phenomenological thinking. Discourse analysis as a method is difficult to describe; it is concerned with meaning making emerging from discourse (Parker 1990, Potter 1997), where language is seen to construct
events, rather than being seen as a transparent medium (Coyle 1995). Each method will be briefly defined, the key characteristics of the approach highlighted, a discussion of the selection of one method to conduct this study concludes this section.

2.1 Grounded theory

Grounded theory is an approach that was introduced by Glaser and Strauss (1967). The primary intention is that the theory that emerges in the process of a study is grounded in the research process, a process that involves the systematic gathering and analysis of data (Strauss and Corbin 1990, Glaser and Strauss 1967). It is a method that encourages 'latitude for ingenuity and an aid to creativity' (Strauss and Corbin 1990:273). It also is used mainly when the researchers aim is to make generalisations from the theory that is generated in the course of a study (Strauss and Corbin 1997). Literature pertaining to the phenomenon is reviewed following collection and analysis of data. There is a reliance on description and interpretation, and as such it draws on both hermeneutics and phenomenology.

The researcher by reading and re-reading the data, which is generally in the form of transcripts of interview data [primary source of data] (Moustakas 1994, Strauss and Corbin 1994); codifies and groups emerging themes together (O'Callaghan 1996). This coding assists with conveying credibility (Glaser and Strauss 1967).

The sample size is usually small, and increases as the emerging theory is tested out with another group of people who have experience of the phenomenon. Each testing out of the theory has the potential for further aspects to be illuminated; the process of checking out emerging theory continues until no new aspects of the phenomenon emerge (Strauss and Corbin 1990). Initially understanding is checked out with those involved (specificity) and this then acts as a guide for generalising. The researcher is actively involved in the meaning making process, as they are required to interpret the phenomenon, and to verify the emerging concepts. As such grounded theory is ‘a way of thinking about and conceptualising data’ (Strauss and Corbin 1990:274) [original emphasis].

The focus of a grounded theory method is to elicit the understanding and the representation of how meaning is conferred on an experience and the resultant human behaviour (Strauss and Corbin 1990). The concern is not individual responses to a given situation; rather it is about eliciting patterns of actions, the discovery of processes which can then be presumed to be the general response to the given situation (Strauss and Corbin 1990).
2.2 Heuristics

This method is rooted in the phenomenological approach (Moustakas 1994). Whereas, Churchill et al (1998:64) commenting on the interpretative aspects of the phenomenological approach suggest that Heidegger's notion of foresight and Husserl's notion of anticipation informs this process. As such they suggest there are two preparatory moments of interpretation, intuition (which is about familiarising self with the phenomenon or living it) and analysis in which the researcher 'discern the constituents of the phenomenon'. Thus it would seem that it is difficult to isolate phenomenology and hermeneutics, that whilst phenomenology is about describing a phenomenon, there is a tendency for the researcher to interpret the description.

'Interpretation calls for us to take a deep breath and turn inside while considering our data and the experiences of collecting them to imagine, reflect, and ultimately understand what we experienced in our research. It is probably only partly a rational process and also partly an intuitive one' (McCutcheon 1990:281). This reference of intuition underpins the heuristic approach as defined by Moustakas (1990); he suggests that intuition is founded on the principle of tacit knowing as defined by Polanyi (1967), whereby we know more than we can tell. Whereas, Benner (1994:xvii) appears to be advising caution when interpreting data, and is mindful of the need for the researcher to be aware of their own understanding of the phenomenon of the study, she states: 'Good interpretation is guided by an ethic of understanding and responsiveness, one must not read into the text what is not there. Self-knowledge is required to limit the interpreters projection of his or her own world onto the text'.

According to von Eckartsberg (1998:21) adopting a phenomenological approach to research enables the researcher to 'reveal the essential general meaning structure of a given phenomenon in answer to implicit research guiding questions: what it is essentially'. There is a reliance on description, and there is a need for the researcher to bracket their experience of the phenomenon (Spinelli 1989). Whereas, Moustakas (1990) considered a strength of a heuristic inquiry is that the researcher is actively involved in the process, and that the first step is the need for the researcher to own a personal issue, an issue that provides the impetus for the study (Douglas and Moustakas 1985, Moustakas 1981). According to Patton (1990:71) a heuristic inquiry 'brings to the fore the personal experience and insights of the researcher'.

'A heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate' (Moustakas 1990:15). A similarity with hermeneutics, but where the variation occurs is that 'the question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives' (Moustakas 1990:20). Reflexivity is an essential element in a heuristic inquiry, and there is a need for the researcher to keep a journal to
track the meaning making process (Moustakas 1990). Keeping a journal, according to Bungay and Keddy (1996) is a record of thoughts and feelings and can make the researcher's role explicit, they are therefore more active in the meaning making process. It is suggested here that a journal can also assist in making known the processes that informs their interpretation. Without this reflexivity there could be the tendency for the study to be focused too much on the self of the researcher and their experience of the phenomenon, however, by referring to their journal it could be said that that there is the potential for the dialectical element of meaning making to be foregrounded.

There is also the potential for consensus collusion (Torbet 1981) whereby the researcher only hears the story of the other if it resonates with theirs. As such there is a foreclosure applied to hearing the lived experience of the other. The support of an independent person, who is involved in hearing of the researchers meaning making/interpretative process, can restore an element of openness to hearing the story of the other (Rose and Loewenthal 1998).

The stages of conducting a heuristic inquiry involve collection of material, immersion in the material, incubation and illumination. The final report representing the lived experience of the phenomenon as shared by the researcher and the research participant (Moustakas 1990). The process can be lengthy, and as such there is no time limit to the process (Storey 1995). The researcher continues until there is a sense that the essence of the phenomenon is captured (Moustakas 1990). An example of a heuristic inquiry in the field of facial difference is the authors previous study (Rose 1997) and in relation to psychotherapy (Sussman 2001, West 1998).

2.3 Case study

As a research method, case study is more about description in preference to ascribing meaning (Stake 1994, Yin 1994); it is a method that has been applied by many disciplines (Bergen and White 2000). 'Case study is not a methodological choice, but a choice of object to be studied' (Stake 1994: 236). This implies that the participant in the study is an object rather than a subject who is actively involved in the process. Also there is a need for the researcher to be aware that they cannot tell the whole story, for 'the whole story exceeds anyone's knowing, anyone's telling' (Stake 1994:240). Thus a case study may provide an in-depth insight into a particular phenomenon, for it is about reporting the real life context (Yin 1994, Robson 1993). A popular misconception is that a case study is singular, however it can also be collective (Stake 1994, Yin 1994, Robson 1993). It can also draw on evidence from 'documents, archival records, interviews, direct observation, participant observation, physical artefacts' (Yin 1994:78). Whereas, Hamel (1993) includes field studies. It can contain both quantitative and qualitative elements, and the evidence can be used to explain, describe, illustrate and explore the phenomenon. Alternatively it can provide a meta-evaluation (Yin 1994).
Through the process of being involved in the case, the researchers' written account represents both the process and product of their learning (Stake 1994).

Examples of case studies in the field of facial difference are by Milioria (1998) and Niederland (1975); they provide an account of the therapeutic process and draw on psychoanalytic theory to support their discussion. Within the field of psychotherapy, Freud drew exclusively on case studies to support his newly founded psychoanalytic theory. The application of a case study method, is more about description of the life event being studied, as such there is a need to provide verbatim account, to enable the reader to get a flavour of what went on (Yin 1994, Hamel 1993).

2.4 Discourse analysis

We use language to describe, to explain and to discuss the meanings conferred on experience. The language used is not transparent, rather it constructs events (Coyle 1995). According to Parker (1992:5) our discourse is 'a system of statements which construct an object' and that discourse analysis 'deliberately systematises different ways of talking so that we can understand them better' [original emphasis]. As such, the analysis of discourses 'emphasises the way versions of the world, of society, events and inner psychological worlds are produced in discourse' (Potter 1996:145). Thus it would appear that a key concern is with meaning, either the uncovering of meaning (Dickerson 1996), or the dynamics of meaning (Parker 1992), and/or the multiplicity of meanings (Coyle 1995).

As a research method it is hard to describe and learn (Potter 1997); there is no rigid framework to employ (Coyle 1995, Potter and Wetherell 1994). For it is a 'craft skill' and a process that relies on 'tacit knowledge' (Potter and Wetherell 1994). There is a need for both the researcher and the research participant to be reflexive (Potter 1996, Parker 1992); 'reflexivity is used to denote our deliberate awareness of our place in things and our difference from others' (Parker 1992:79). There is as such no end result, rather the researcher generates hypothesis (Coyle 1995); also the reader of the work may offer a different interpretation (Potter 1996). Therefore a definitive meaning will not emerge from a study, rather that there is a multiplicity of meanings, and this locates the method with the postmodern paradigm.

Although recognising that there is no rigid framework to conduct an analysis of discourse, Potter and Wetherell (1987:175) devised a ten-stage model which they state is 'a set of suggestions about how discourse can be best studied and how others can be convinced findings are genuine'. The ten-stages involve questions, sampling, collection of records and documents, interviewing, transcription, intermission, coding, analysis, validation, the report, and application. Of particular note is the reference to interviewing, and the style; where the researcher makes the interview 'a much more
interventionist and confrontative arena than is normal' (Potter and Wetherell 1987:164); that the researcher is involved and argumentative (Potter 1997). Thus it would appear that during the interview, both participants are actively involved in gaining a clear a picture as possible, the interviewee responds to the interviewers' question, and then the interviewer questions the response, checking for clarification, drawing attention to any discrepancies; together they create a discourse that responds to the question posed. In the final report, both the interviewers and interviewees discourses are provided, to enable the reader to ascertain the veracity of the hypothesis generated.

The involvement of the researcher in the process of data generation has been questioned; an area of concern focuses on the influence of the researcher and the issue of counter transference (Potter 1997). Consequently there as been an increase in analysing texts where the researcher has had no involvement, as such the material is ‘less affected by the formulations and assumptions of the researcher’ (Potter 1997:150). It would appear that interview data is not often used when conducting a discourse analysis (Dickerson 1996). When it is used, there is a need for the samples to be small, so that varieties in discursive forms can be recognised (Coyle 1995).

3. The selection of a method to guide this study

Of the methods discussed different ones appeal for different reasons, for example, the issue of providing closure appears to be stronger in grounded theory and heuristics. In grounded theory, the theory is tested out until no new aspects of it emerge and with heuristics the researcher conducts the interviews until no new material arises. However, how possible is this? With grounded theory there is an inherent supposition that all will experience the same. For when the theory is tested out with a new group, there is a view that a new group will eventually experience a sense of 'sameness'. Is it that the researcher picks a homogenous group and thus minimises the potential for difference? In heuristics, the telling of an individuals' story until there is no more to tell again implies a foreclosure to experience, for in the telling of an experience more may become known. As such there is an implication that the 'telling' is the definitive truth once and for all, when in essence, the 'truth' is in the moment. It is suggested here that the comment by Stake (1994) advising caution about how when employing a case study method, the whole story can never be captured or told, applies to both grounded theory and heuristics, indeed it could be said of all research methods. It would seem that all that is possible is to record a 'snapshot'; an at the moment experience of a phenomenon.

This could be applicable to a descriptive case study; a method that allows for an individual to describe their experience of a phenomenon, thus it could be said to describe the 'lived experience'. However, a potential stumbling block is the need to elicit the real life context. In this study it would be for the researcher to be a therapist (as in the studies of Milioria (1998) and Niederland (1975))
and to comment on their understanding of the learning components of therapy. If the clients' view is sought, this would be a retrospective account.

The interview style in discourse analysis as described by Potter and Wetherell (1987) appears to be rather 'aggressive' in comparison with the heuristic interview as described by Moustakas (1990). The first advocates that the researcher questions and challenges what the interviewee is expressing, to elicit more clearly the claim the interviewee is making; as such the researcher is actively involved in the meaning making process. Whereas, the heuristic interview is unstructured and with the researcher usually asking one question – to invite the research participant to tell of their experience of the phenomenon. The researcher asks further questions to seek clarification. The mediating effects of the researcher is recognised in discourse analysis, so much so that preference is now given to texts, previously recorded accounts of a phenomenon that are then analysed by the researcher. The role of the researcher in influencing the sharing of the story in heuristics is not acknowledged; however, the need for them to have personal experience of the phenomenon is, as such the researchers personal experience is the impetus for a study.

There is something about the transparency of discourse analysis and heuristics that appeals to the researcher, for this transparency creates the opportunity for researchers to share their meaning making processes. There is recognition of the need for the researcher to be reflexive, for through this process the tacit dimension of knowledge can be uncovered, knowledge that informs the interpretation of data.

On balance discourse analysis appeals as it supports the ethos of multiple meanings, and heuristics appeals because it is an approach which focuses on the lived experience of therapy and this is cognisant with the question posed by this study (Is counselling/psychotherapy a form of learning for people with a facial difference?). The intention is for people to speak of their lived experience /or opinion of therapy, and from this to discern if there are learning activities or potential learning needs. Discourse analysis in this instance would appear to be more suited to analysing texts of peoples understanding of the learning that took place through the process of therapy. Therefore, heuristics is the method of choice for this study.

The methodological framework used to guide this study, comprises of two cycles of interpretation. The first cycle culminates in the primary construction of meaning that emerged from the generation of data. This construction becomes the pre-understanding for the next cycle of interpretation. This cycle of interpretation culminates in a secondary construction. A deconstruction of the text is the proposed method of analysis, where deconstruction is a way of looking at a text to see what has been privileged, what has been left out (Derrida 1998, 1996). It is as such a reading between the lines
There is no set method for a deconstructive reading of the text (see Burman 1994); rather it is an exploration of the taken-for-granted assumptions embedded in a text (Parker 1992).

In the process of the secondary construction, there is the potential for the heuristic method to be expanded and thus re-conceptualised as a post-heuristic method. For there is a shift from the modernist perspective of the ‘I’ of the researcher being at the centre of the meaning making process, to a postmodernist perspective of the ‘I’ being de-centred; for the ‘I’ is subject to (Sarup 1993).

**Conclusion**

The design of the study emanates from the research question ‘Is counselling/ psychotherapy a form of learning for people with a facial difference?’ The macro and micro perspective of the research field identified the parameters of the study: The macro perspective is the meeting of the client and therapist, where the client seeks a therapist to explore their perceived difficulties in living/coping with a facial difference. The micro perspective represents the specific aspects that may influence the meeting of the client/therapist, and the creation of a therapeutic relationship. Due to the recognition that this study is addressing a previously unreported area, that is the lived experience of therapy by people with a facial difference, the size of the population sample is unknown. The researcher has widened the research sample, to include those who live with someone with a facial difference, and those with a facial difference who were willing to express an opinion on therapy. The inclusion of these dimensions will provide additional information on the lived experience of the phenomenon of facial difference and the implications for therapy as a form of learning. Information that maybe beneficial to those providing therapy to this client population, and for people wishing to access therapy, as they may gain an insight of the potential outcome of therapy, together with an awareness of some of the issues that people may take to therapy.

The methodological framework developed in the previous chapter and to be tested out in this study, influenced the selection of the research method. The following methods were considered grounded theory, heuristics, case study and discourse analysis. From these heuristics was selected as a method that would enable the extrapolation of the lived experience of therapy or the opinion of therapy, and from this either learning experiences, or potential learning needs can be elicited. The knowledge gained through this research process may enable the development of a model to generate further conversations on how psychotherapy can be seen to be a form of learning.

With the inclusion of a second cycle of interpretation (a deconstruction of the primary construction) together with a critique of the research process (final stages of the methodological framework), there is the potential to provide information on a different way to using the heuristic approach, a post-
heuristic approach. The next chapter focuses on the next phase of the methodological framework the employment of the method to generate data for analysis.
Chapter Five

Method

Introduction

This chapter focuses on how the data was generated and represents stage three of the methodological framework that is being tested out in this study. As referred to in the previous chapter, the heuristic research method has been selected to guide the data generation and analysis, culminating in the primary construction. According to Moustakas (1990:43) ‘there is no exclusive list that would be appropriate for every heuristic investigation, but rather each research process unfolds in its own way’. However, he does give guidelines and these form the framework to structure this investigation.

Firstly, there is a discussion on the ‘owning of a personal issue’ (Moustakas 1990:43); the researcher shares her learning experiences resulting from therapy. This experience also forms part of the interpretative lens of the researcher and as such completes stage one of the methodological framework. Stage two of this framework, the research design and method was discussed in chapter four, and this chapter focuses on the third stage, the research method, the generation of data for analysis. There follows a discussion of the preparation undertaken prior to contacting potential participants, consideration is given to the nature of the information potential participants would require to enable them to make an informed choice whether to participate in the study. Next is a discussion on how the potential participants were located. Followed by a discussion on the contract developed for potential participants.

The generation of data is discussed, followed by an explication of the profiles of the participants who took part in this study. The final section of the chapter outlines the stages involved in the data analysis; both the primary and secondary constructions.

1. Owning of a personal issue

The first step to a heuristic investigation is the owning of a personal issue; it is usually an issue that matters a great deal to the researcher. In this study, the first step was made several years ago, during the researcher’s own process of therapy. Therapy had been commenced to meet with the mandatory requirements of the counselling training course she was attending. On reflection this legitimised the need for therapy; the impetus was external (course requirement) rather than internal (personal need). However, the experience provided an opportunity to talk about living with a facial difference. To recognise how, on the one hand it is a visible/public phenomenon (visible to self and others) and yet
on the other it is an invisible/private phenomenon (experience only known to self), as it was not
talked about. Therapy thus became the place to speak the unspeakable, to challenge the unwritten
rule that 'it' was not spoken about; also there was a shift from the external need for therapy to an
internal one.

This early experience of therapy raised the following questions; is my [the researcher’s] experience
of living with a cleft [a congenital facial difference] similar to/different from others? What are the
commonalities in experience? How have others coped/managed? Is there a need for a
counselling/psychotherapy service to be made more readily available to this client group? These
questions provided the impetus for the researcher’s first experience of undertaking a heuristic
investigation. Rather than stating that there was a need for counselling/psychotherapy for this client
group, which would have been based solely from the researcher’s experience, the aim was to elicit
peoples lived experience of having a cleft (information that was currently unavailable in the
literature), and from this to determine if there was a potential need for the provision of a
counselling/psychotherapy service.

Five themes emerged from the heuristic investigation of the lived experience of having a cleft; the
cleft (how the person described their appearance); teasing (a common experience, which influenced
interactions with others, and the view of self); experience of treatment (part of the process to
‘becoming normal’); change in perspective (view of self changed either due to change in
environment or a particular treatment); not talking about it (a common experience, the cleft was not
usually talked about within the family environment). In conclusion, the provision of a
counselling/psychotherapy service would enable people to have a choice, to talk about their
experience if they so wished; therefore a counsellor/therapist was considered to be an essential
member of the multi-disciplinary team caring for people with clefts from birth to maturity (Rose
1997).

The findings of the study were presented in the newsletter of the Cleft Lip and Palate Association
and verbally [by the researcher] at the annual general meeting in 1998. The researcher was moved
by people’s reactions to the verbal presentation, for the findings appeared to resonate with those in
the audience who had their own experience of the phenomenon. As such this experience supports
the underpinning tenet of the heuristic approach, that as a method it captures the ‘lived experience’
of a particular phenomenon. Initially this is in relation to the participants of the study, which as such
represents the specific or micro perspective; and the feed back given by others, who have their own
experience of the phenomenon, the generic or macro perspective. It would appear that the heuristic
approach can illuminate for others the experience of a particular phenomenon.
Since the researchers first study, there has been an increase in the recognition of the need for psychological services, in particular counselling, to be made more available for people with a facial difference (CSAG 1998, Turner et al 1998, McGrouther 1997, Partridge 1997a). However, what is missing in the literature is the experience of the person who has a facial difference and who has had counselling/psychotherapy. As previously stated in the literature review (chapter two) the researcher located two studies (Milioria 1998, Neiderland 1975) that comment on psychotherapy with people with a facial difference. The two case studies focus on the nature of the treatment and the sense the therapist made of the relationship. In the available literature, the overall tendency is to suggest that a person with a facial difference, requires therapy to cope with the psychological problems encountered (see McGrouther 1997, Partridge 1997a, Bradbury 1996, Bull and Rumsey 1988). It is suggested here that there is insufficient information available on what people may bring to therapy in the way of presenting issues, and how therapy may facilitate a change in perspective thereby enhancing their ability to cope with their facial difference. The intention here is to explore whether these changes are a form of learning. That therapy is reparative; it enables a return to learning from experience. But how can this be shown? How can the factors that contribute to a change in perspective be identified? How can psychotherapy as a form of learning be explicated? How can this knowledge be made available to others, so that they can explore their experience of therapy, to open further conversations on how psychotherapy is a form of learning? The exploration of these questions provided the impetus for this study.

Through the process of her own therapy, the researcher came to realise how an environment had been created within the therapeutic relationship, that enabled her to challenge misconceptions in beliefs and attitudes about self and others in relation to her facial difference. There was a change in perspective, a shifting of previously held beliefs. Could this change be aligned to learning? Learning from experience? Learning that is personal and transformative? Learning that is about enhancing emotional well being?

An example of a change that occurred through therapy was my (the researcher's) perception that it was only people who had a facial difference who encountered problems in relating to and with others. A belief that stemmed from childhood, the reasons for this belief are multi-faceted and intertwined. Firstly, learning to speak and making myself understood by others was an arduous task. Involving twice-weekly speech therapy, and daily lessons at home, endlessly repeating the same sound over and over again, until it was deemed to be satisfactory. Memories of asking for something in a shop pre-school age, and being told to repeat what I wanted because they did not know what it was that I was asking for. My mother then accusing the shopkeeper of focusing on how I looked, rather than hearing what I said, and being forced to repeat for the umpteenth time what it was that I wanted. Experiences that put me off from speaking to unknown others.
Secondly, were the comments from unknown others about my appearance. These were most confusing, as the only mirrors in the house were out of my reach; I did not know what I looked like. Rather the reactions of others to my appearance became a ‘mirror’; a mirror that implied that I was not the same. The name calling, staring, and shunning by others that seemed to be an everyday occurrence during pre-school and infant school years, also helped to create the view that I was less than others. Going to hospital for surgery to improve ‘my looks’ prior to going to school, and again pre-primary school, further supported this view; and creating the ‘mind set’ that all difficulties to relating with others was blamed on ‘my face’. I became wary of meeting new people, anticipating the reactions from them to my face, expecting rejection. In a way my wariness sometimes engineered what was most feared. My fantasy was that if I had a ‘normal’ face then everything would be fine, this became translated to, people who have a ‘normal’ face don’t have problems relating with/to others. This view/belief was not challenged, and meeting new people always had the potential for resurrecting the fear; re-creating the scenario learnt in the playground.

The challenging of this view started during personal development group experiences during initial counselling training in the mid-eighties; people were sharing their difficulties of living and relating with others. And continued when working with clients, hearing of their difficulties, the things that made them vulnerable. Also there was a common reference to how they felt ‘different’ to others. It is with a sense of incredulity that I write this, for how had I got it so wrong? Further challenging took place when I facilitated workshops on body image for health professionals working with people with facial difference; one of the exercises was on body ideal. A constant feedback was that people (without a facial difference) were not happy with their body image, they all had an ideal that they aspired too, as such they too were chasing an illusive body ideal. Gradually I had become aware that my beliefs surrounding non-facial difference were erroneous and had no foundation other than my fantasy. Also that my views on facial difference were skewed in favour of sameness; that all would encounter similar experiences.

Working as a therapist, provided experience of working with a range of people who identified themselves as different and who through the process of therapy, this perspective was challenged, and as a result there was a change in outlook. For example there was ‘Anne’ who had recently been divorced and as a result she felt different to other women; ‘Jim’ had always felt different because he had been adopted; ‘Susan’ had always felt that her appearance marked her out as different; ‘Ian’ thought he was different because he felt so alone. A range of differences, that somehow marked the person out from others in a negative way, that somehow they were not as good as their contemporaries. Through the process of therapy and the therapeutic relationship they came to see their situation from a different perspective. There was a freeing from previous held beliefs, perhaps this is a form of transformative learning? The change was specific to the person, the change was
recognised by the person, perhaps this is a form of significant learning? The change was usually accompanied by an increased sense of self-worth, of confidence; perhaps this is a form of emotional learning?

Thus the personal issue that guides this study, is that therapy creates an environment that brings about change, a change that may be a form of learning. The aim of this heuristic investigation is to explicate the lived experience of therapy for people with a facial difference, from the perspective of the client and the therapist. As previously stated an added dimension to this lived experience is to include the perspective of those with a facial difference who have not had therapy but who would like to share their opinion of it, and those who live with someone with a facial difference. The inclusion of these views has the potential to inform the context within which people with a facial difference decide to access therapy.

The researcher acknowledges that the possibility of learning experiences in therapy may not just happen in a one-to-one situation, there is the potential for this to occur in all forms of therapy (e.g. couples, groups, family therapy); and that the possibility of learning opportunities in therapy are not restricted to those with a facial difference; rather that these are the parameters to this investigation.

2. Preparing to make contact with potential participants

Prior to making contact with potential participants there is a need for the researcher (author) to be clear of what it is they would be required to do. Moustakas (1990:45) suggests that this stage of the inquiry involves 'developing a set of instructions that will inform potential co-researchers of the nature of the research design, its purpose and process, and what is expected of them' [original emphasis]. Moustakas referred to the participants sometimes as co-researchers in deference to their prominent role in data generation and the checking of findings, for consistency the term participants will be used in this study.

Each of the points raised by Moustakas will be discussed in relation to this study:

(i) The nature of the research design - potential participants would need to know that it is a heuristic inquiry, and that this approach, focuses on the research participants experience of the phenomenon of the study. In this study it is their experience of either giving or receiving therapy, or their opinion of therapy. The client group are people with a facial difference.

(ii) The purpose - from the researcher's perspective this is to determine if therapy is a form of learning. However, to inform potential participants of this may skew the results. The concern in relation to this study would be that by stating the link with learning, this might detract from the participants 'lived experience'. For in the re-telling of their experience,
they may try to fit it in around learning. That somehow the experience will be refracted through what they think the researcher wants to know. As such there is a potential for closing down, or placing a structure/format to the re-telling of their experience. To state the purpose to explicate the lived experience of therapy, or the opinion of therapy for people with a facial difference will place the participant in a freer position to speak about that which is important to them. From the data generated, it may then be possible to discern factors that contribute to the learning experiences intrinsic to psychotherapeutic practice. This knowledge could then be made available to others, so that they can have a way of looking at therapy as a form of learning, to open up further conversations.

(iii) The process - participants would share their experience of the phenomena either in writing, or by face-to-face or telephone interview. Following this, participants would be invited to comment on the veracity of the information shared, to decide if they wished to make any changes, to exclude, some, all or none of it from the study. Following analysis, participants would then be invited if they so wished, to comment on the findings of the study, to determine if it captured their experience of the phenomenon.

(iv) What is expected of them - to give of their time, to share their experience of either having therapy or their views of therapy for people either having facial difference, or living with someone with a facial difference, or providing therapy for people with a facial difference.

It is suggested here the four elements identified by Moustakas can be encompassed under the term of informed consent; where there is a need to consider what information potential participants require to enable them to make an informed decision on whether to participate or not. Information to be imparted includes the purpose of the study, what they would be required to do, and the likelihood of any negative effects of participating (Barrett 1995, McLeod 1994, Merara and Schmidt 1991). Informed consent also concerns the issue of anonymity or right to privacy, and the need to protect the identity of the research participant (Fontana and Frey 1994, Black 1993). This involves more than just changing names, but to also avoid inadvertent clues, such as giving the location, and background information that may lead to identification (Paddison 1995).

Another aspect of informed consent (which Moustakas does not make reference too) is the protection from harm, whether it is physical or emotional (Fontana and Frey 1994). In relation to this study, the concern would be of an emotional nature, as there is the likelihood of causing psychological distress when dealing with sensitive issues (Hart and Crawford-Wright 1999). Whereas, Homan (1991) suggests that when participants belong to vulnerable groups researchers need to identify how they will be supported. It is suggested here, the need for support should also extend to the raising of sensitive issues. In relation to this study, there was the potential for participants to touch inadvertently on material that has not been worked through, in an attempt to
minimise this risk, the researcher needs to be mindful that this is a research interview and not a therapy interview. Potential participants need to be informed of this potential risk, and that should this happen, support would be available in the first instance by the researcher, and if required further support could be called upon, from a colleague.

Although Moustakas (1990) guidelines focuses more on the participants, it is suggested here, there is also the need for the researcher to determine their responsibility in data generation, prior to making contact with potential participants. The main method of data a generation in this investigation will be interviews, either face-to-face, or via the telephone. Interviewing is widely used in qualitative research to elicit the personal knowledge of the research participants view on a particular subject (Baker 1997, Holstein and Gubrium 1997, Silverman 1997); as such ‘both participants create and construct narrative versions of the social world’ (Miller and Glassner 1997:99).

From a technical point of view, there is a need to keep the interview focused on what the researcher wants to know; ask the right questions and you will generate the right information (Baker 1997). This is more likely to happen in the structured interview, whereby the researcher asks the participant to respond to a specific set of questions. Whereas, Silverman (1997:248) suggests that the interview can be aligned to ‘the technology of the confessional’, whereby the interviewee tells all. This is more likely with semi-structured interviews where the researcher may ask a limited number of questions and unstructured interviews when the topic may be introduced and the participant gives their opinion or experience of the topic. The later approach was to be the style of interviewing for this study, participants would be asked to share their lived experience of the phenomenon, and the researcher would ask questions to clarify, and check understanding.

From an ethical standpoint, Hart and Crawford-Wright (1999) suggest that interviews of the nature proposed can make an interviewee vulnerable, and the researcher has a responsibility to protect the interviewee. As such there is a need to be sensitive to the ways research participants may be effected (Patton 1990). However, learning how to interview is not easily taught, for it is dependent on experience (Rennie 1996), and there is the need for the researcher to be aware that it does not lead into a therapy session (Campbell 1997, Hutchinson and Wilson 1994, Gale 1992). On the one hand the research interview may parallel the therapeutic process (Kvale 1999, Patton 1990, Lipson 1984), and on the other hand, ‘the therapeutic relationship and the research interview appear on the surface to have something in common’ (Hart and Crawford-Wright 1999: 205). They suggest that the difference is in whom is helping whom, in the research interview the interviewee is helping the researcher, and in the therapy interview the therapist is helping the client. Etherington (1996) suggest that there is the potential for the therapist as a researcher to experience some role conflict.
As such there is a need for this researcher to be mindful that the interviews conducted in the process of data generation in this study, are research interviews, and that she has a responsibility to the participants that they have adequate information, on which to make an informed choice to participate or not, and that this choice extends during the research interview, and beyond. At any stage, the participant may terminate the interview, or withdraw from the study.

The following three areas were identified for inclusion in the information to be given to potential participants:

(a) **Process**: potential participants would need to know the nature of the interview, that it would involve them sharing their experience of the phenomenon, that the researcher was more interested in hearing their story, than eliciting responses to a ready prepared schedule of questions. The researcher would ask questions to clarify and/or check out what had been said. At the end of the interview they would be asked if they would like any, or all of the information disclosed excluded from the study (this could mean all, some or none of it).

(b) **Confidentiality**: that their anonymity would be ensured.

(c) **Potential risks**: When asking people to share their experiences there is always the potential for this to raise unexpected issues and emotions, which may cause concern. Therefore, the researcher would inform potential participants of the possibility of this happening, and that the responsibility for disclosing information was theirs. Also, at the end of the interview, if unexpected emotions and issues had surfaced, that they would like to explore at a later date, they could do so with either the researcher or a colleague.

In this study participants would either be sharing their lived experience by interview (either face-to-face or by telephone) or by written correspondence. In relation to written correspondence, people would share their experience either on paper, or send it by electronic mail. The issue of the researcher influencing the data is reduced with written correspondence (Potter and Wetherell 1987), for the participant remains in control of what information to share. This lack of involvement of the researcher can be seen either as disadvantage for clarification can not be sought regarding the meaning of the content. Or as advantageous, as the account would not be contaminated by the influence of the researcher, it would be the experience of the phenomenon as perceived by the participant.

3. **Locating the research participants**

The next step according to Moustakas (1990:46) is ‘Locating and acquiring the research participants, developing a set of criteria for selection of participants’ [original emphasis]. As identified in the previous chapter, the criterion for the research participant was that they were either a therapist providing therapy for people with a facial difference, or a person with a facial difference.
who either had experience of therapy, or had an opinion on therapy, or were living with someone
who had a facial difference, who either had experience of therapy, or an opinion on therapy.

The criterion that potential participants (male/female) must meet were either a – c, or d:
(a) To either have a facial difference or to be living with someone with a facial difference. The
inclusion of the second category stemmed from the findings of the study on the ‘lived
experience of having a cleft’ (Rose 1997); the views of parents or significant others was
identified as an area which merited exploration.
(b) To be over eighteen years of age. This age limit was set after consideration of issues of
informed consent, with children there was a concern if someone gave consent in loco parentis,
would the needs of the adult take precedent over the child’s willingness to take part? Also
would a child be able to speak of their experience with only minimal prompts from the
researcher? If the researcher needed to ask more questions to elicit a response, the data could
become contaminated by the views of the researcher. In light of the above thoughts, a lower age
range of eighteen years was set, with no upper age limit.
(c) To either have had experience of counselling/psychotherapy or to share their views/opinions on
counselling/psychotherapy for people with a facial difference. The number of people who have
had counselling stemming from issues around facial difference is an unknown phenomenon.
Therefore, it was decided not to limit this study to those who had, rather by opening it up there
was the potential to not only explicate the views of those who had; but to also identify the
opinions of others in the field who may or may not think it has a place. This provides another
dimension to the phenomenon, and may provide additional information on the need for
psychotherapy as a form of learning.
(d) To be a therapist providing therapy for people with a facial difference.

To access people who meet with criteria a-c; it was decided to advertise in newsletters of support
group(s) for people with a facial difference. Initial contact was made with Cleft Lip and Palate
Association, who had shown an interest in the first project, and was supportive of the aims of the
current study; an advert was placed in their nation-wide newsletter. The heading of the advert read
‘What can counselling/psychotherapy offer people who either have, or are living with someone with
a facial difference?’ Brief details of the study and what participants would be required to do was
given, interested participants were invited to contact the researcher for further information to assist
with their decision to participate or not. This advert had the potential to recruit either people with a
facial a difference and people living with someone with a facial difference.

To recruit therapists (criteria d), who had experience of working with people with facial difference,
contact was made with two organisations that provide one-to-one counselling for this client group.
The Cleft Lip and Palate Association does not provide one-to-one counselling, however, people who contact the organisation requesting this are informed of 'Changing Faces' a charitable organisation that also provides information, support, training and counselling for people with facial difference. This organisation [which is known to the researcher, she has conducted several Changing Faces training workshops for health professionals working in the field of facial difference] was willing for their counsellors/psychologists to be involved with the study. Another organisation 'Face the Future' in the Northeast of England, located via an Internet search was contacted and they agreed to participate in this study.

The other routes of gaining access to potential participants was through meeting people at the annual conference of the Cleft Lip and Palate Association, speaking at conferences in Belfast, Dorset and training workshops. All those who expressed an interest in taking part in the study were invited to contact the researcher for further information.

4. Developing a contract
Moustakas (1990:46) defines the next stage as 'developing a contract' which involves making contact with potential participants, discussing issues to enable potential participants to make an informed choice about participation, and permission regarding the use of information disclosed. Once contact was made either via letter, e-mail, telephone, a standard for responding was determined. The framework developed in the previous section (on process, confidentiality and potential risks) was used to guide the discussion, the purpose of which was to enable the person to decide if they wished to proceed. There was also the opportunity for them to ask questions. At the end of the conversation, participants were invited to consider the additional information and a mutually convenient date and time was organised, for the researcher to contact them to determine if they still wished to be involved in the study.

Twenty-one people expressed an interest in taking part in the study; fourteen responses from the advert, three from direct contact, and four from workshops and conferences. After being provided with more information, four people decided not to proceed. According to Moustakas (1990) heuristic research focuses more on the quality of response than quantity, and as such advocates small participant numbers, in his study of loneliness (Moustakas 1972) fifteen people shared their experience. The response from people interested in this study therefore would seem to be adequate; purely on a 'numbers bases' the decision not to recruit further participants however, was mainly influenced by the richness of the data generated by the seventeen participants who shared their experience. The implication of limiting the recruitment to the one advert, was to restrict the experience to those who had a congenital form of facial difference, however, the current view is that the cause of the difference does not affect how a person copes (Robinson 1997, MacGregor 1990,
Rumsey and Bull 1988), and therefore this factor would appear not to be significant when considering the research sample.

5. **Data generation**

5.1 **Method**

The main route for data generation was through interviewing participants either face-to-face (four interviews) or by telephone (twelve interviews). Interviews lasted from thirty minutes to ninety minutes; the variation was due to the length of time people needed to answer the open-ended question posed. The preference for telephone interviews was due to distance and arose from the request for participants appearing in a nation-wide newsletter.

Once contact and had been made with potential participants, and after they had agreed to be interviewed for the study, a set procedure was followed. Permission was gained prior to starting the interview for the material to be used in this project or any subsequent publication, and for the interview to be either recorded or notes made. Once this was established the person shared their experience of either receiving or providing therapy, or expressing an opinion of it. At the end of the interviews, the researcher sought permission once more for the material to be included, either in its entirety, or with some amendments. Participants were invited to make comments on the transcription of the interview, or a summary of the notes made; three people wished for some of their comments to be rephrased so that it further captured their experience.

The participants were eager to share their experience, and provided very detailed accounts with minimal input from the researcher. Prior to conducting the interviews some people were concerned that because they would not be asked questions on specific issues, they may not provide the correct information. However, once it had been explained that the researcher wished to hear of their experience, of that which was important to them, this led to telling of their experience in their own way.

One person chose to communicate via e-mail (for two others this was the first contact, followed by telephone contact), once the person was aware of the purpose of the project, they sent a copy of a paper that they had written in response to a request from a support group to hear of peoples experiences of living with a facial difference. There followed three e-mail conversations when further details of their experience were shared, with a particular emphasis on their experience of therapy. Another person submitted a course assignment that focused on their experience of having a facial difference (this was sent prior to a telephone interview, to provide the researcher with ‘background information’). The next section provides information on the number of people who contributed to the study.
5.2 Participant profiles

The total number of people who took part in the study was seventeen, however due to some of the participants belonging to two groups, they were able to comment on both perspectives. There were three groups of participant responses, therapists (three people), person with a facial difference (twelve people, [two were also therapists]), living with someone with a facial difference (six people, [two also had a facial difference]), altogether representing twenty-one responses.

Three therapists took part in the study, all were female, and two had a facial difference, and had had therapy. All were working in the field of facial difference, affiliated to an organisation providing one-to-one counselling. All had had training for their role, either as a counsellor (two people) or as a psychologist (one person). All received either clinical supervision and/or peer support.

Twelve people with a facial difference either shared their experience of therapy (eight people) or opinions of it (four people). Four of the group were therapists, two of whom worked in the field of facial difference. Three of the group were male (two of whom had experienced therapy) nine of the group were female (six had the experience of therapy). For all, the presence of the facial difference had been present since birth, one person had the hereditary skin condition neurofibromatosis, and eleven people had a cleft lip. One had a parent with the same congenital facial difference. Three people had no siblings, and of the nine people who had siblings, two had siblings with the same congenital facial difference (their parents did not). Five people were single, and seven were either married or living with a partner. Of the four people who had children, two had a child with the same congenital facial difference.

The six people, who were living with someone with a facial difference, were all parents (mothers) who had given birth to a child with a facial difference. All mothers shared their opinion of therapy (two people had the same facial difference as their child – one of the two had had therapy [for coming to terms with their own facial difference] many years prior to the birth of her child). Three had no family background of facial difference, of these one is now a grandmother to a child with a facial difference (none of her other family members took part in this study). Of the three people who had a family background of facial difference, two had their own facial difference, and one had a great-uncle with a facial difference. All six people had no further children following the birth of the child with a facial difference, two had one child, three had two children and one had three children.

The information contained within each group was not requested it emerged in the sharing of their experience, and is representative of the many variables that contribute to a person’s experience. It forms part of the micro perspective of the research field as identified in the research design (chapter four, section 1.2).
6. Data analysis

This is a lengthy process (Patton 1990, Douglas and Moustakas 1985, Moustakas 1981) and requires the researcher to become familiar with the data generated; Moustakas' (1990) eight-point guide was followed:

1. **Collection of material**: this comprised of interview transcripts and notes, written correspondence and journal entries. The investigation involving seventeen people generated data in the form of sixteen interview transcripts and notes, five written accounts (two papers/articles and three e-mail correspondence). Plus the researcher’s journal, Moustakas (1990) advocates the researcher keeps a reflexive journal, charting their thoughts and feelings as the study progresses. This may provide additional information to support the final stage of the analysis, the creative synthesis.

2. **Immersion**: 'the researcher enters into the material in timeless immersion until it is understood. Knowledge of the individual participant’s experience as a whole and its detail is comprehensively apprehended by the researcher' (Moustakas 1990:51). This process required the researcher to read and re-read each participant’s ‘lived experience’ time and time again, the aim was to 'hear' his or her words rather than what the researcher thought should be there.

3. **Incubation**: the need to leave the data alone for a period of time, with the intention that on return to it, with renewed energy, new perspectives may emerge. The researcher found that this was a difficult stage, and it required her to trust the process that in so doing new perspectives may emerge. It was helpful to be reminded of the analogy of when trying to remember someone’s name, one that eludes recall, when focusing on something else; the name may be recalled. By taking a complete break from this study and focusing on leisure pursuits, returning to the data did provide fresh insight on the learning experiences of therapy.

4. **Individual depiction**: The researcher returns to the original data from which the individual depiction was created to ensure that there is consistency. Also these can be shared with the participants to ascertain accuracy, to check that the experience has been captured.

5. **Steps one to four** are repeated for each participant. There then follows a further period of incubation, during which ‘illumination’ may occur; this is when the researcher gains a new awareness of the phenomenon. Moustakas (1990:27) suggests that this phase is spontaneous, and is linked with tacit knowing; and it is the incubation phase that allows for the ‘inner tacit dimension to reach its full potential’. The process of immersion, and incubation prepares the researcher for the next phase of explication, the individual depictions are reviewed and commonalities are grouped together under themes. In this study the responses of the
participant's were grouped into two areas, the experience of providing and receiving therapy, and experiences that may precipitate the need for therapy, themes emerged within each of them, initially the focus was on the lived experience as shared, and from this the identification of learning processes and learning needs inherent in their lived experience.

6. **Composite depiction**: The individual depictions are reviewed as a group, and further immersion takes place, from which a composite depiction is developed. Moustakas (1990:52) states: 'The composite depiction (a group depiction reflecting the experience of individual participants) includes exemplary narrative, descriptive accounts, conversations, illustrations, and verbatim excerpts that accentuate the flow, spirit, and life inherent in the experience'. In this study, the composite depiction develops the conversation started in the elaboration of the themes, here the learning processes inherent in the experiences shared are further explored.

7. **Exemplary portrait**: This step involves the presentation of individual portrait(s), which exemplify the experience. A portrait of John (pseudonym) is provided, and his 'lived experience' reflects the experience of people with a facial difference that had experienced therapy. John's experience includes comments from his parents about his birth, which correlates with and is representative of the parents who spoke of their experience of giving birth to a child with a facial difference. This information had been provided as part of their [parent's] opinion on the place of therapy for people with a facial difference from the perspective of a person living with someone with a facial difference.

8. **Creative synthesis**: This final phase requires the researcher to draw upon the knowledge gained and to elucidate for others their understanding of the phenomenon. To create new understanding and meaning for others to read, this may be in the form of 'a narrative, story, poem, work of art, metaphor, analogy, or tale' (Moustakas 1990:52). Underlying this phase is tacit knowing. By drawing on the analysis of data up to this stage, and reflecting on her journal entries, the researcher required a further two periods of incubation interspersed by a final period of immersion, for the new understanding of the phenomenon of learning experiences in therapy to be stated. This was necessary partly due to the content of the material being explored; it was at times a very moving and emotionally draining experience, and partly to ensure that the synthesis emanated from the data.

The methodological framework guiding this study, advocates a second cycle of interpretation, and the creative synthesis as it is representative of the understanding of the phenomenon arising thus far from the investigation will be deconstructed, a process that involves questioning the meaning of a text (Derrida 1996, 1972); to open up a conversation of what may be missing in the text, for
example which voice was represented and which voice silenced. There is thus an opening up to the possibility of multiple meaning. In this study, two concepts that emerged from the creative synthesis were explored. From this discussion, a model is developed to enable practitioners to begin to open up further conversations on psychotherapy as a form of learning.

A dilemma posed was how to present the data in such a way that it brings the reader alongside the process the researcher went through in analysing the data; for there are two interconnected strands to the analysis. Firstly there is the story as told by the research participants, a story that covers three different aspects of people's experience of therapy. There are the people who provide the therapy (therapists working in the field of facial difference), there are the people who have a facial difference who have either had therapy or expressed an opinion on therapy for people with a facial difference, and there are the people who live with someone who have a facial difference, who shared their opinion of therapy for people with a facial difference. From the participants 'lived experience'; the researcher could then identify elements of learning, an approach that Colazzi (1973) advocated as a way of eliciting people's learning processes. This identification represents the second strand of the analysis.

The learning can be seen to be either significant learning, learning that makes a difference in how a person perceives their situation. Or transformative learning that involves the identification and working through of distortions in previous learning. Or emotional learning, a learning that involves developing a language to speak about feelings and through this to affect a change in how a person feels about their situation, which then informs relationships with others, and may enhance decision making and problem solving. Or it could be that the learning that emanates in therapy is a combination of all three, for they are not mutually exclusive terms.

The dilemma is how to present this two layers of analysis, the voice of the research participant and the voice of the researcher as she interprets the data from the perspective of learning. A paradoxical situation, for in the privileging of humanness and an openness to experience, the research participants were asked to share their experience or opinion of therapy, to have asked them to share their learning experiences of therapy, or the place of therapy as a form of learning, would on the one hand made the analysis of data not such a complex activity, and on the other provided a foreclosure to hearing their ‘lived experience’ it would have been filtered through the lens of what they thought the researcher wanted to hear. In the primary construction the experiences of the research participants are shown, and where appropriate the researcher identifies the learning inherent in the experiences shared.
Conclusion
The aim of this chapter was to discuss the method used to generate the data to enable the exploration of the question posed by this study. The framework provided by Moustakas (1990) was utilised. Firstly the owning of a personal issue which underpins a heuristic investigation was explored. The researcher shared her experiences of changes that have emerged from her own therapy and from working with clients, and she questioned whether these changes are forms of learning.

Prior to generating data to explore the question posed, there was a discussion on the information that would need to be imparted to potential participants to enable them to make an informed choice whether to participate. This information included the nature of the research design, the purpose of the study and the process, together with what was expected of them. The researcher’s aim was to recruit people who would share their experience of either providing or receiving therapy, or their opinion of therapy. Three categories of experiences were defined, from the perspective of therapists working in the field of facial difference, from people with a facial difference and from people who lived with someone with a facial difference. Potential participants gained information about the study either through the advert (this recruited people for the latter two groups), or by direct contact (this recruited people for the first two groups).

Before participating in the study, potential participants were given the information of what they would be required to do, their right to withdraw from the study at any stage, and that their anonymity was assured. The data was generated through either face-to-face interviews, telephone interviews, or written correspondence. Participants had the opportunity to screen what they wished to omit or leave in. Participant profiles were provided to give an insight to the multifaceted nature of the variables found within the research sample.

The data was analysed following Moustakas (1990) guidelines and forms the primary construction. An individual depiction for each participant was created, which was checked for accuracy. These were then reviewed and commonalities were grouped together under themes. Within these themes learning experiences were identified. A composite depiction was developed which is representative of the group experience. An exemplary portrait that exemplifies the experience was also generated. A creative synthesis that captures the experience of therapy as a form of learning for people with a facial difference concludes the first cycle of data analysis. A deconstruction of the two main concepts that emerged from the creative synthesis completes the second cycle of interpretation and culminates in the secondary construction.
The primary construction that emerged from the first cycle of analysis of the data is provided in the next chapter (chapter six), a discussion of these findings is provided (chapter seven) followed by the secondary construction (chapter eight).
Chapter Six

Primary Construction

Introduction
This chapter represents stages four and five of the methodological framework (as discussed in chapter three). Stage four is a cyclical process, whereby the researcher moves back and forth between the data generated and the emerging construction (stage five). The construction presented here is structured as per the heuristic method (as discussed in the previous chapter).

Initially, the two areas that were explored as part of this study are discussed; these are the therapist and client experience of therapy for people with a facial difference, and experiences that can precipitate the need for therapy for people with a facial difference. Within each of these areas, themes emerged from the analysis of the data generated (details of this process were provided in chapter five). As previously stated, the use of the term learning was omitted from the question posed, to enable the participants to talk about their experience without boundaries imposed by the researcher.

Presenting the findings represented a dilemma for there are two layers to this activity. There is the experience as shared by the participants and the identification of experiences that are indicative of either the learning experiences of therapy, or the barriers to learning, that may precipitate the need for therapy as a form of learning. Thus in the presentation of the findings (particularly in the themes), the researcher makes explicit for the reader, the learning or barriers to learning implicit in the experiences shared (these will be located in the literature in the discussion of findings in the next chapter). The working definition of the three learning theories/concepts (significant, transformative, emotional) as identified in the literature review on learning (chapter two) informs the presentation of findings. This reference to learning begins the conversation on how therapy can be seen to be a form of learning, and will be further developed in the discussion of the findings in the next chapter (chapter seven).

The presentation of themes is followed by the composite depiction, which represents the experience of the group, and it is divided into the two areas of the study, an exemplary portrait follows this. The portrait of ‘John’ was selected as his experience exemplifies experiences that can precipitate the need for therapy, and also illustrates the learning intrinsic to the experience of therapy. The presentation of themes, composite depiction and exemplary portrait are supported with examples of the research participants words, these are in Italics, and the participants involved in providing therapy are referred to as therapists. A creative synthesis concludes the primary construction; a synthesis that represents the researcher’s understanding
emerging from the exploration of the research question: Is counselling/psychotherapy a form of
learning for people with facial difference?

1. Areas that were explored as part of this study
To begin the process of opening up a conversation, on a way of looking at psychotherapy as a
form of learning, the people who took part in this study were invited to share what for them was
important when responding to the question posed by the researcher. People with a facial
difference were asked to share their experience of either having therapy or their opinion of
therapy, therapists were asked to share their experience of working with people with a facial
difference, people who live with someone with a facial difference were asked to share their
opinion of therapy for this client group.

The data generated was initially divided into the following categories, providing therapy
(analysis of therapists’ transcripts); experience/opinion of therapy (analysis of the following
transcripts (a) people with a facial difference both those who had had therapy and those who
expressed an opinion of it; (b) those living with someone with a facial difference i.e. parents,
none of whom had had therapy following the birth of a baby with a facial difference); and
experiences that can precipitate the need for therapy (analysis of all transcripts).

Within each category, commonalities in experience were grouped together and there were
correlations with the therapists and the clients experience of therapy and these were merged
together, thus there are two broad areas that emerged from the data analysis; therapist and client
experience of therapy, and experiences that may precipitate the need for therapy. Within each
area themes emerged from the consistency from which an issue was spoken about. Three themes
were generated in the therapist and client experience of therapy area; reasons for seeking
therapy, therapeutic experience, and the outcome of therapy. The experiences that can
precipitate the need for therapy, were sub-divided into two categories, ‘parents’ and ‘person
with a facial difference’. Two themes emerged in the parents’ category, reactions to giving birth
to a baby with a facial difference, and ongoing concerns. Four themes emerged in the second
category, stories about their birth, reactions from others, reactions to others, effects of
difference.

2. Themes that emerged from the analysis of the individual depictions
2.1 Therapist and client experiences of therapy
There were commonalities in the responses from clients and therapists (none of the therapists
and clients had worked together), however, there was a difference in the area of focus, the
therapist spoke more on what they thought were the clients reasons for seeking therapy and less
on the outcome. Whereas, the clients spoke more about how the experience had changed them
and less on the reason for seeking therapy.
2.1.1 Reasons for seeking therapy

Three therapists working for two charitable organisations, solely involved in work with people with a facial difference, commented on the service they provide for their clients. Both organisations provide a range of literature on facial disfigurement related issues, run workshops for people having difficulties in living with a facial disfigurement/difference, and provide one-to-one support either face-to-face, by correspondence or by telephone. All clients, who contact the organisations, self refer.

From their perspective, the clients reasons for seeking therapy are related to meeting unknown others. For example, one therapist said, 'some people [clients] comment on how it is so difficult some days to go outside, they feel that everyone is looking at them. They only need someone to comment and this reinforces to them that they should stay indoors, away from the prying eyes of the public'. Another said, 'of all the people [clients] I have seen over the past three years, all make comment on how difficult it is to socialise. They see their appearance, as setting themselves apart from society'.

It is as if previous negative experience(s) have created anxieties about the next encounter of meeting strangers/members of the general public. From a learning perspective, if a particular situation creates anxiety, then further encounters of being in a similar situation, can create a re-experiencing of the anxiety; anxiety that creates a barrier to learning from experience. For the outcome of the as yet to be experienced experience is already predicted based on the previous experience; there is a closure to experiencing the new, as such there is an inability to learn from experience.

Another general theme to emerge from the conversations with the therapist's was that through the experience of working with a range of clients, there was a sense that if the person did not have the 'disfigurement' then all would be well, for then they would not have to cope with the reactions of the general public. For example, one therapist said 'they want to be perfect, and that would be the end of their problems', another said, 'there is a tendency to blame all their problems on the disfigurement. So the disfigurement is sometimes blown out of proportion'.

There was also a sense that the person with a facial difference had no responsibility, no role in social interactions, for it appeared that interactions with others just happened, without their involvement; they happened in a predictable way. For example, one therapist said, 'what they [the client] do not seem to realise is that their own behaviour is also a contributory factor'. Another said, 'for some [clients], rather than face the situation, they blame it all on the disfigurement'.

The therapist's commented that some of their clients believed that if they had more plastic surgery, this would hold the key to their future happiness, that further surgery would make them
more acceptable to society. For example, one therapist said, 'plastic surgery is the convenient key to make everything all right', and another said, 'some see it as the answer to their problems; they would rather have surgery than learn to live with it'.

For some of their clients the desired surgery did not have the anticipated result. For example, one therapist said, 'several people [clients] found that the longed for operation, the one that would make it all better, did not live up to expectations. One person in particular talked of how the difference in his appearance was hardly noticeable, and he was very angry with the surgical team, for building up his hopes'. Another said, 'I worked with someone who found that the operation, the one that marked the end of her treatment, did not make a difference in how people responded to her. She was still having difficulty in fitting in with people...she still felt on the outside...the edge of society'.

The therapist's commented that for some clients, if surgery did not have the answer then the counsellor/therapist would. For example one therapist said, 'for some it [plastic surgery] is a magic wand, and if it's not then maybe the counsellor will have the magic wand. It's really about them not conforming to society's desire for perfect beauty, and if they don't have it, then they are not acceptable'.

Overall, the therapist's response seemed to be indicating that there was a sense that the 'problem' [the facial difference] was seen as if it were external to them [clients], a dissociation between body and mind. As such there appeared no sense of self separate from the 'disfigurement', that the label of 'disfigurement' defined them. There appeared an inability to experience their experience, for there was a degree of predictability to how they perceived other people's response to them.

Eight people shared their experience of therapy, this was either via their primary health care team (two people) [referral by general practitioner], a voluntary service (one person) [self initiated], or funded privately (five people) [self-referral, or at the suggestion of another person]. Two people commented that it was through training to be a therapist that they accessed therapy, for example one person said, 'I changed my name ...and then I started training, my therapy was about getting qualifications'. The others had sought out therapy due to appearance related difficulties in living and relating with others. For example one person said, 'I'd reached a point in my life where there was so much that I was unhappy with ...I'd just come out of a long term relationship ...I didn't feel good about myself ...I was referred to counselling by my general practitioner'. Another said, 'on an in-house training programme at work, the facilitator said to me that I seemed to keep people at a distance, and perhaps counselling may be beneficial'.
2.1.2 Therapeutic experience

All three therapists had different theoretical backgrounds (cognitive behavioural, psychodynamic and person-centred), and all described their role as being premised on the need for the client to take responsibility for their actions. One therapist said that her role was about 'facilitating peoples own effectiveness' another said, 'with a bit of support they can turn their lives around'. Another therapist said it was about enabling the client to realise that they are 'not at the mercy of other people that there are things they can learn to do, to be in a more powerful position'.

From the clients perspective, the therapist was perceived to be 'supportive', for example, one person said, 'my counsellor was an independent ear; I did not have to worry about upsetting someone', another person said, 'my therapist was there for me'. Overall, it appeared difficult to say what it was that was helpful, a word frequently used was 'feedback' for example one person said, 'the feedback I got from the therapist was a turning point ... it was about not being so hard on myself'.

Two people, commented on how they had not had a good experience of therapy. For example, one person said 'my own therapy was a struggle to be heard, that somehow the therapist had preconceived ideas about how I should feel with my disfigurement'. Another said 'I tried a non-disfigured counsellor, and she could not understand how I felt about my face, all she kept saying was that I looked OK, and for me that was not what I wanted to hear. I wanted my concerns about my face taken seriously'. For both people it appeared to them that they had not been listened to, and the inference either implicit or explicit was that, had the therapist had a facial difference then this would have been more helpful. One client who had had a positive experience of therapy, believed that what had been most beneficial was 'her [the therapist] having a disfigurement helped, she could understand me'.

The therapists also commented on the issue of whether or not the therapist should have a facial difference. From their perspective the presence of a facial difference could place them in the position of being a good role model, (two therapists had a facial difference). One therapist commented on how she thought clients perceived her own facial difference, 'if she's done it then so can I. People see I am some way down the line; I'm living my life profitably'. The other said, '90% are pleased that I have a disfigurement, as I am on the same wavelength. It may give them that bit of comfort, that 'I'm not alone'. Whereas, the therapist who did not have a facial difference said, 'people do ask on the phone – do you have a disfigurement. I do actually challenge that. You know I don't think you see a heart specialist because he has a heart defect. I think that what they really want to know is do you understand the issues that I am asking for help with. But I do recognise that there are some people who see my colleague who has a disfigurement and that this alone is remarkably helpful. I can understand that'.
On the one hand it can be perceived as helpful for the therapist to have a facial difference, and yet on the other it is about whether the client feels the therapist can understand them. Perhaps if both client and therapist can be open to the experience of the other then the issue of their respective appearance may not rate so highly in the conversation. There appears to be a preference for sameness rather than difference, where sameness equates with a closure to learning from experience, for experience is the same and predictable. New experiences will be evaluated, as per previous experience; there is as such a sense of certainty. Whereas, a preference for difference would equate with openness to learning from experience, each experience has the potential to be different and there is an element of uncertainty.

The perspective of those who commented on what they thought a service should provide them gave an indication of a person's willingness to be open to the experience of therapy. For some people they wanted the service to provide answers for and to their experience. For example, one person said 'I need to know if I am doing the right things... is this the norm?' Another person said 'I'd like to speak to someone who can say this is what it will be like in five years... so that I'd know what to expect'. It would appear that both people wanted some certainty to their experience. Whereas, others wanted the therapist to listen to them, and to help them understand what was going on for them, for example, one person said, 'how to make sense of it', another said 'to try and come to terms with it, to know that I am not alone', and another said 'I want the chance to share the downside, with someone who will listen and not judge me. I want to try and understand what it all meant and means'. As such there appears to be more of an openness to the process of therapy of not knowing where the exploration will take them; for the answer is not known in advance of the encounter. There is thus an openness to experience, and the potential to learn from experience.

2.1.3 Outcome of therapy

The three therapists commented on how they perceived the outcome of therapy, this information was gained either at the final session, or from comments made by the clients during sessions about how they were feeling 'different' about their situation. Overall there was a sense that therapy had enabled the client to effect a change in their lives, for example, one therapist said 'to feel more comfortable with life and experience – to do things they had not previously been able to'. Another said, 'for them to find and have their own experience of what works for them', and another said 'to be more accepting of their situation, and that's up to them how they cope with the public's interest in them'.

The clients (six) who had stated positive affects from therapy referred to how the experienced had changed them, how their self-perception had altered. How they felt in 'a different place' or
‘a better place’. Part of this process was the recognition of previous distortions in learning, for example:

‘Learning to be normal despite cleft ... I learnt such a lot ... who I am. That I am good enough. I came to realise that a lot of my thinking was distorted, due to my early childhood experiences’.

‘In therapy my disfigurement was not the focus, it was more about how I was making sense of things, and how this thinking was distorted. After therapy I felt more positive about myself’.

‘Counselling gave me a lot of confidence in myself ... I’m not six feet tall, I’m not miss world... but I have got on with it and I am getting on with it’.

‘Through counselling, finding a voice, and not to bottle up feelings. Also that peoples perceptions are different’.

‘Increase in self-esteem, and facing my greatest fear ... talking about having a different face... and what it meant and means to me’.

‘I came realise that I expected people to treat me just like others before had. I did not give them a chance to be different’.

There appeared to be an increased awareness of how they felt about their facial difference, and a realisation of the uniqueness of experience. That all people do not respond in the same way, people’s perception can be different; their perception can be different. For there is the potential for another way of responding to others; it is this shift in perspective that is indicative of learning from experience.

Learning through the process of therapy is not just in the domain of the client. All the therapists made reference to how through the process of either supervision or peer support, they had been able to reflect and acknowledge their own learning, emanating from the therapeutic relationship. For example:

‘Being with clients is a learning curve for me. Its made me think much more about things that perhaps I had been dismissive of earlier on and hadn’t picked up through reading the literature. Learning from the client ... the sort of lag between the difference between what people look like objectively and what they feel subjectively’.

‘Need for me to change my view of counselling that I was not there to solve it for them. It is a two way process ... I think they have to participate and they don’t need to look to me as the fairy godmother to make everything right; that they have responsibility’.

‘One client was desperate for surgery... but you know to me she looked so attractive. And I came to recognise that there is not a scale of beauty to ugly ... a universal scale... that each person has their own perception of what is beautiful and where they fit on this imaginary scale’.

It would appear that the therapists too, through working with clients were learning how to experience their own experience.
2.2 Experiences that can precipitate the need for therapy

The themes that emerged in this section were from the interviews with people who shared their opinion of the need for therapy for people with a facial difference, their perspective was either as a person with a facial difference, or living with someone with a facial difference. The themes are grouped into two categories, parents and people with a facial difference.

2.2.1 Parents

There are two themes in this section, reactions to giving birth to a child with a facial difference, and ongoing concerns.

2.2.1.1 Reactions to giving birth to a child with a facial difference

The parents (six mothers) identified how difficult it was to have given birth to a baby with a cleft (congenital facial difference), an experience that was associated with a mixture of negative emotions, for example:

'**My family said it was not on our side of the family... it must be on his. But me... I just felt so guilty ...I mean this wasn't supposed to happen ...I must have done something**'.

'I found it terrible ...I feel terrible guilt... obviously in time it disappears'.

'At the birth I was shocked ...somehow I managed to switch into caring mode... but it was difficult ...she was not what I had expected ...I mean I'd never seen anything like it before...such a shock... The worst bit has been that as a mother I can't remedy it ... I just take one day at a time'.

'As a mother I was churning on the inside, but on the outside it was business as usual. But then I would see other mothers with their perfect babies, and I wanted to leave him ... to hand him over to someone who would want him...really want him...then I'd feel guilty at having such feelings ... its like being on a rollercoaster'.

Two of the mothers had the same facial difference as their child, for them there was a sense of history repeating itself. A concern was that their child might experience what they had. For example one mother said, 'I was devastation at the birth.... It was my fault...I had passed it on...I feel so guilty...and I don't want him to go through what I have'. There is the potential here for a closure to experience, for there is an expectation that the child will experience what they had. Which may create a situation where the responses to the child are premised on their own experience. Responses that can be seen as representative of an inability to learn from experience. There appeared to be the potential for this to be an intergenerational process. For example, one mother said 'my father did not want to see her, my mother went to pieces...we were not to tell people...not to let them know....it had happened again'.

For those whose parents had not had the experience of giving birth to a child with a facial difference there were comments made given of differing negative responses to the birth of their grandchild. For example one person said, 'my mother said it was not on our side of the family it must be his... I should never have married him. Such shame had been brought on the family'; another said 'my family said to me just ignore it and it will be OK'; and another said 'my parents
did not want to see him until he’d had his first operation’. As such the parents appeared to have to contend with their own feelings surrounding the birth, plus the reactions of the extended family.

There was evidence of their need for support, however, asking for help appeared to be difficult, for example one person said ‘as a parent, I needed a lot of support and education. I would have appreciated help – what to say, what not to say to others. But I felt I couldn’t ask, I felt as if I should know how to cope’. Also, accepting help appeared to be difficult. One parent commented on how when her son was eighteen months old, a referral to a psychologist was suggested. The offer was turned down ‘I did not want to be seen as someone who couldn’t cope...he was my baby and it was up to me to get on with it...I was not ill...I didn’t need to see that sort of person’. On reflection she wondered if it would have been helpful to explore her feelings of ‘guilt at having produced baby Frankenstein ...I feel better towards him now...but I do worry about what the future holds ...I mean the scars are becoming more obvious now’.

It could be that the difficulties in asking for and accepting help left the mothers with a missed opportunity of putting thoughts and feelings into words. There was a sense of being left to cope on their own, of not knowing what to say to others, perhaps because they did not know themselves. A mother, who had had therapy to come to terms with her own cleft, appeared to have more of a sense of knowing how to respond to others. For she said, ‘when people comment on my baby, I just said to my other child, never mind them, this is our baby and if they can’t cope ...tough. Sometimes when people comment, I say don’t be so bloody ignorant...others just say she’s got such a sweet face. My husband too has stood up for her. People were commenting when we were on the train...look at that baby’s face ...he said excuse me that’s my daughter’. In this example, there is a sense of the parents being able to see beyond the facial difference, to be open to the person behind the label. It could be that without the opportunity of exploring the difficult feelings engendered by giving birth to a baby with a facial difference there is the potential to not see beyond the difference. An emotional learning experience could provide the potential for an exploration of feelings, for the development of a language to talk about emotions. The potential outcome of such learning is for improved relationships with others; here it would be between mother and her baby with a facial difference.

2.2.1.2 Ongoing concerns

All the parents commented on how their concerns for their child continued due to developmental changes and the need for ongoing medical and surgical treatment. For example one person said, ‘you know I felt so helpless each time I handed her over to the medical team. Each operation was painful for me too. You know it’s not just a one off repair, when she was little, I thought two operations and that would be it. And although the repair is brilliant, she still looks different, and then they suggest another operation, and they know best, so you say yes. I
always found the hospital a safe place, away from the teasing and bullying, everyone was equal, no matter how they looked'.

Another concern was that having a child with a facial difference affected the whole family. For example one person said, 'cleft palate and harelip have given my family and me much pain. It was seen as a tragedy', and another said 'having a child needing hospital treatment, and one, who looks different to others, has put a strain on my marriage'.

Also there was the difficulty in coping with teasing, staring from others. For example one person said, 'starting playgroup was difficult ...having to face a lot of new people, the children were OK towards her, but the other mothers were curious. Primary school was all right; she spoke to the class about her surgery. Secondary school, well she's on her own ...she doesn't want me to interfere ...but I worry about her ...I mean they are so appearance focused at that age ...and boyfriends ...how do I tell her that she does not have a chance? No one prepares you for this'.

It would appear that each age range brought further challenges; challenges possibly that kept the facial difference 'always present'. For example one person commenting on her daughter who was in her thirties said 'people say she is 'normal' it has not blighted her life. But you know when I look at her; all I see is the cleft'. And another person commenting on her son in his twenties, 'if you look at a photograph of him, you know he looks almost perfect. But then if you look closely you can see it, the lopsided nose ... the surgeon did a good job, but he's never going to look normal'. There is a sense of an ongoing trauma, that the trauma of the birth that was not talked through becomes a barrier to seeing the person; the label defines them, creating the potential to see their 'child' primarily through the lens of facial difference, there appears to be a closure to experiencing it any other way.

2.2.2 People with a facial difference
There were four themes that emerged in this category, stories about their birth, reactions from others, reactions to others, and effects of difference. Although the reactions from and to others are represented as two categories they are mutually interdependent, and inform the 'effects of difference' category.

2.2.2.1 Stories about their birth
During either childhood or adulthood, people commented that their parents shared recollections about their birth. For example: -

'Dad said to me last year, I had to persuade your mum to look at you'.

'My parents did not want anything to do with me. I was left in the hospital until I had had my operations...about three months. When I had counselling, as a teenager, they came along for one session, and they made it clear they did not want me. If it had been left to my mother she would have had me adopted'.

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‘My mother’s’ mother refused to acknowledge my existence to her friends for the first six weeks of my life."

Another person commented ‘my mother had a nervous breakdown, when I was in my teens and the psychiatrist said it was as a result of delayed guilt at having borne me’.

Others shared their memories of how their parents appeared to have difficulty in accepting the presence of the cleft. One person recalled how when she was at secondary school, they were doing a project and needed to take in a baby photograph, her mother’s response was ‘you were too ugly we had none taken’. The first photograph she has of herself was taken at junior school. Another person told of how when she was little her father, ‘would hide her from visitors to the family home’. And her stepfather, has advised her in her adult years, ‘you should not have children...its not right to bring children into the world...like you’.

These stories and memories have the potential to create and sustain the mindset that having a facial difference is a term that is associated with being ‘less than’. A perspective that can be traced back to their birth. Left unchallenged this view can become a barrier to learning from experience. There is a foreclosure to it being any other way; there is such an inability to learn from experience.

It was generally acknowledged by the people with a facial difference that ‘parents had a lot to shoulder’, and they recommended that all parents of the new-born baby with a facial difference should have the opportunity to talk about the experience of the birth; the coming to terms with not having a ‘perfect baby’. Perhaps this is indicative of how they believe that some of their difficulties of living and relating with others stem from their own childhood experiences.

2.2.2.2 Reactions from others

The main concern was about staring and teasing. That somehow they felt they stood out in the crowd in a negative way. They felt part of a minority group. A typical response was, ‘it’s the staring and teasing, people can be cruel. The teenage years were the worst years...it was so difficult..teased many times...sometimes it seemed all the time...the laughing...the staring. You know children are quite cruel to children...’

All seemed to have a recollection of how people had singled them out for being different. One person recalled, when she was about 8-9 years old, she was invited to a birthday party, she had not met the family before, when she knocked at the door she was told ‘sorry you are not wanted, here is some cake, you must go now. The door was shut, I did not go to the party, and I was left with the present in my hand’. Another person, remembered a time at school when the teacher selected her to play a part in a play, ‘I was so pleased, it was the first time I had been chosen, but a so called friend, said to the teacher, oh don’t pick her, we can’t understand what she says...so someone else was chosen instead of me’.
Previous experience can create and sustain a sense that others perceive them in a predominantly negative way. Previous experiences can form a 'blueprint' for experiencing, a template against which future experiences are anticipated and evaluated. Without challenge, previous experience creates distortions in perception, for there is an inability to be open to experiencing the new, an inability to learn from experience. These templates inform their response to others.

### 2.2.2.3 Reactions to others

All commented on how they respond to others, particularly unknown others, for example:

- 'I instinctively expect people to reject me'.
- 'I always hid my nose/mouth behind my hand, until someone said that this drew attention to it'.
- 'When I speak to people, I wonder what they will think of me. If I stay away from people I won't get hurt'.
- 'Feeling isolated with lack of confidence. I just know I go into myself, when I meet people – I don’t want to get hurt'.
- 'Before I meet people, I rehearse what I want to say. I don't like being unprepared'.

There is a sense that there is a repetitious predictable cycle of how others will respond and how they respond to others. This cycle is premised on previous experience, where distortions in previous learning form barriers to learning from experience.

### 2.2.2.4 Effects of difference

All the people with a facial difference, commented on their reactions to their appearance and how it has effected them. There was a sense that their facial difference is always present, that it does not go away, and as such they all had their own way of describing their appearance. For example:

- 'My upper lip is narrow, and my nose is a bit wonky and I sound different. In a way I’m bottom of the tree in every way'.
- 'I have phases when I am not happy with the way I am, I would say that I am never 100% happy, with the way I look'.
- 'I’ve always thought I was ugly. Others see a funny nose, and I think I 'snarl' due to cleft lip'.
- 'Being incomplete and inferior, those were the terms I used and that was the sort of difference I applied to myself. I wasn’t good enough'.

All commented on how their appearance has affected their lives, how as a result they 'lack confidence' and their self esteem is 'low' or 'poor'. For example one person said, 'if you are different everybody has the right to treat you differently. They don't think you've got feelings, they think you don't look right, mentally impaired, and then when you don't speak right they don't want to know'. Another person said, 'I think that no one with a cleft palate speaks without
thinking are people going to understand...either overtly or secretly. Me, I am always waiting to be ridiculed. Speech - that for me is the root of all my inferiority.

The overall view was that having a face that was different to others was difficult, and that it resulted in a low self-esteem and lack of confidence. There was also a sense of the past being replayed in the present, the past created a way of interpreting experience in a fixed way, a predictable way. There appeared a certain inevitability in what they spoke about, a sense that they had ‘been there’ and ‘done that’. There was a sense of it not being possible for it to be any other way, for there was no questioning, no awakening to the possibility that it could be different. It was as if the future had already happened; there was an inability to learn from experience.

3. Composite depiction

The composite depiction develops the conversation further, and was created from the themes that emerged from the individual depictions, as such the views of the group are presented in two sections; the therapist and client experiences of therapy, and experiences which can precipitate the need for therapy.

3.1 Therapist and client experiences of therapy

All the therapists were committed to providing therapy for people with facial difference; they had worked in the field for an average of five years. During this time they had worked with a variety of people who had accessed the service because they were having difficulty in living with a face which was visibly different to self and others. A central issue for the therapist was about empowerment, to help the client to learn new skills, new ways of interacting with others, and in so doing to see their situation from a different perspective. It was believed that the presence of a facial difference should not be a barrier to leading, a ‘normal life’. And those who accessed the service did so due to ‘problems of coping with the reactions of the general public’.

It was also recognised that ‘the issues they present with are facial, but then very quickly there are a whole lot of other things. I think so often they are so caught up in there on own conditions of worth, which have been imposed by parents, teachers, friends, non-friends...to be able to put that on the side and say I value me because I am alive’.

The potential outcome of therapy was for them ‘to feel comfortable with life and experiences, to take part in things they have previously not been able to. Firstly to acknowledge why ‘am I’ stuck, and then how can they move forward, but without me telling them how to do it’. Also that it is about the need for the person to recognise themselves; ‘I’m not whatever it is, that I am not someone with what ever it is...I am not a label, I am me’. It was also acknowledged that ‘therapy is a two-way thing...I think they have to participate and they don’t need to look to me as the fairy godmother to make everything right. They have got a responsibility and they need to decide that the time has now come ‘for me’ to take action to improve ‘my life’. During the
process of therapy they begin to 'recognise where they have been stopping themselves, or putting their lives on hold'. Also, 'there is a dawning realisation that they cannot blame it all on their face, because part of it is how they react to other people, that they are reactive instead of proactive'.

Therapy was about enabling a person to talk through their experience of living with a facial difference and through this process they were able to challenge previously held beliefs and attitudes about how they perceive themselves and other people's reactions towards them. It was a change process, and one that encompassed learning through exploring their current situation and looking at alternatives; 'to think about things.... examining alternative ways you can think about an issue...and being able to choose from those alternative explanations, one that helps you feel more confident about how you feel in that situation'. Also, that 'with a bit of support, they can turn their lives round'.

The three therapists recognised that 'being with clients is a learning curve', for some it is the realisation that the effect of the difference is more profound than stated in the literature. Or that their previously held beliefs about difference were challenged and called into question. The issue of training was also raised, and it was acknowledged that it is 'important to know how you think about the world before you embark on any form of training, because it actually should help you decide what sort of counselling training you do and what you offer to other people'. Another issue that was raised centred on whether the therapist should or should not have a facial difference when working with this client group. For some, it can be deemed helpful; 'I think sometimes they will think about it along the lines of if she's done it then so can I, or they may say, that their difference is not so major, or minor. But I think it's more about them realising that they don't need to accept this negative view of self...and I suppose in a way, if I can be seen as a positive role model then so be it'. Whereas, it was also felt that 'having a disfigurement was not the real issue', as what clients 'really want to know is, do you understand the issues that I am bringing; asking for help with'.

From the clients perspective, therapy had been self initiated, usually an event or a series of events had culminated in the need to talk about things; 'there were situations at work, my fathers demise, the 'bubble burst' and I felt so alone, isolated and lacking in confidence, I saw a counsellor for twelve months'. Some had experienced one, two or more therapeutic relationships; the experiences lasting from a few weeks to several years.

Overall it was considered helpful to talk to someone who was neutral; who did not know the family, 'who would not be upset by what I said'. It was difficult to be specific about what it was that made therapy helpful, 'I'm not sure what she did that was helpful that made me realise that my views about my face were ones that I had learnt from others, I'd never really explored what it means to me. I think maybe it was being with someone who was there for me, who was really
trying to understand me...when she did not understand she asked me to say more about it, or explain what I meant...that was really helpful; it made me think about what I was saying. It made me realise that a lot of my thinking was distorted'. There were elements of being listened to and that their story was worthy of being told and heard by another; ‘my therapist listened to me in a non-judging way. She did not criticise me; my feelings about myself, my face, were heard for the first time ever. It was not just about her hearing but I could hear myself. I was able to articulate how I felt and feel; and that was good’.

For some the process was ‘frustrating at times, because there were no straight answers, it was not a conversation with a friend. There were times when my views were challenged, and this made me think about what I had said, and I gradually came to realise that a lot of my thinking about myself was not right. I still held on to the hurt from the playground taunts ... I created an invisible barrier around myself, to protect me, to keep people away ... I expected them to respond to me as others had ...I did not give them a chance to be different’. For some the frustration could not be worked through, for it was too difficult – ‘I could not remember what it used to feel like, for example when I was ignored at school. Possibly too, my memory is selective, and blocks unpleasant things to protect me’ – and therapy was discontinued.

For those who stayed with the process, there was generally a feeling that a change had taken place, ‘I now realise, through therapy that it’s up to me how I deal with it. It’s no good being a shrinking violet...it’s about pushing self forward...to meet with people and feel positive about myself’. Alternatively, ‘therapy made me aware that I can’t change how I look, but I can change how I think and feel and about myself. I always thought I was ugly, but in therapy I began to look at the qualities I had, and then to explore what it is that I like about myself. My thoughts not what the family said, or people at school; you know you have to like self first. And that gave me a lot of confidence in myself’. As such therapy had provided the opportunity to explore thoughts and feelings around their facial difference, and through the process to learn about how they felt about themselves; how they make sense of their experience, it was learning that was significant to them, a transforming of previously held beliefs and attitudes. Therapy offered an opportunity to return to learning from experience.

3.2 Experiences that can precipitate the need for therapy
Parental concerns can start pre-birth, either as a worry that a familial congenital anomaly may represent itself, or the presence of the anomaly was picked up at routine pre-natal scanning. On discovering that she had passed on her congenital anomaly to her son at a routine pre-natal scan: ‘I went to pieces, and I wanted to have him terminated. Even though I knew there was a risk because of the family history, and I had been for genetic counselling...I just thought it would not happen again. After I got over the shock, I mean I know its not life threatening, my main worries were that he is not going to go through what I went through. I did not accept him, could not push him into the world, so I had a caesarean. It was a real struggle to feed him; we were in
and out of hospital. The staff just thought I would know how to handle it, because of my own experience, but I didn't, they just said I could cope. He's due to start school soon, and I expect he will come home and say that children have been calling him names ...it's just history repeating itself.

For others the condition presented itself at the birth. At birth the issues focused on telling others the news, coping with their own feelings of guilt and rejection, and coping with feeding difficulties and surgery some time during the next three months. 'When I gave birth to her I did not know what it was, a complete malfunction. I did think that she would die — solve all the problems — best thing for everybody. She was my second child, if she had been my first then I'd never had had anymore. She was a one off ...its hereditary but I suppose it had to start somewhere. People on the whole were not sympathetic, my father would not see her and my mother went to pieces. My husband was OK, but he was not as loving to her as our first child. He also did not want me to tell people, not to let them know about her face. I found it terrible - I feel terrible guilt. Obviously in time it disappears. You put your child through eleven or twelve operations. But you know that whenever I look at her, I see someone whose face is not perfect. It does effect the whole family and puts a strain on your marriage. It has affected her too, she has 'black moods'; it's a legacy. When she was small and we would pass the butchers shop she would scream when she saw his white coat, it reminded her of the hospital. When she was in hospital it was the best place to cope, because everyone was in the same boat. At school she was teased a lot; school was difficult she was always moaning that people were staring and laughing. You know it was heart wrenching to hear about it, as a mother I could not make it better. Although, things did get better when she was a teenager, well as long as nobody made a spectacle of her. I used to try to pre-empt reactions, and as she got older I needed to be more vigilant, I just took one day at a time'. Overall, there was a view that parents need both support and education as their child relies on them to help them cope with having a face, which is visibly different.

When they were older, usually late adolescence or early adulthood, some parents were able to talk about their reactions to the birth. The memories of this were then available for re-telling. 'When I was born at 2.45 am, the midwife told my mother that I had a cleft. Mum had read an article about this, and thought its OK, because there is surgery for this. Meanwhile, I was thrust into my fathers' arms. He left the hospital about 5 a.m., went straight to his mothers and wept in her arms. My mothers' mother refused to acknowledge my existence to her friends for about the first six weeks of my life. At the age of ten, my mother developed some kind of neurosis. I later learned from my father that the psychiatrist blamed it on her reaction to bearing me. Having a cleft was seen as a tragedy: It need not have been. It has made me a very sensitive individual, but also a very vulnerable one, easily stressed and depressed'.


'My dad said to me last year, I had to persuade your mother to look at you and to hold you. She didn't want to accept me because of my cleft, and was anxious to know which side of the family did it come from...each side were blaming the other. It does have a major effect, always knowing that I was treated differently in the family. My parents would not talk about it when I was younger. I think how you feel about yourself in the beginning can have problems in later life. For me, I've always held back, never really felt good enough'.

For those with a facial difference, a commonly held view was that other people would comment negatively about their appearance, and that this had been a learned response from childhood. "When I speak to people I wonder what they will think of me. I tend to stay away from people...then I won't get hurt...I learnt that at a young age...I can still hear the names they called me. I became timid and shy and a loner at school. You know there are two choices, either blend into the background or become aggressive. But I am what I am, and I'd like to be able to say that...to say this is me...this is the package...like it or lump it. But I find it hard to stand up for me...I go red, I blush and then I walk away'. There is a tendency to withdraw; 'when I am with other people, I go into myself. I instinctively expect people to reject me, and am surprised if they don't'.

As a result of the reactions from other people, a picture of himself or herself is formed as someone who is 'different': 'If you are different everybody has the right to treat you differently, they don't think you have got feelings. They think because you don't look right then you are mentally impaired and then when you can't speak right they don't want to know. Jobs...as soon as they look at you, you are discriminated about...for example a job on the telephone - need someone to speak in a clear and concise manner. If involved with members of the public, the image they want is blond haired instead of someone with a lopsided face. But you know a cleft is not a major disability. However, there is a stigma attached to being different. And it is others who make you feel different, especially at school, made the butt of everybody's jokes'.

The reactions from others can subsequently effect how they interact with others. 'At school, I was lonely because it seemed that virtually no one would speak to me. The girl who had to sit next to me in class was spiteful to me. I was very shy and inhibited in my teens. I used to walk about on my own during school break times, assuming that the gang would not want my company. Today, I lack confidence in my ability to socialise, and as a result I feel rather isolated. Also I'm not able to form a lasting relationship with a partner'. Early negative experiences act as a template against which current reactions are measured. Positive comments are disregarded, 'I'm told how people often don't notice for a while but I don't believe them. My partner says its not noticeable, so why do I make such a fuss whenever I meet new people; he doesn't understand'. Early childhood experiences impact on how they perceive themselves and how they respond to others; and there is a persistent view of 'still standing out'. Previous learning experiences can create a template for anticipating and evaluating future experiences,
meaning making is distorted for it is premised on previous learning, these distortions create barriers to learning from experience.

4. Exemplary portrait

When John was five, he asked his mother about his appearance, she replied 'you are a punishment for something I have done'. John recalled that as an adult his father told him 'you were such a shock to your mother, she had problems for many years with her nerves'. When he was sixteen John was going to ask a girl out, and he told his mother of his plans, she said 'the girl might laugh at you - so don't do it'. I took this to mean that girls wouldn't want to go out with me, and it would be better not to ask. This early experience did not do a lot for my confidence, and this comment by my mother virtually emasculated me, and I regarded women as being 'out of bounds'. It was my wife who asked me out, she was a friend of the family'. In later life, his father used to say to him 'you were such a shock to your mother; this too did not do much good for my self-esteem'.

He also recalled, how although he was academically bright, winning a prize at primary school, when he went to sit a scholarship 'the maths paper covered subjects I had not done, I did not have the confidence to say this, so I just got up and walked out of the examination. My parents constantly reminded me of my inability to complete anything'.

John entered therapy when he was in his fifties, his marriage was over, and he was having difficulty in socialising. He was in therapy for five years, during which time he also commenced training to be a therapist. He commented 'therapy was a marvellous experience, and it has made such a difference. For me my relationship with women was a central issue - I can trace it back to my early experiences. I began to explore my views around my appearance and speech, for me my speech has been my major difficulty. For example, I would rehearse for ages before asking for cinema or theatre tickets, and if I were not understood I would walk away. Now I know that people can understand me, and if they don't I will repeat, its no big deal. I have even started to initiate conversations with people. Pre-therapy this was something I would not have contemplated - I feared rejection. My self-confidence has increased many folds.

Through therapy I have confronted many issues, my therapist would challenge my views about myself, and would often say that I was good enough. Gradually I have come to see that maybe I am good enough. My therapist was a mirror. It was good to say what I wanted and to be accepted for who I am. It is a struggle to accept normality, to know that I don't sound OK and to not give a damn. Learning to be normal despite cleft - it works some of the time'. Commenting on the outcome of therapy: 'I have improved self-esteem...due to facing my greatest fear...I'm sure that looking at things correctly ...a lot of the time my thinking was distorted. I realise now how important our early experiences are. Also through therapy, I have come to realise that we socially and emotionally set ourselves apart'.

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5. Creative synthesis

Therapy provides an opportunity for a person to talk through their experiences of living with a facial difference. Through the therapeutic relationship and process the person is able to explore how they make sense of their experience. To explore how facial difference can define the person. This exploration has the potential to uncover distortions in how they perceive the world. These distortions usually emanate from early learning experiences, and have the capacity to act as a standard for all future experience. For example, experiences of being treated negatively by others may create the mindset of being less than others, not quite the same, not quite good enough. When meeting new people there is an expectation of being received as per previous experience, and this negates experiencing the new. Previous experiences are thus the template for evaluating future experiences. As such there is an inability to learn from experience; where there is trauma there is an interruption in learning from experience.

In recognising how early socialisation processes have the preponderance to generate distortions in learning, there is a need for parents to explore their experience of having a child with a facial difference. For example they may experience guilt at having produced a baby that was not anticipated; they need to mourn the loss of the baby they did not have. They need to explore their experience of witnessing their child being responded to negatively by others. As such there is the potential for it to be an intergenerational process; both child and parent experiencing feelings of being less than; with the potential for this to impact on relating to others and each other. Where there is trauma there are interruptions to learning from experience.

Therapy provides an opportunity for re-learning; it is a reparative discourse where the potential is for the person to return to learning from experience. To experience his or her own experience; facial difference does not need to define the person.

Conclusion

The heuristic method of analysing data informed the findings presented; there were two areas that were explored in relation to facial difference, the therapist and client experience of therapy and experiences that can precipitate the need for therapy. As the participants were not asked to speak of learning experiences (so as not to influence the experiences shared) there were two layers to the presentation of findings. There was the participant’s experience and the researcher’s identification of learning through therapy and the barriers to learning that may precipitate the need for therapy as a form of learning. The research participant’s words were in Italics, alongside, where appropriate the researcher identified either barriers to learning and/or learning (these were not at this stage located in the literature) drawing on the three working definitions of significant, transformative and emotional learning (as developed in chapter two, and restated in chapter five).
Initially the themes that emerged from the data were stated, there were three themes within the area of therapist and client experiences of therapy (reasons for seeking therapy, therapeutic experience, and the outcome of therapy) there was evidence that therapy provided the person with an opportunity to explore their difficulties in living and relating with a facial difference. Through the process distortions in meaning making were uncovered and worked through, therapy provided an opportunity to return to learning from experience. The six themes that emerged in the area of experiences that can precipitate the need for therapy, were subdivided into two categories, parents (reactions to giving birth to a baby with a facial difference, and ongoing concerns) and experiences of people with a facial difference (reactions to stories of their birth, reactions from others, reactions to others and effects of difference). Giving birth to a child with a facial difference appeared to be an emotionally traumatic experience. There was evidence of the trauma being ongoing, and the need for a place to explore their feelings around giving birth to a child that was not expected. Living with a facial difference can create difficulties, difficulties that can be premised on distortions in meaning making perspectives. Where previous experience becomes the template for evaluating future experience. Templates that are barriers to learning from experience.

The next stage of analysis was the presentation of a composite depiction, which represents the groups experience of the phenomenon. An exemplary portrait of one person was provided that captures the flavour of the lived experience. Both of these stages further develop the exploration of therapy as a form of learning for people with a facial difference, and draw on the participant’s words. The final stage of data analysis, the creative synthesis represents the researcher’s understanding of the phenomenon that emanates from conducting this heuristic inquiry. Early experiences can create a negative view of the self; that facial difference defines the person. An inability to learn from experience can sustain this negative view. A view that may be passed down from the parents, an intergenerational transmission of a template for the evaluation of future experience; facial difference becomes a term that can define the person. Therapy can provide a reparative discourse to enable a return to learning from experience.

The next chapter is a discussion of the primary construction presented here, and completes the first cycle of interpretation of the methodological framework being tested out in this study.
Chapter Seven

Discussion of the Primary Construction

Introduction

The aim of this chapter is to develop a conversation on how therapy can be seen as a form of learning and builds on the presentation of findings (the primary construction) in the previous chapter. The particular emphasis is on people with a facial difference, and therefore the conversation is developed in relation to how people with a facial difference may require therapy as a form of learning. The three literature reviews (discussed in chapter two) on psychotherapy, learning and facial difference inform the exploration. The discussion of findings is structured as per the headings of the previous chapter, initially there is a discussion on the themes that emerged from the individual depictions, followed by the composite depiction and exemplary portrait. Next is the discussion on the creative synthesis, that is representative of the researcher’s understanding of how therapy can be seen as a form of learning. In conclusion a review of the discussion is provided, and the two phrases from the creative synthesis that will be deconstructed in the next interpretative cycle identified.

1. Analysis of themes that emerged from the individual depictions

Initially the three themes that emerged in the category of ‘therapist and client experience of therapy’; reasons for seeking therapy, therapeutic experience, and the outcome of therapy, will be discussed. Followed by a discussion of the six themes that emerged in the category of ‘experiences that may precipitate the need for therapy’.

1.1 Therapist and client experience of therapy

1.1.1 Reasons for seeking therapy

The therapists in this study were working for two charitable organisations that provide a range of services for people with a facial difference. The organisations provide information, support and befriending, one-to-one counselling and training workshops for social skills training. Hughes (1991) makes reference to, the plethora of self-help groups, which have sprung up to meet with consumer demand for more information and support with particular conditions. It is acknowledged that the support and information provided by someone who has gone through a similar experience can be helpful to some people (Partridge and Nash 1997, Robert et al 1997, Brammer et al 1993). Whereas, others benefit from ‘befriending’ on a one-to-one basis; a ‘befriender’ is not only someone who has been through a particular experience, but has been ‘trained’ in the skills of offering support to others (Clarke 1999a). Social skills training is recognised as a method of providing coping strategies for handling social interaction, and as a result may enhance self-confidence and reduce anxiety.
(Robinson 1997a, Robinson et al 1996, Partridge et al 1994, Bull and Rumsey 1988, Rumsey et al 1986). The combination of counselling with social skills training is recognised as being helpful in supporting an individual coming to terms with a facial difference (Kent and Keohane 2001, Newell 1998, Clarke 1999a, Turner et al 1998). Thus it would appear that the two organisations provide a range of activities to meet with the educational and psycho-social needs of people with facial difference.

The therapists commented on why people sought out therapy, this was because they were experiencing some difficulty in coping with their appearance and the response they got from the general public, this is supported in the literature (Moss 1997, Bradbury 1996, Robinson et al 1996, Partridge 1994, MacGregor 1990). There is a similarity in the effects of facial difference irrespective of the type or the cause of the difference (Solomon 1998, Moss 1997, Robinson 1997a). Contrary to popular belief there is no correlation between the size of the ‘disfigurement’ and the extent of psychosocial difficulties encountered (Robinson 1997a, Elks 1990); minor facial anomalies are considered to be more difficult to cope with (MacGregor 1990). Within the literature reviewed, it was Pertschuk and Whittaker (1982) who commented on why this may be so, and suggest that the defence mechanism of repression may create and sustain this situation, whereby the person with a larger defect may rely on repression as a coping mechanism. Therefore on observation they may give the impression that there are minimal psychological problems associated with their appearance. The therapists in this study did not make the distinction between the types/forms of facial difference, they focused on the issues that were considered important for the person to seek therapy.

Another general theme was that if the person did not have the facial difference then all would be well, and as such this links in with their appearance and how it does not measure up to the perceived norm. The ‘beauty myth’ contributes to the desire to be ‘perfect’ for the myth compounds the view that success and happiness come to those with the perfect/ideal image (Coutinho 2001, Robinson et al 1996, Jackson et al 1995, Woolfe 1990). In her book The Beauty Myth Woolfe (1990:16) suggests that ‘the modern arsenal of the myth is a dissemination of millions of images of the current ideal’. The media as such fuels the myth (Coutinho 2001, Woolfe 1990, Bull and Rumsey 1988). The key to this myth is the notion that physical attractiveness equates with goodness, and that badness is associated with physical unattractiveness (Dion et al 1972); therefore, those who have a facial difference are considered to have a less than acceptable form of appearance, (Bronheim 1994, Feingold 1992, Eagly et al 1991, Hatfield and Sprecher 1986). This can be representative of a sociocultural distortion in meaning perspective, Merzirow (1990); whereby the stereotypical viewpoint creates a closure to experience, for there is an anticipation of how the person should be, based either on previous experience or from opinions of others.
Another related aspect of not measuring up to the perceived 'perfect image', is that it has the potential to impact on social interaction, and for some they believe that reconstructive surgery (plastic surgery) will be able to restore their appearance. Or rather that surgery is designed to make those with an atypical appearance more acceptable to society (Glover 1988); and make them feel attractive (Bronheim 1994, Thomas 1990). Both of these perspectives appear to be incorporated in the following quote by McNeil (1998:327) who comments in his book The Face 'some people blame their problems on facial flaws and see plastic surgery as a royal road to happiness'. However, in relation to people with a facial difference, the view that surgery can solve all problems is another myth (Partridge and Cooper 1996), and as such 'surgery is a magic wand that will remove my disfigurement and solve my problem' (Coutinho 2001:8) [original emphasis]. This myth is representative of an epistemic distortion in meaning perspective (Mezirow 1990), here the knowledge of plastic surgery is incorrect, for there is the belief that it can restore a normal appearance.

Reconstructive surgery is helpful to a certain degree, in repairing damage due to illness or trauma, or correcting congenital anomalies (Pruzinsky 1997, Cash 1990, Thomas 1990). The focus on reconstructive surgery is to see the problem purely as a medical one (Robinson 1997) and there is a need for a shift in emphasis from surgical outcomes to emotional outcomes (Cochrane and Slade 1998). Shaw (1981) also mooted this perspective when he suggested that now surgical techniques have reached a plateau there is a need to look for alternatives in helping people to adjust to facial disfigurement.

It is recognised that people who are not happy with their appearance, both those with a recognised form of facial difference, and those who are labelled as having body dysmorphobia (those who have no physical imperfection but believe in their mind that they are grossly deformed) (Cash 1994); have high expectations of reconstructive surgery (Pruzinsky 1988). The collaboration of plastic surgeons and medical psychotherapists is advocated for this client group, as it can both increase awareness of the expectations of surgery, and lessen the repeated requests for surgery (van Moffaert 1992, Edgerton et al 1991).

One therapist in this study commented, 'I think for some they are so fixed on the surgery providing the answers, that I explore with them where this thought comes from, how realistic is it'. This seems to encapsulate the idea of beginning to explore and challenge the misconceptions that surgical techniques can provide all the answers; for it is recognised that some people may benefit from psychotherapy as opposed to surgery (Webb 1987). It is suggested here that the emphasis on surgery is the technical remit, whereby there is a focus on the outer presentation, the quest for outer perfection to meet with the current perceived media generated ideal image. Whereas, psychotherapy
can provide an opportunity for an individual to explore their thoughts and feelings about their appearance, and to challenge faulty perceptions. It is about valuing humanness. There is also the potential to transform previously held beliefs and attitudes.

From the client's perspective there appeared to be two referral routes; either a referral was suggested by others (e.g. general practitioner, colleagues, counselling training requirements) or self-initiated. This was generally linked to a crisis related to their appearance, either they were not happy with their appearance and/or the reactions of the general public, the outcome of which created difficulties when meeting new people.

There was a correlation between the presenting issues identified by both therapists and clients. The difference being in the language used, clients referred to a specific crisis in their lives, for example one person said ‘it suddenly all got too much for me ...I had just finished a relationship and I blamed it all on my face.... But I realise the feelings about my face were there before the relationship and that the two were not connected. He did not finish with me because of my face...it just gave me the excuse to enter therapy ...I should have done it years ago’. Whereas the therapist’s commented more on the generic need for therapy and this was appearance related. This study provides previously unreported information on the clients' experience of what initiated therapy.

Within the literature on facial difference, there were two direct references to why a client accessed therapy, and these were from comments filtered through the therapist. ‘I have a portwine stain on my face. I got laser treatments for it last winter and realised I have a lot of feeling about it that I have never dealt with’ (Milioria 1998:386). Whereas, Niederland (1975:450) said that the client was referred to him as she suffered from ‘frequent anxiety attacks ... and recurrent episodes of depression’. These were attributed to her facial disfigurement and her difficulties in socialising. Bradbury (1996) in her book Counselling People with Disfigurements, makes reference to how a crisis in life may trigger unresolved conflicts about an individuals disfigurement, and the crisis may as such not be related to their appearance. It would thus appear that the findings of this study correlate with Milioria (1998), Niederland (1975) and Bradbury's (1996) comments.

There was a sense of the person with a facial difference not owning their difference, rather the 'problem' was externalised, for if they had a perfect image then this would solve their problems. Previous experiences have informed their self image, an image that may have been formed by the negative responses of others to their appearance, it is as such a distorted image, and this can create a barrier to learning (Williamson 1998, Rogers 1967). Williamson (1998:174) goes on to state 'many people remain trapped within ascriptive images of themselves which have been built up for them and which are opposed by others. Lacking the means to question this they remain confined with
narrow assumptions of their lives'. This appears to be representative of the experience shared in this study, for those with a facial difference can be 'trapped', and it is suggested here that therapy offers an opportunity to question their 'ascriptive image'.

1.1.2 Therapeutic experience

The therapists in this study preferred mode of working stemmed from the training they had received. One of the therapists relied on cognitive behavioural therapy techniques, and this approach is the one that is most widely referred to in the literature for being effective with people with facial difference (Newell 1998, Bradbury 1997, Rosen et al 1995, Bronheim 1994, Bradbury 1993, Cash 1990). Although in agreement, Heinberg et al (1997) make the distinction of how this is particularly so in cases of visible scarring, e.g. hands and face. Whereas, Kent and Keohane (2001) suggest that the combination of cognitive behavioural therapy with social skills is the most effective form of treatment. The other two therapists relied on person-centred and psychodynamic approaches. As such, the range of underpinning theoretical orientation of the therapists in this study, is representative of the three main approaches to therapy (McLeod 1998, Stewart 1992, Mahrer 1989). The link between them is the therapeutic relationship (McLeod 1998); as one therapist commented 'I think it is more about seeing each person as an individual and the relationship we develop'. It was this aspect that the therapists commented on, their experience of the working alliance. How it is fundamental to empowering the individual 'that there are things they can learn, to be in a more powerful position'.

The therapists were describing how they are facilitators of learning (Heron 1989, Knowles 1984, Rogers 1967), whereby they encourage the clients to discover their own solutions, and this embraces the notion of self-directed learning. The learner is active in the learning process, and previous experience is acknowledged. The relationship between teacher and learner is a necessary requisite for this form of learning (Rosenow 1998, Jarvis 1997). The use of the term 'teacher' can be misleading, for the traditional view of the teacher is the one who imparts knowledge to the students, Laubrillard (1993:29) suggests 'that teaching is a rhetorical activity: it is mediated learning, allowing students to acquire knowledge of someone else's way of experiencing the world'. This is at odds with the role of the facilitator, which encompasses the notion of facilitation, learning how to learn (Knowles 1984, Rogers 1983). In relation to therapy, it is the relationship between the therapist and client that is fundamental to learning, where the therapist is a facilitator of learning.

From the client perspective, of those who had a positive experience of therapy, it was the therapists' ability to listen to them and for them to feel listened to that was most important, and this correlates with the views of the other client's experience of therapy (Stracker and Becker 1997, Howe 1993). There were also comments that the therapist was 'an independent ear, could understand me, and
was interested in me'. As such these support Orlinsky's (1989:427) view, 'the human qualities of the relationship have more consistent impact on patients than do technical aspects of therapy'.

Those who found the experience to be less than satisfactory commented on the apparent lack of understanding of the therapist concerning how the person with the facial difference felt about their appearance, for example one person said, 'all she [therapist] kept saying was that I looked OK, and for me that was not what I wanted to hear. I wanted my concerns about my face taken seriously'. It could be argued that the therapist was challenging the person's perception of her appearance, and that this is what the client needed, to explore their distortions in previous learning. However, the timing of the interpretation is questionable, for the client was unable to work with this, and subsequently terminated therapy. It could be that prior to challenging previously held beliefs, there is a need for the therapeutic relationship to be established. For the client, to feel safe and accepted prior to exploring and challenging previously held beliefs, as such the therapist needs to provide a secure base (see Holmes 2001, Bowlby 1988).

Another possible interpretation could be transferential issues, the client projecting a previous experience onto the therapist (see Freud 1915). Or countertransferential issues, Bronheim (1984) makes reference to this in the field of working with people who have had radical head and neck surgery, and the need for the therapist to be aware of their thoughts and feelings surrounding facial difference so as not to project these onto the client. He also suggests that the therapist needs to have knowledge of available treatments, (particularly when working with clients in the immediate post-operative phase) otherwise a form of psuedotherapy can take place.

In relation to the therapist being aware of their thoughts and feelings of facial difference, is the concept of stereotypes. Bull and Rumsey (1988) reviewed eight papers on the unattractive client, and how the therapists perception conclusively demonstrated that therapists prefer to work with attractive clients as they think they are more honest, and likely to be more committed to the relationship. As such, 'a clients level of physical attractiveness may affect the therapeutic process in some way' (Bull and Rumsey 1988:250).

It is suggested here that if a therapist has not worked with someone with a facial difference before, and who also has not had the opportunity to explore their views on the subject, they may inadvertently seek to reassure a client that their face is 'OK' to them, and this has the potential of being heard as not understanding the difficulties that the client is trying to articulate. It is potentially a veritable mine field; for we will never know what the other thinks of us, it is left to fantasy. However, if the therapist is able to mirror the willingness to be open to the client's experience, and
not to impose closure then there is the propensity for the therapist to be a role model, for facilitating a return to learning from experience.

The views of therapy as either 'being helpful' or 'not being helpful', represent opposing ends of a continuum. Into the equation is the skill/quality of the therapeutic relationship, which is dependent on the meeting of the client and the therapist. The ability of the therapist to hear the story of the other without imposing closure, for example one person said, 'all she [the therapist] kept saying was that I looked OK ... I wanted my concerns about my face taken seriously...' could be placed along an imaginary continuum representing therapist responses; of judgmental to non-judgemental. This response would be at the judgmental end, and the willingness to accept the client and their perception of reality at the opposing end.

An area both the therapist’s and client’s commented on was in relation to the whether or not there is a need for the therapist to have a facial difference to work with this client group. Of the three therapists interviewed, two had a congenital facial difference, and this may have contributed to this being an area that was identified as being of relevance when discussing the service offered. The opinions expressed suggest that it could be perceived as being helpful. The comment by the therapist without a facial difference, is illuminating, for she raised the issue of would you only see a heart specialist if he had a heart defect; rather it is the skills of the person that are important.

Bull and Rumsey (1988) comment on four papers they reviewed regarding the physical attributes of a therapist, and conclude that a therapist who is unattractive is perceived as being less credible and helpful. They suggest 'that unattractiveness in the counsellor may enhance the perceived similarity between the facially disadvantaged client and the counsellor, thus increasing the interpersonal interaction of the two, and facilitating the counselling process' (Bull and Rumsey 1988:248). It is suggested here that this could be part of the reason why people wish to see someone with a facial difference. Or it could be that as the potential client approached an organisation working within the field of facial difference, there was an expectation that the counsellor would have a facial difference.

The therapist can be seen to be role model (Corey 1996, Fromm 1994) and this correlates with the views expressed by the therapists in this study regarding whether or not the therapist should have a facial difference, for they have been through a similar experience. However, it could be that their experience of the phenomenon could provide a foreclosure to the client being able to experience their own experience, as there is the potential for the therapist's frame of reference to be imparted to the client. There is a need for the therapist (with a facial difference) to be mindful that therapy with a client who also has a facial difference does not become a form of vicarious therapy. Schapira
(2000) makes this case when the therapist does not have personal therapy, and the therapy they provide for others, is doing for others what they can not do for themselves.

Requesting to see someone with a facial difference is rather like requesting to see someone from the same ethnic background, gender, or sexual orientation. According to Spinelli (1994:65) 'only therapists from the same culture as their client can understand and deal with particular issues brought to them'. This would seem to be the case for some people with facial difference and possibly underpin their request to see a therapist with a facial difference. Although it is recognised that the perceived similarity between the therapist and the client (not just physical attributes) can enhance the therapeutic relationship (Vera et al 1999); it appears that the client with a facial difference focuses on the physical attributes, i.e. appearance to gauge similarities. It could be that this focus is representative of their own experience, that other people’s focus is on their appearance. However, it is suggested here that this focus has the potential to impose closure to meeting the other; for acceptance is dependent on similarity; rather than a willingness to be open to difference, to meet with another and for meaning to emerge in the in-between.

Of the views expressed of what people want from the therapist, there were three differing perspectives, there were those who wanted to know ‘is this how it should be?’ and those who wanted to know ‘what I might expect’ and there were others who, wanted to ‘make sense of it’. The first two views appear to be expressing a need/desire for certainty, there is the potential for the answers given to be perceived as the correct way, or the only way of being; in essence to create sameness. Whereas, the third view appears to embrace the notion of a willingness to be open to experience, to explore what it means for the individual. It is suggested here those whose expectations fall within the third perspective are more likely to perceive the therapist as someone who will not provide answers, but someone who will facilitate exploration of the sense they are making from their experience.

At the heart of transformative learning is critical reflection (Mezirow 1990). It is suggested here that this process contain elements of critical thinking (see Brookfield 1987) and reflective learning (see Jarvis 1987). The outcome of critical reflection is ‘identifying and challenging distorted meaning perspectives’ (Mezirow 1991:87). There is as such a questioning of personal knowing, an exploration of commonly held beliefs and attitudes. Distortions are barriers to learning (Williamson 1998, Boud and Walker 1993, Claxton 1984). Mezirow (1990) is in agreement and defines three forms of distortions, epistemic (about the nature of knowledge), sociocultural (accepted cultural norms) and psychic (psychological anxiety), fundamental to these distortions are previous learning experiences.
Examples of these three types of distortion can be found in this section. For example, epistemic, the assumption is that others will know the answer, for example expecting the therapist or surgeon to have a ‘magic wand’ to make everything better, or needing to know what to expect in five years time. This assumption is founded on providing some certainty, to remove the uncertainty inherent in experiencing experience, and learning from experience. An example of a sociocultural distortion, is accepting the ‘beauty myth’ (the cultural prevailing norm of what is acceptable in the beauty stakes), can create a stereotypical view, that good looks equates with all the good things in life. An example of a psychic distortion is how previous experience can create anxiety, an anxiety that can be evoked by the thought of encountering a similar situation. It is suggested here that the three distortions are not mutually exclusive. It would seem for the person with a facial difference there is the potential for all three to be present.

The person with a facial difference may have difficulty in social interactions, and this has the potential to create and sustain distortions in meaning making perspectives. One way of interpreting this is, that firstly within the sociocultural domain the acceptance of the ‘beauty myth’ can create a sense of being less than, there is an anxiety that others may perceive them to be less than. This belief informs a psychic distortion, the result of which may be an avoidance of situations that may evoke anxiety. There can be a withdrawal from social interactions, and a search for either a surgical or medical solution to the problem (an epistemic distortion); the problem is blamed on their appearance. The difficulties in working through the barriers to learning emanating from these distortions in meaning perspective may require the assistance of therapy (Mezirow 1990). This need for therapy is also acknowledged when there is a need to work through barriers to learning (Cell 1984, Boud et al 1993, Moore 1974).

It is suggested here that distortions in meaning making perspectives can create a way of seeing the world, of providing foreclosure to experience; distortions are barriers to learning from experience. For there is as such a reduction to sameness, experience ‘happens’ in a predictable way without an exploration of the ‘why’ it is this way. An exploration of the ‘why’ is fundamental for fostering openness to experience; for transforming previous ways of experiencing; and a return to learning from experience.

1.1.3 Outcome of therapy

Both the therapist’s and client’s commented on how therapy is about a change in perspective. The therapist’s commented that their role was about empowering the individual; and subsequently decreasing anxiety and social avoidance. In essence following therapy the clients appeared to view their situation differently, and were subsequently more able to cope in their day to day activities. As such it was about being more positive about self and capabilities; therapy thus has the potential for
facilitating change. Personal change is a consequence of learning (Arlidge and Lavender 2000, Williamson 1998, Rogers 1961). According to Williamson (1998:65) ‘learning is a psychological process which takes place in particular settings of social interaction’, and it is suggested here that the therapeutic relationship is a ‘particular setting’. The term situated learning can be used (Lave and Wenger 1991), a learning that can be implicit or tacit.

A commonly expressed view by those who had had therapy (ranging from six months to several years), was that therapy had changed the person, and this correlates with the therapists perception of the outcome of therapy for this client group. Both therapist’s and client’s referred to therapy as a change process and one that incorporated learning, for example ‘I learned so much about myself’.

From the client perspective, it could be said that those who had experienced therapy and reported that it had changed the way they felt about themselves, had experienced ‘interpersonal learning’ (Strupp 1986). For example one person said, ‘increased confidence in myself, increase in self esteem and feeling more positive about myself’. Several participants referred to how through therapy they had learnt things about themselves and how they relate to other people: ‘I learnt such a lot ... who I am and that I am good enough. I realise now that I expected people to reject me, without even giving them a chance to get to know me’. It is suggested here that these comments are encompassed in the statement of Orlinsky (1989:414): ‘Therapy as a form of education focused on the cognitive and social skills required for effective interpersonal and self-management of behaviour’.

Another frequently stated outcome of therapy was how the person now perceived their situation differently. Through the exploration of thoughts and feelings, and the reflection on previous experiences they came to realise that their previous thinking was distorted. The comment of ‘learning to be normal in spite of cleft... my thinking was distorted’ appears to encompass the view of Orlinsky (1989:416) who suggests that during childhood patterns of behaviour are learned in response to life situations. If the behaviour is maladaptive, then therapy is required as ‘a remedial emotional education’. As such psychotherapy is an ‘educational or learning process’. Whereas Laplanche and Pontalis (1988:373) suggest that psychotherapy is ‘a benign learning experience’ and a ‘psychological re-education’.

The use of the term ‘benign learning’ appears to encompass the experience of the research participants, for although they shared their experience of therapy, and the researcher specifically did not refer to learning so as not to skew the discussion, it would appear that learning was inherent in their discussions. Some specifically referred to the term, whereas others spoke of the changes that had emanated from therapy. Changes that were representative of learning. As such they had all experienced therapy, as a form of learning, learning that was either covert or benign.
The concept of change emanating from therapy is well documented (see Ferrara 1994, Sanford 1990, Zeig and Munnion 1990, Holmes and Lindley 1989). It could be said that therapy enables the person to reconfigure their problems (Eaton 1998), or that they come to realise that they have choices (Hoeller 1990); post therapy they realise that they have ‘freedom of choice and responsibility in the conduct of his life’ (Szasz 1990:172). Whereas, Spinelli (1989) makes the distinction that therapy itself does not produce change, rather it creates awareness that change is possible. It is suggested here, that the experience of therapy can provide the person with the opportunity to explore their current difficulties and to begin to recognise that there are choices in how to respond to a particular situation. That they do not have to rely on previous responses, for this in essence is to place a foreclosure on and to experience; or they can as Casement (1985:27) suggests be ‘Blinkered by past thinking that often functions too much like a set of rules’. Rather, with the growing awareness that change is possible, there is the possibility of being more open to experience. Without choice, there is closure; there is a re-experiencing of a similar experience. Therapy provides the opportunity for a return to learning from experience.

In defining the learning processes inherent in psychotherapy, the terms ‘relearning’ and ‘unlearning’ were used. It is suggested here that these terms encompass the notion of a return to learning. For example, relearning in therapy can be related to behavioural or emotional competencies (Hunt 1948). Whereas, the term unlearning can either be in relation to previous ‘inappropriate’ learning (Elliott 1995, van de Veer 1974), or that it is working through (Gross and Fugstein 1992), and that this process involves emotions (Albee 1999). Both these terms indicate that previous learning was incorrect, or as Mezirow (1990) suggests previous learning can create distortions in meaning making perspectives. It is suggested here that there is a need for ‘corrective’ or ‘reparative’ learning experiences, to enable the reassessment of the foundation to the distortions, a process that involves exploration of personal meaning schemes. Through this process there is the potential for the emergence of learning that is significant to the individual, the experience can transform previously held beliefs and attitudes, and there is a reconnection with the feeling domain of experience. There is thus an increase in emotional well-being, as there is a ‘reowning and reassimilating’ of personal emotional schemes (Greenberg and Paivio 1997:95).

The person who commented that in therapy 'my disfigurement was not the focus' correlates with the views expressed by Milloria (1998) and Niederland (1975), as the disfigurement was not talked about outside therapy, the same is likely to be repeated within the therapeutic relationship. As such the therapist should not expect it to be openly spoken about in the first instance. Rather there is a need for the development of the therapeutic relationship prior to the person being able to speak the unspeakable, to put words to the feelings surrounding the experience of having a facial difference. As Bowlby (1988:140) suggests there is a need for the therapist to provide a secure base (attachment
theory) or a holding (Winnicott) or a containing (Bion) environment, ‘to enable exploration’ of thoughts and feelings.

There was recognition of how previous thinking was distorted; some were able to locate the distortion in ‘early childhood experiences’. It is recognised that early childhood experiences are important in shaping the personality (see Rogers 1951, Freud 1915). Distortions in learning can be transformed by reflecting on the experience, recognising the distortions and for the end result to be re-learning. Mezirow’s theory can be an overarching framework for looking at how learning can bring about change (Brown-Shaw et al 1999).

An issue discussed by some authors is how early experiences may distort how an individual perceives their reality and how there is preponderance to have certainty. Mezirow (1990:5) suggests that ‘when experience is too strange or threatening to the way we think or learn, we tend to block it out or resort to psychological defence mechanisms to provide more comfortable interpretation’. It would appear that the individual is in a fixed position, and as such unable to learn from experience. Another term that is used is ‘dysfunctional learning’ which ‘principally stems from obstacles we encounter in our struggle to be a significant person’ (Cell 1984:3). He suggests that dysfunctional learning is a defence about anxiety, and posits that the aim of learning is to be significant and to cope with meaningless and powerlessness.

Emotions are fundamental to being human, they shape our perception of reality; they are ‘at the very core of psychotherapy’ (Greenberg and Saffran 1987:vii). If during childhood misleading messages are experienced about self image, perceptions may be skewed, and therapy provides an opportunity for an individual to explore these distortions; Bowlby (1988:139) suggests that this exploration enables a person ‘to cease being a slave to old and unconscious stereotypes and to feel, to think, and to act in new ways’. It is suggested here that therapy provides an opportunity for emotional learning, learning that brings about a transformation in how a person views their situation, their self and their relations with others.

This form of personal learning that may emerge through the process of therapy, is not prescriptive, for it is not possible to say what an individual may learn through the process of therapy, rather each will experience learning that is significant to them. Rogers (1951) refers to how significant learning, is individual, learning that matters a great deal to the person, and it would appear that this encompasses the views expressed by the participant’s who share their lived experience of therapy with the researcher. They were commenting on that which was significant to them. Their feelings about themselves had changed, ‘emotion is the basis of both experience and personal meaning’ (Greenberg and Palvio 1997:viii). They also suggest that therapy is about transforming feelings, and
advocate a three stage model for working with emotions in therapy, there is a need for bonding, evoking and exploring emotions, and through the process there is both an emotional experience and an emotional restructuring.

Within the literature reviewed on facial difference, there was a limited reference to how therapy may be helpful, it was generally assumed that it would enable the person to cope better (Partridge 1997a, Ambler et al 1997, Caviccholi 1994, Hughes 1991, Bradbury 1993, Bull and Rumsey 1988). Whereas Bradbury (1997:367) commenting on the place of counselling for children, stated that it would enable ‘them to develop strategies for coping with teasing, with their feelings of difference and with their emotional reactions to their cleft’. And Nash (1995) suggests that counselling for parents of babies with a cleft may help them to express how they are feeling.

The two psychotherapy case studies by Milioria (1998) and Niederland (1975) were unique in that they reported working with someone with a facial difference. Both female patients had a congenital form of facial difference, and the authors commented on the perceived benefits of therapy. Niederland (1975:457) suggested that therapy provided the opportunity to work through ‘the feelings of ugliness and monstrosity, the feeling that she was a member of another species’ and how these were changed during the therapeutic process. Whereas, Milioria (1998:392) suggested that it was a form of ‘emotional work’ ‘transmitting internalization, to change her sense of herself from a freak – flawed and defective – to an attractive talented woman’. The concept of change connects both Miloria and Niederland views, also there is a correlation to the findings of this study that a potential outcome of therapy is change; a change in perspective.

An area that all three therapists commented on was the personal learning achieved through working with this client group. Of particular note was that although they were aware of the literature in the field of facial difference; how a person's subjective perception of their appearance does not necessarily equate with the objective appraisal by others (MacGregor 1984, Pruzinsky 1992). Also that there is no correlation between the size of the disfigurement and the degree of psychological discomfort experienced (Solomon 1998, Moss 1997, Robinson 1997a). However, they were surprised to experience this in practice, some clients appeared to them to have ‘a minor problem’ but in hearing the clients story they became aware of how much time and energy was spent in avoiding situations that were perceived as difficult, or perceived by them to accentuate their sense of difference. In essence their experience echoes Partridge's (1997:4) sentiment, that the facial difference ‘may actually be quite minor but they feel it is significant’ [original emphasis].

Thus working with clients was a learning experience, ‘it made me think more about things’, ‘change my view of counselling that I was not there to solve it for them’, ‘I came to recognise’; statements
that incorporate a change in perspective in the therapists, that mirrors the potential outcome of therapy for the client. It would appear that supervision, talking with colleagues and the process of personal reflection was helpful in recognising their change in perspective; the impetus for change occurring in the therapeutic relationship. Casement in his two books, *Learning from the patient* (1985), and *Further Learning from the patient* (1990), identifies that the meeting of the therapist and client, presents an opportunity for learning. Whereas, Symmington (1986) makes the distinction that in the process of therapy, there is the potential for both client and therapist to be changed. Thus there is an assumption that learning is the potential outcome.

Both Milioria (1998) and Niederland (1975) also described their respective client’s, as being attractive, although the patient thought their ‘disfigurement’ was unattractive. As such it could be said that satisfaction with facial appearance is an individual phenomenon (Thomas et al 1997, Lansdown et al 1991). However, the comments of Milioria and Niederland were not explored further, and it is suggested here that a potential learning opportunity was missed. For can the therapist allow for the difference in perception? How can this be used therapeutically to assist with the uncovering of distortions in perception? How to challenge the prevailing norm of the ideal image? Can the therapist as a facilitator of learning be open to their experience? Can the therapist be able to respond to Lauzon’s view of the need ‘to live with paradox, ambiguity and uncertainty’ this is he suggests is ‘the key to human survival. These capacities can only be developed through the soul’ (Lauzon 1998: 325)? He recognises the shift in education from the imparting of knowledge, to the embracing of uncertainty and personal knowing. He advocates that there is a need to engage in peoples biographies of learning, and from this distortions in learning can be revealed. There is as such an embracing of humanness and the ability to experience our own experience. It is suggested here that therapy provides a ‘situated learning’ experience, where there is the potential for relearning to learn from experience.

1.2 Experiences that can precipitate the need for therapy

Two groups are identified in this section, firstly, those who are living with someone with a facial difference. All who participated in the study were parents (mothers) who talked of their experience of having a child with a facial difference and why they thought there was a need for therapy to be made more readily available. Secondly there were the experiences of people with a facial difference some had had therapy and some expressed their views on the need for therapy. It would seem pertinent to include people’s opinion of therapy as this provides information on how people perceive their situation prior to having therapy, how people construe their reality. Williamson (1998:27) suggests a precursor for learning, is ‘to know how people have come to learn the ways in which they frame their experience and perception of the thresholds they inhabit’.
Initially the two themes that emerged from the ‘parents’ group will be discussed; reactions to giving birth to a baby with a facial difference, and ongoing concerns. Followed by the four themes of the ‘experiences of people with a facial difference’ group; reactions to stories of their birth, reactions from others, reactions to others and effects of difference.

1.2.1 Parents

1.2.1.1 Reactions to giving birth to a baby with a facial difference

The mothers, who shared their opinion of the need for therapy, shared their reactions to giving birth to a baby with a facial difference; and it appears that it was a traumatic time. There was evidence that it took time to come to terms with, and to adjust, to having produced a baby that was not anticipated. It would appear that as well as coping with their own reactions, ‘I must have done something, I feel so guilty’ they had to cope with the responses of their extended family ‘my parents did not want to see him’. These views are represented in the literature.

The sense of the mother having ‘done something’ is acknowledged as being a common response (Hearst and Middleton 1997, Bull and Rumsey 1988); it is suggested that this stems from folklore surrounding difference (Rumsey 1997). Also the feelings of wanting to blame someone, can impact on how the mother responds to the baby (Bradbury 1997, Hearst and Middleton 1997). Niederland (1965:532) is in agreement and suggests that parents reactions to the birth of a child with an anomaly are “recognition shock” and states ‘from the time of recognition of the defectiveness (“recognition shock”) there is a marked disequilibrium in the relations between mother and child – a disequilibrium which hardly ever subsides’. He says that as a result of this faulty mother-child interaction, there is trauma.

It has been acknowledged that it is more stressful to bring up a child with a cranio-facial anomaly (Speltz et al 1990); and that this may be due to witnessing negative reactions of both families and strangers to the child. As such there is a need for a period of time to adjust to the birth, and the feelings of guilt engendered in not producing a ‘perfect’ baby (Bradbury 1997, Walters 1997, Bronheim 1994, Speltz et al 1990). However, the period of time of adjustment is not stipulated, rather there is an expectation that ultimately they will adjust. Whereas, Niederland (1965:323) appears to suggest that the trauma of giving birth may be ongoing, ‘some mothers go into prolonged postpartum depression, which may be later followed by renewed depressions or anxiety states’.

Some parents appear more able to cope than others do, and ‘some do remain acutely distressed and transmit feelings of guilt and shame to the child’ (Bradbury 1997:366). This may result in difficulties with the emotional bond between mother and child (Hearst and Middleton 1997, Barden
et al 1989). Walters (1997:114) reviewed six studies on attachment and concluded that the child with a facial difference experienced ‘less sensitive, less responsive and less nurturant parenting from their mothers than do infants of normal appearance and that this impaired interaction is of a kind that may prejudice the development of secure attachment’. She also refers to how this may impact on ‘future well-being and interpersonal functioning’.

Whereas, a study by Speltz et al (1997) although recognising that there is an increased likelihood of psychosocial problems for people with a cleft, the origins remain unclear. They considered that this might be due to early attachments, emanating either from feeding problems or the baby’s facial appearance, both of which could effect the relationship between the infant and their family. Their study focused on maternal attachment; the hypothesis was that children with a cleft would have an increased risk of insecure attachment. However, this was not supported by their findings (they focused on attachment during the first year of life), and conclude ‘Contrary to social-psychological formulation, the facial appearance of infants with CLP [cleft lip and/or palate] had no adverse effect on the quality of maternal attachment’ (Speltz et al 1997:12). Yet they acknowledged in an earlier study, that by the time a child with a cleft starts school they are three to four times more likely than the control group to have psychological disturbances resulting in behavioural problems (Speltz et al 1993). It would appear that it remains difficult to isolate the cause of the emotional problems, and it is suggested here that this difficulty may emanate partly from the research methods employed. There has been a preponderance to rely on quantitative research methods; to objectify a subjective experience. That in privileging science and technology over humanness, the experience of the human phenomenon is impersonalised, and thus may become unrecognisable from the experience of the experiencer.

A key emotion expressed by the mothers was guilt. This corresponds with a study by Dolger-Hafner et al (1997) who suggest that this is a common emotion, and may lead to depression if the mother is not provided with emotional support and information. According to Hearst and Middleton (1997) the guilt may stem from anger around the unanswerable question of ‘why me?’ To address parental guilt there is a need to provide programmes that will help individuals and the families (Coles-Gale 2000). As such these programmes are about enabling parents for a ‘letting go of their hopes for a perfect child’ (Bradbury 1997:366). However, the nature of these programmes remains elusive, Bradbury (1997) does make reference to how counselling may be beneficial. It is also recognised that there is a need to listen to parents and family experiences of living and coping with facial difference to determine the level of support required (Coulter et al 1999); to assess the needs of parents and children, and to refer for psychological support if there are difficulties in coming to terms with a facial difference (Hearst and Middleton 1997).
There is a sense that the trauma of giving birth to a child with a facial difference may if not worked through becomes a source of intergenerational trauma; a term that has been referred to survivors of sexual abuse and the holocaust (Gardner 1999, Walker 1999). According to Greenberg and Paivio (1997:186) ‘with trauma, the fundamental sense of self-coherence and assumptions about reality are shattered or broken, and the self is deeply wounded. Psychic wounds cannot heal, and the person is vulnerable to these wounds being continually reopened’. An individual may protect themselves from this trauma by creating distortions in their meaning making perspectives, distortions that can create an inability to learn from experience, for to do so there is the risk of the ‘wound’ being opened. Therapy could provide an environment for the working through of emotions surrounding the ‘trauma’ and in so doing there can be a change in meaning making perspectives; there may be a return to learning from experience. Therapy provides the potential for unlearning and relearning, for a transformation in perspective, a transformation that is significant to the person and encompasses both cognitive and affective domains of learning. Greenberg and Paivio (1997:32) suggest that ‘the inability to regulate anxiety is at the core of much dysfunction. Ultimately therapeutic change involves addressing dysfunctional emotion regulating strategies and redeveloping more adaptive ones’.

1.2.1.2 Ongoing concerns

It would appear from the comments made that the difficulties in coping were not limited to adjusting to the birth, but also extended to adjusting to the need for surgery. Pruzinsky (1992) comments on the need to discuss the surgical reality with parents who have a child with a craniofacial anomaly. He does suggest that some parents have difficulty in hearing this, due in part either to denial (that this has happened), or hope (it will be all right), or resort to magical thinking (the surgery will make my baby as he/she should have been). It would appear that some of the comments from the mothers in this study, support Pruzinsky’s view; for despite their children now being adults one said ‘all I see is her cleft’ and another said ‘he [the surgeon] did a good job but she is never going to look normal’. Thus suggesting that accepting the surgical reality was difficult, that perhaps there was a hope that somehow surgery would restore that what was taken away by the congenital anomaly – the perfect image. This is an example of an epistemic distortion in meaning making perspective, for there is the belief that someone with the knowledge can provide some certainty to his or her experience. Or there is a hope that the situation is only temporary, it can be made better if the right ‘expert’ is found, to restore the equilibrium.

The mothers also, talked of how the difficulties were ongoing, that each age range presented new situations that needed to be overcome, for example starting school, changing school, further surgery, adolescence, and finding a partner. They not only had to cope with their own feelings, but to be there to support their child. Coping with the reactions of others to their child, at times was also
difficult; according to Pertschuck and Whittaker (1992) there is a tendency for people to presume that the child is unintelligent and unfriendly, and therefore treats them more formally than others. They also felt that having a child with a facial difference effects the whole family, and this is supported in the literature (Amber et al 1997, Bradbury 1997, Hearst and Middleton 1997, Walters 1997). One mother commented on how the birth of her child had effected her marriage, and this view correlates with Speltz et al (1990).

The mothers commented on how helpful the Cleft Lip and Palate Association, as a support group had been in normalising their experience, to realise that they were not the only ones to have a child with a facial difference. These comments support the opinion of the place of support groups (Partridge and Nash 1997). Overall, they felt that therapy was something that their child could benefit from, to help them come to terms with the reactions of others to their appearance. But it would appear that the parents, also have a need for information on how to respond to others 'I would like to know what to say to others...how to respond'; but what is not acknowledged is the need for them to talk about their feelings and emotions. This would appear to be necessary particularly as there is the potential for the mothers reactions to the child to impact on the mother-child interaction, which has implications for the child's emotional development.

According to Bowlby (1988) there is a need for parents to provide a secure base for their child's emotional development. Thus, therapy could provide an opportunity for the mothers to explore their thoughts and feelings about facial difference, to enable them to provide a secure base for their child's emotional development. Having a baby with a facial difference is traumatic (Ambler et al 1997, Bradbury 1997, Walters 1997), and as previously acknowledged when there is trauma there is an inability to learn from experience (Loewenthal and Snell 1998). There is as such an inability to experience experience. Whereas, Greenberg and Paivio (1997:71) suggest that the inability to express emotions impacts on 'peoples inability to accept their own experience'. Reactions to having a baby with a facial difference are individual, and therapy can offer the potential to explore feelings of either not having what was expected/anticipated (a child without a facial difference) or coming to terms with the fact that 'history had repeated itself'. There is the potential if the parents are not able to talk about what is going on for them for 'it' to be either unconsciously or consciously transmitted to the child (Bradbury 1996, Nash 1995).

1.2.2 People with a facial difference
1.2.2.1 Stories about their birth
All participants made reference to the stories they had heard about their birth, and there is a correlation with the stories told by the mothers (participants were not related); having a child with a facial difference was difficult. There was evidence of how some parents experienced ongoing
emotional problems, which is something that Niederland (1965) alluded to. One person commented
on how she was left in the hospital for three months until after she had had the cleft repaired. It
would appear that her mother had difficulty in forming an emotional bond. It is acknowledged that
some parents are unable to form a strong emotional bond with their child, therefore ‘children with
facial anomalies are more likely than those of normal appearance to be fostered, adopted or placed
on a child protection register’ (Walters 1997:114).

It would appear that there was a translation of feelings of guilt and shame onto the child (Bradbury
1997) for one person reported how they had to hide away when visitors came. This was also an
experience shared by the patient in the case study presented by Niederland (1975). Other examples
of responding negatively to the child were comments made about appearance, or saying that the
person should not have children in case they ‘look like you’. One possible explanation could be the
defence mechanism of projection, according to Bateman and Holmes (1995:81) ‘We commonly
attribute our more difficult and unacceptable feelings to others – for example, blaming those that are
close to us for our own shortcomings’. It is suggested here, that if the parents have unresolved
feelings around the birth of the child, a child that was usually not expected, then they can be
unconsciously projected onto the child. For example saying to the child not to have children because
they may look like you could be a projection of the parents feelings of being unable to accept that
they have produced a child that is not perfect. The reverse of projection is introjection, here the
person takes on board the projected feelings of the other and owns them as if they belong to his or
her self.

Overall it was recognised that having a child with a facial difference was difficult for parents, and
that therapy should be available to them as part of the overall package of care. This sentiment
appears to echo the mothers’ view, that the child should have the opportunity of therapy; both
groups advocating that the other should have therapy, perhaps this is a further example of projection.
However, people with a facial difference also acknowledged the need for therapy for themselves
(those who had had therapy), while those who had not were divided, some saying that they would
have liked the opportunity, and others saying that it should have been available when they were
growing up.

Again there is the notion of how previous experience can impact on a person’s ability to experience
their own experience, rather there are set ways of perceiving a situation, and this set way is an
attempt to reduce the anxiety that may be evoked, or put another way if emotions are not
acknowledged, where there is as such no language for emotions there is the potential for there to be
a rationalised way of perceiving the situation. Symmington (1986:289) suggests that ‘we have
cognitive templates so that we ‘actively’ shape the environment that we see’. Therapy could
provide an opportunity to question meaning making perspectives, to make known the cognitive templates that inform a person’s perception of a particular experience.

1.2.2 Reactions from others

The experience of being treated differently by others correlates with the findings in the literature. Overall the reaction is negative, comprising of staring, teasing and comments (Bradbury 1997, Partridge and Cooper 1996, Houston and Bull 1994, Bull 1990, MacGregor 1990, Bull and Rumsey 1988, Rumsey and Bull 1986), together with feelings of avoidance/rejection or being perceived as deviant (Newell 1998, Robinson 1997, MacGregor 1990). These experiences are a form of social discrimination (Bradbury 1997, McGrouther 1997). This sense of being treated differently is not just paranoia on the part of the person with a facial difference (Robinson 1997a, Bull and Rumsey 1988). Whereas, Bronheim (1994) suggest that they (those with a facial difference) are sensitive to the reactions of others.

Both of these viewpoints are further supported by research studies into the response of others to those with a facial difference. Studies have been conducted, whereby people have an engineered cosmetic facial difference, and are sent out into community to observe and record reactions from others (Houston and Bull 1994, Strenta and Kleck 1985, Rumsey et al 1982). The conclusions drawn support the view that people did respond negatively to them; they tended to avoid eye contact, stand further away or stand on the unaffected side.

The study by Strenta and Kleck (1985) was unique in that although the research participant’s thought they were having a facial difference cosmetically applied, however, this was not the case. They went outside to meet with the general public thinking that they did have a facial difference, and on feedback of their experience, they too reported a difference in response from others to them. This suggests that they were more sensitive to the reactions of others, and thus support Bronheim’s (1994) view; as such they were anticipating being treated differently, and they were. Or it could be that their behaviour towards others was different, that somehow the presence of the ‘facial difference’ made them behave in a different manner, so much so that others were drawn to their behaviour rather than the facial difference.

A further study by (Rumsey et al 1986) combined effective and/or ineffective social interaction skills with a facial difference and/or a non-facial difference, (as before the facial difference was cosmetically applied). The conclusions drawn were that effective social interaction skills can mediate the effect of the presence of a facial difference. This view supports the belief that training in effective social skills training can enable the person with a facial difference to cope better with the reactions of the general public (Turner et al 1998, Robinson et al 1996, Partridge et al 1994, Bull
and Rumsey 1988). Part of the social skills training involves education on how ‘everyone who has an unusual appearance, whatever the cause has to cope with curiosity from the rest of the world’ (Clarke and Cooper 1997:10); as such it is a natural response. This view appears to correlate with Goffman (1956:21) who suggests that when we meet with another person ‘he will want to discover the facts of the situation’. This discovery however, is not just restricted to their physical appearance, but for the person with a facial difference this is their focus of their difficulties, of people’s perceived response to them.

There have been several theories put forward as to why this may be so, on the one hand there is the sense that the myths and folklore that surround facial difference are responsible (Jackson et al 1995, Bull and Rumsey 1988); and on the other, that the person with a facial difference challenges the assumption of a just world (Newell 1998). Or alternatively drawing on Levinas, that prejudice is representative of a learned pre-judgement, and a ‘refusal to find humanity in the face of the Other’ (Davis 1995a: 72). It would appear that whatever the foundation, the presence of a facial anomaly can alter other peoples opinions (McNeill 1998).

The most common stereotype surrounding facial appearance is that good looks equate with success. ‘People who are seen to be physically attractive are also seen to be more socially desirable, likely to secure more prestigious jobs, have happier marriages, be better parents and more competent spouses, more likely to find an acceptable spouse, and marry earlier’ (Elks 1990:36).

Subsequently those who have a facial appearance that is deemed to be unattractive are seen to be less competent, i.e. the reverse of the above description (Jackson et al 1995). These views are formed on meeting the person, and as such there is discrimination without getting to know the person (Bronheim 1994, Bull and Rumsey 1988). This appears to encompass the experience of the people who took part in this study.

Stereotypes appear to be formed early in childhood, a study by Sigelman et al (1986:18) concludes that ‘all signs point to pre-school years as the period when children first display negative reactions to individuals who are physically different in some way’. Of particular note that this ‘some way’ could be the wearing of spectacles, being in a wheelchair, or a facial difference. There appears to be segregation into ‘same’ and ‘different’, where difference equates with a sense of being less than. Within schools and organisations ‘attractiveness bias may operate unconsciously to benefit attractive children and adults’ this has implications for the less attractive (Jackson et al 1995:18). Stereotypes influence person’s perceptions; as such they are not open to experience, they expect the person to be as per their stereotypical image. Some people are of the opinion that people with a facial difference do not experience social discrimination that is appearance related; this could be due to the difficulty in owning for self and others that we treat others differently (Bull 1990, Bull and Rumsey 1988).

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These views represent further evidence of distortions in meaning making perspectives, for example, epistemic (people that have a facial difference are different to us), sociocultural (stereotypes surrounding facial difference) and psychic (anxiety, avoidance). These distortions in meaning perspectives can be barriers to learning from experience.

1.2.2.3 Reactions to others

Overall there was a sense of keeping others at distance; that previous experiences of being rejected influenced how they were when meeting new people. These views are supported in the literature, for social interaction represents a major problem (Robinson 1997a), and there is a sense of putting a greater distance between self and others (Bull and Rumsey 1988); resulting in avoidance of situations to protect the self from potential rejection (Kent and Keohane 2001, Newell 1998, Robinson 1997a).

It would appear that others represent a 'social mirror whose reflections are interpreted by the anomalous person' (Bull and Rumsey 1988:187). Thus if the person experiences negative responses from others, they learn to avoid the perceived threat (Robinson 1997). The comment by Chappie (1997:19) speaking of his experience of living with a facial difference appears to support this, 'I had grown so used to my face being rejected that I couldn't imagine anyone being interested'. As such there is a reversal of the social discrimination experienced by those with a facial difference; this time they are doing the discrimination.

The findings of this study also support the view that the reaction to others is shaped by previous experiences, and as such there is a closure to experiencing new situations differently, as such previous learned behaviour is the template for future experience. The inability to see their situation from a different perspective is indicative of non-reflective learning. Where experience is not open to questioning, to exploring 'why' it may be that way as opposed to this way. To critically reflect on experience is fundamental to personal knowing (Mezirow 1990, Jarvis 1987, Schön 1987, Rogers 1967).

Claxton (1984) defines four beliefs that can create barriers to learning, competent (personal worth depends on actions); consistent (the need in any situation for predictable behaviour and responses); control (the need to know what is going to happen); comfortable (the need to not feel guilty or anxious). He states:

'any learning situation that threatens to make me incompetent, inconsistent, out of control, and uncomfortable appears to be a threat to me – to my survival as the person I think I am or hope I am or ought to be. When one of these triggers is pulled, learning is resisted regardless of what learning is about' (Claxton 1984:145) [original emphasis].

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Within this sphere of interpretation there is a closure to experiencing the new, for there to be learning from experience.

1.2.2.4 Effects of having a facial difference

All described how they perceived their difference, and there was a sense of how other peoples' opinions shaped their sense of inferiority. As such they have introjected the views of others as if they were their own experience, another example of an inability to experience their own experience. Within the literature reviewed there were very few comments on how a person perceived their difference, due mainly to the lack of written accounts from people with facial difference.

The following three quotes appear to encompass how the three components of reactions from others, reactions to others and effects of difference, are not mutually exclusive, rather they are intertwined; they also are representative of the views expressed by the people who shared their experience of living with a facial difference.

‘Distortion of the face is to put at risk the individuals full participation in life’ (Hughes 1991:505).

‘Disfigured people are constantly under the scrutiny of others, and are restricted across the broad range of social situations. They are acutely aware of the responses of others and the generally negative attitude these reveal’ (Newell 1998:68).

‘Social anxiety, lowered self confidence, negative self-image, depression and lowered self-esteem all of which can have a cumulative effect on future interaction’ (Robinson et al 1996:103).

It is suggested here that this ‘cumulative effect’ is representative of the need for therapy, to enable the individual to explore their thoughts and feelings around their facial difference, to recognise projections and introjections and how these impact on their ability to respond to others in the here and now. Therapy offers an opportunity to break the cumulative cycle, and offers the opportunity of a return to learning from experience.

Of the impact of facial difference on life, there were two differing views expressed, there were those who appeared to have no sense of the other, and as such were self-focused, and were unaware that others might be having problems in responding to them (Bull and Rumsey 1988). As such others were blamed for all the problems, for example ‘when you don’t speak right they don’t want to know’. Whereas, others were aware of others, and of their own role in how they set themselves apart, for example, ‘we socially and emotionally set ourselves apart’. Those who had had therapy were more likely to recognise how their attitude can contribute to their sense of difference.
From the findings on peoples' experience of living with a facial difference, there appears to be issues that have their foundations in early childhood and how these have been influential in creating their inability to learn from experience. The key one appears to be around issues of early emotional attachment, that as a group they are more prone to experience a more negative attachment than those without a facial difference (Hearst and Middleton 1997, Walters 1997, Barden *et al* 1989), this has the potential of creating difficulties with emotional development and subsequent interactions with others (see Bowlby 1988). It is suggested here that therapy may provide an opportunity for a return to learning from experience. Learning that is significant to the person whose experience it is, learning that transforms beliefs and attitudes and results in a change in perspective, learning that enhances emotional well-being.

2. Analysis of composite depiction
Firstly the discussion is on the 'therapist and client experience of therapy', followed by 'experiences that may precipitate the need for therapy.

2.1 Therapist and client experience of therapy
The therapists in this study commented on how the process of therapy involves 'empowerment' which encompasses the notion of people taking responsibility for their actions, a concept that is cognisant with self-directed learning (Knowles 1984, Rogers 1983). The therapists described a process of therapy that focused on the need for clients to acknowledge 'why am I stuck', this appears to be indicative of focusing on their current situation. There is an exploration of thoughts and feelings, and through this process there is a reflection on previous experience and the identification of distortions in previous learning. When working with emotions in therapy, Greenberg and Paivio (1997) have identified the need to evoke emotions, and it suggested here that perhaps in the speaking about 'why I am stuck' emotions can be verbalised.

Once the client gains a sense of why they are stuck, the therapists suggest that the client 'can move forward'. This moving forward is indicative of action, emanating from a change in perspective. It could be said that this change is representative of re-learning (Elliott 1995, Hunt 1948) or re-structuring (Greenberg and Paivio 1997). Part of the learning process is the exploration of what the label facial difference means the for client. There is thus a questioning of socio-cultural, epistemic and psychic distortions in meaning making perspectives (Mezirow 1990). It could be said that the therapeutic process provides opportunities to question current meaning making perspectives, and that the learning that emerges encompasses elements of significant, transformative and emotional learning.
The therapists also commented that the process of therapy may enable the client to ‘learn new skills; new ways of interacting with others’. It is recognised that if a person has good interaction skills, or social skills, then this can lessen the impact of the facial difference when meeting new people (Turner et al 1998, Robinson et al 1996, Partridge et al 1994, Rumsey et al 1986). Social skills training is recognised as a way of helping people with a facial difference (Clarke 1999, King 1997, Bull and Rumsey 1988). This view is cognisant with Woolfe (1992) who suggests that there is a need to educate people about difference rather than pretend that it is not there. Education of the general public is also important (Clarke 1999a, Partridge 1997a).

A study by Robinson et al (1996:282) reviewed whether the perceived benefits of attending a social skills training workshop for people with a facial difference, was still evident six-months later. The focus of the training was on the need for participants to ‘discover more about social interaction process and how they can influence the reception they get from others’. Each social encounter is viewed as a potential learning opportunity for the development of effective social interaction skills. At a six-month review of the course, sixty per cent of the participants reported that the effects of the workshop had been sustainable.

However, what if the person is not able to learn from experience? Could it be that the minority, who were unable to sustain the positive effects of the workshop had an inability to learn from experience? Their previous distortions to learning from experience acting as barriers to learning (Boud et al 1993). Is there a need for people to be able to learn from experience prior to attending social skills workshops? There is recognition of how combining social skills training and cognitive behaviour therapy is helpful (Kent and Keohane 2001, Newell 1998, Turner et al 1998). Where the process of cognitive behavioural therapy is seen to be re-educative (Blackburn and Twaddle 1996, Mahrer 1989). As such it would appear that when working with people with a facial difference, the educative role of the therapist could be seen to incorporate social skills training.

It is suggested here that social skill training is to favour the technical over humanness. Where humanness, would be to acknowledge that the response to facial difference is multifaceted and individual (Robinson 1997a, Partridge 1994, MacGregor 1990, Bull and Rumsey 1988). Therapy in contrast to social skills training may enable a person to be more open to their experience, by acknowledging that previously learned behaviour can provide a template for evaluating future experience; as such there is a closure to experience. It could be that following therapy, some may not need social skill training, whereas, for others it may enable them to engage with the social skills programme, to see each opportunity of social interaction as a potential for learning from experience.
From the clients perspective, therapy was self initiated, usually at a time of transition or crisis (McLeod 1998); and it would appear that for the development of an effective therapeutic relationship, there is a need for the client to enter therapy of their own volition. Therapy is a place to explore ‘what it means to be me’ where it can be whatever the person chooses. Not the therapist, for if this is the case, the client metaphorically can replace one set of parents or significant others (who know what’s best for them) with another. One client said that speaking to the therapist was different because of their neutrality, someone ‘who would not be upset by what I said’. It would appear that speaking about feelings surrounding their facial difference could not be openly spoken about. Perhaps unconscious ‘guilt’ from the parents creates and sustains a stance of not being able to speak about it. Not being able to speak about it embraces the notion of ‘it was as if there was an unwritten rule that they could not talk about it: ignore it and it will be OK’ (Rose and Loewenthal 1998:110).

It was difficult for people to be specific about that which was the most helpful aspect of therapy, and this correlates with current research findings (Stracker and Becker 1997, Howe 1993). The elicitation of the process of therapy remains elusive partly because of the nature of therapy and the difficulties in selecting an appropriate methodology (McLeod 2000, Parry 2000, Parry and Richardson 1996, Garfield 1992). A scientific approach is more geared to quantification of outcome measures (Patton and Meara 1992), and qualitative studies the process (Turpin 2001, McLeod 2000). It is suggested here that another difficulty is the representation of what happened in the ‘saying’ of therapy; for re-presentation renders it ‘said’, the aliveness of the encounter is evaded when trying to recreate what happened in the moment. Language can create a barrier in not being able to articulate the feelings engendered in the therapeutic session (Gordon 1999), also that since the event further experiences will have occurred and these have the potential for further learning (Boud et al 1993, Cell 1984), so when recounting the experience of therapy, the time lapse can distort what happened in the session. Alternatively the significance of what happened in the session, may only be revealed, or become apparent some time later (Straker and Becker 1997).

In his book On Being a Client (Howe 1993:15) suggests that clients prefer therapists ‘who attend to their feelings and help them to think about themselves’. Bateman and Holmes (1995:248) appear to be in agreement when they state that it is the ‘personal qualities of their therapist rather than technical procedures’ that clients comment on when speaking of the therapeutic relationship. This view seems to correlate with the findings of this study, for the therapists were perceived to be ‘trying to understand me’; ‘listening’. No specific reference was made to technique apart from ‘when she did not understand me she asked me to say more about it’. There is the possibility of this being seen on the one hand as a technique, but on the other hand, it can be perceived to be an encouragement or an invitation to continue exploring.
According to Howe (1993:12) what the therapist provides as experienced by the client is; ‘accept me, understand me, talk with me’. Acceptance seemed to be important to the clients with a facial difference, as this is perceived to be the root of their problems. A perceived example of non-acceptance by the therapist is how they ‘did not take my concerns about my face seriously’; it would appear that the therapist did not invite an exploration of the client’s concerns; rather the therapist’s view was that the clients’ face was ‘satisfactory’, this however became a barrier, a closure to meaning emerging in the in-between. In this instance the therapist took up the position of previous others, for example ‘my partner says that I look OK’. But what was missed was the client’s feelings, it could be hoped that through the process of exploration a return to learning from experience could be fostered. But for this to be achievable there is a need for, and willingness from, the client to explore and uncover previous distortions in learning, in the safety of the therapeutic relationship. Bowlby (1988) suggests that therapists provide a secure base to enable the person to explore their attitudes, values and beliefs that underpin their behaviour. Greenberg and Paivio (1997) in their three phase model for working through emotions in therapy, suggest that there is a need for bonding; that the client feels a bond with the therapist and this facilitates the evoking and restructuring of emotions.

If the opinions of the therapist take precedence to the feelings of the client; for example ‘she [the therapist] thought that I looked OK, she did not take my concerns seriously’ there is a foreclosure to experiencing it any other way. Rather than staying with the uncertainty of not knowing, which in essence is what ‘exploration’ is about. When the therapist embraces encompassing ‘exploration’ there are no guarantees of what may happen; certainty as such is imposed by the boundaries of the meeting, for example time, place, and cost. The ‘therapeutic technique has something in common with a code for manners’ (Lomas 1999:66). What happens in the in-between in the therapeutic hour is unknown, unpredictable. To put the other first, encompassing the Levinasian notion of ethics, it is not to do violence in the face of the other, by reducing knowing in the moment to what is previously known. To do so is to provide foreclosure to the meeting of the other, rather than being open to the unknown.

The person who said that through therapy they realised they had ‘learnt views from others’ correlates with the views that behaviour is learned from others. Freud (1924:20) states ‘the impressions of that early period of life, though they were for the most part buried in amnesia, left ineradicable traces upon the individuals’ growth and in particular laid down the disposition to any nervous disorder that was to follow’. The nervous disorders are referred to as neuroses, and it is considered that during childhood the child becomes fixated at one developmental stage and it is this that ‘determines the choice of neurosis’ (Freud 1924:22) [original emphasis]. It would seem that the standards for behaving to others are laid down, these then inform future interactions, through the
process of transference which is ‘a universal phenomenon of the human mind .... and in fact dominates the whole of each person’s relations to his human environment’ (Freud 1924:26).

Early distortions in learning are responsible for future behaviour, and as each experience has the potential to further strengthen the early distortion; an early analysis is advocated to undo this early learning (Klein 1923). However, childhood analysis appears to only take place if a child showed gross maladaptive behaviour (see Axline 1964). For the majority the distortions go unnoticed and unchallenged, in fact it is generally perceived by people that as early childhood memories can not be readily recalled, there is a sense that it is an unimportant period in life (Lemma-Wright 1995). Where in fact the reverse is the case, through the process of repression, memories are rendered to the unconscious and exert an unconscious influence on behaviour. As such the past can be replayed in the present; therapy is a reparative discourse, where the unconscious material is made conscious, and there is then the potential to exert a change, in essence to return to learning from experience.

It is suggested here that once the early foundation is laid down, there can be an inability to learn from experience; as such there is a passivity to experience, and the prevailing norms of the culture and family values are accepted ‘as is’, rather than questioning; the status quo is accepted. This can create a sense of ‘I'd never really explored what it means to be me’. But where does one go to explore? Therapy offers this potential; the use of the word potential does not provide foreclosure, for to say that exploration will happen is to predict; to favour certainty rather than uncertainty. The use of words like probabilities, possibilities, potentialities, maintains and fosters an openness to experience. To accept certainty is to assume a taken-for-grantedness, there is however, a need to be open to exploration, to challenge this taken-for-grantedness perspective. To reject this certainty is to acknowledge the juxtapositions; to explore the ‘maybe’, the ‘perhaps’ in preference to ‘it is’.

An outcome of therapy is a ‘change in how I think and feel about myself’, this impacts on behaviour as there is an increase in confidence and self-esteem (Turner et al 1998, Grealy 1994). This correlates with Rogers (1951: 280-1) view, that ‘therapy produces learning’s or changes’, he identifies five conditions for this learning. Firstly the client needs to face the problem, secondly in meeting with the therapist; he/she is met with congruence, unconditional positive regard and empathic understanding, all of which need to be communicated to the client. His belief was that if the client experienced these they would change:

The person comes to see himself differently.
He becomes more self-confident and self-directing.
He becomes more the person he would like to be.
He becomes more flexible, less rigid, in his perceptions.
He adopts more realistic goals for himself.
He behaves in a more mature fashion.
He changes his maladjustive behaviors, even such a long-established one as chronic alcoholism.
He becomes more acceptant of others. He becomes more open to the evidence, both to what is going on outside of himself, and to what is going on inside of himself. He changes in his basic personality characteristics, in constructive ways. I think perhaps this is sufficient to indicate that these are learning’s which are significant, which do make a difference’.

It is suggested here that Rogers concluding comment of learning being significant and making a difference, is to encompass the notion that it is the individual who defines what is ‘significant’ and the individual who experiences ‘the difference’. Also that the individual ‘becomes more flexible, less rigid in his perceptions’; is to embrace an openness to experience. It is suggested here that at the heart of this significant learning is how the person feels about his/her self, and through the process of therapy the person is able to develop a language to speak about emotions (Greenberg and Safran 1987).

The outcome of therapy for one client was the realisation that ‘my feelings about myself, my face were heard for the first time ever. It was not just her [the therapist] hearing but I could hear myself’. This is an example of exploring, of questioning, of the client ‘hearing’ their story rather than it being a repetitive discourse. The outcome of this exploration was not known in advance, for to do so would be to ascribe a meaning to the client’s experience, a meaning that does not belong to the client. There is a need for the client to be engaged in the process of therapy, ‘I could hear myself’ and this is an essential prerequisite for the client to take responsibility for the learning experience intrinsic to therapy. Another example of the client taking responsibility, is the person who said, ‘it’s up to me how I deal with it’, this is representative of a shift, a change in perspective, the ‘problem’ is owned, rather than externalised. Another person said, therapy was about a ‘change in how I think and feel’ there is a sense here of a change in perspective, or that there was a transformation in how they perceived their situation. The use of the personal pronoun ‘I’ is indicative that the learning was personal, learning was significant to them, not the therapist or others; but for him/her self.

Another example of exploring, questioning and a transformation in perspective is provided by the client who said ‘I always thought I was ugly, but in therapy I began to look at qualities I had, and then to explore what it is I like about myself. My thoughts not what the family said, or people at school; you know you have to like self first. And that gave me a lot of confidence in myself, I’m not six foot tall, I’m not Miss World, but I can get over it and I can get on with it’. Here there is evidence of the learning being personal, for it was not what others thought, thus the learning is significant, also there is a change in perspective ‘I always thought’ and a recognition of the need to ‘like self first’, examples of transforming previous beliefs, therapy as a form of transformative learning. A transformation that includes both cognitive and affective elements.
Through the process of transformation there is a challenging of previous meaning making perspectives, for example one person said 'my views were challenged, and this made me think about what I said, and I gradually came to realise that a lot of my thinking about myself was not right, I still held on to the hurt from playground taunts ... I created an invisible barrier around myself, to protect me, to keep people away...I expected them to respond to me as others had...I did not give them a chance to be different'. There is a sense of this change process being gradual, and it is suggested here that there is a need to go at the clients pace, that it is difficult to set a time limit for this transformation. For prior to the change in perspective there is the need for the client to recognise current distortions in meaning making perspectives, 'I still held on to the hurt from playground haunts', a sense of how this traumatic event has the potential to be replayed in the present (Greenberg and Paivio 1997). Then for the person to recognise how the distortion in meaning perspective can inform current experiencing, 'I created an invisible barrier around myself, to protect me...to keep others away'. This recognition can lead to the identification of the reason for the distortion, 'I expected them to respond to me as others had' there is a sense here of a repetition of experience, for 'I did not give them a chance to be different'. Now that the distortion in perspective can be named and the reason behind it, there is the potential to effect a change. For there to be an openness to experience.

The process of exploring distortions in meaning making perspective can be challenging, particularly if the person is not open to exploring. For example the person who commented 'I couldn't remember what it used to feel like, for example when I was ignored at school'. There is a sense that perhaps the therapist was inviting an exploration of what it was like to have a facial difference, what it felt like. It could be that the person identified that they had been ignored at school, in a way that was dissociated from the self of the experiencer (Laing 1967), there was as such no connection with the feeling behind this experience. As the person went on to say, 'possibly too, my memory is selective, and blocks unpleasant things to protect me', there is a recognition of repressing painful material, but also an unreadiness to explore the affective domain. The process of therapy is about 'witnessing and waiting' (Gordon 1999), the need to go at a pace that is governed by the client, for if it is too uncomfortable this itself can be a barrier to learning (Claxton 1984). If it becomes too uncomfortable there is the likelihood of the client discontinuing therapy, for the working through of the material is too difficult.

This represents a paradoxical situation, on the one hand therapy represents the opportunity for exploring distortions in meaning making perspectives with the potential outcome a return to learning from experience, and on the other hand, the very working through can re-evoke the previous trauma, (trauma that resulted in the creation of the distortion being worked through) and this has the potential to sustain the distortion in meaning making perspective. Mezirow (1990:3-4) suggests that
"the more intense the emotional context of learning and the more it is reinforced, the more deeply embedded and intractable to change are the habits of expectation that constitute our meaning perspective."

One of the determinants of efficacy in psychotherapy is the standard of training (Mace and Moorey 2001, Tantam and van Deurzen 1999, Roth and Fongagy 1996). In this study two of the therapists had undertaken personal therapy as part of the requirements of their respective training courses. The other requisites are that the training course provides the opportunity for discussion of the underpinning theory, integration of this theory to practice, personal development work, discussion of cases (Binder 1999, Charles-Edward et al 1989). The need for personal therapy for trainee therapists is a contentious one, for some decree that it is not necessary (Macaskill 1999), some suggest that until its efficacy is proven by research then it is difficult to draw a conclusion (Macran et al 1999). Whereas, others suggest that it is one of the essential prerequisite for the provision of therapy (Sinason 1999, Williams et al 1999). Personal therapy provides the opportunity to learn about therapy, to address issues arising from training, and enables the person to deal with personal issues (Macran et al 1999, Williams et al 1999).

Without therapy there is the potential to offer vicarious therapy (Schapira 2000), whereas, Glickauf-Hughes and Mehlman (1995:213) suggest that 'many therapists were as children, raised by narcissistic parents, and these children learned to respond to parental needs at the expense of their own development' and how therapy is a 'corrective interpersonal experience'. Personal therapy provides the opportunity for the therapist to attend to their own emotional needs (Norcross 1990); and to experience the helpful conditions of therapy (Macran et al 1999).

The researcher concurs with the need for therapy, for the neophyte therapist to have experienced the therapeutic relationship, to have explored how they make sense of their own experience. However, she suggests the quality of the therapy offered is an area that merits further exploration. For example has the therapist had his or her own therapy? Are they an accredited therapist? Have they experienced their own experience, where therapy enabled them to return to learning from experience? Or have they had a therapy that was technique focused? In technique focused therapy, the skills of the therapist take precedence over the meeting with another. Can the therapist lay aside technique and be open to the experience of the other? Inherent in this is that therapy is not a set of skills that can be utilised in response to what a client says. There is not a manual of how to respond, for it is a craft rather than a technology (Legg 1998). There is a need for the therapist to suspend theory for 'only then can we be truly open to what is before us' (Gordon 1999:72).
The therapist is not the expert in the relationship, rather they are an ‘interested inquirer’ (Gergen and Kaye 1992:182). Through the process of therapy, and the connection between therapist and client (dialogue as opposed to monologue); and through offering a ‘spectrum of therapeutic interaction, support, affirmation, reassurance, empathy, encouragement, elaboration, clarification, confrontation, interpretation’ (Bateman and Holmes 1995:168), the client is enabled to take responsibility; to change; to learn. In this study, through the process of therapy, the person with a facial difference was able to recognise that ‘I’m not whatever it is ... that I am not a label ... I am me’. As such there is an unlearning (I’m not whatever it is) and a relearning (I am me).

The use of a label to define a person is paradoxical, for on the one hand it is to mark out the person as different, and on the other hand it is a reduction to the same. With the privileging of humanness over the technical remit difference is deemed to be more favourable than a reduction to sameness. The use of a label is to not privilege humanness, or the alterity of the other (see Levinas 1947). The ethical relationship in therapy is to privilege the alterity of the other. Gordon (1999:47) drawing on the work of Levinas, comments that therapy as ethics:

‘requires that we abandon a great many preconceptions and assumptions about otherness and about our relations with others, that we have to develop an attitude or position of radical openness towards the other in all his strangeness which avoids reducing the other to what is already known to us’.

The therapist who had not undergone training in counselling, was a psychologist, and had been trained in cognitive behaviour techniques. However, is there an increased potential for her to technologise the interaction? Does an individual need training in how to be alongside another, to put the other first? One could argue that the being alongside another can not be taught, rather it is an attitude towards the other. According to Lomas (1999:6) what happens in the consulting room is unpredictable and ‘there is no technique for behaving well towards another person’. Rather, there is a need for ‘a particular quality of attention and to take responsibility for what we are doing’ (Heaton 2000:12).

Supervision is a forum for the therapist to explore how they are working with their clients (see Gilbert and Evans 2000); it is suggested here that it provides a forum for learning how to be with another person. However, the question of the quality of supervision needs to be explored, for is the supervisor able to learn from their own experience? Have they had therapy that enabled them to experience their experience? Have they had supervision from someone who enabled them to learn how to be with another? Can they foster an openness to the other, to provide an ethical relationship? Gordon (1999:62) refers to the therapists responsibility to client and states: ‘It is part of our responsibility to the other to allow for openness, formlessness, dis-order’. It is suggested here that this is also applicable to supervision, for supervision can parallel the therapeutic process (Doehrman 1976 cited by Gilbert and Evans 2000).
The therapist’s in this study identified how offering therapy was a learning process for them too; as such it is about ‘being’ with the client rather than ‘doing’. It is suggested here that privileging humanness is to ‘be’ with another, to be open to not knowing what will emerge in the in-between, in the dialogue created by the therapist and the client. Whereas, to privilege technique is to be ‘doing’, and the technique favours certainty, to get it right. The creativity of the in-between is stifled by the application of technical skills.

2.2 Experiences that can precipitate the need for therapy

If the parent has a cleft and passes it on to the next generation, there is a sense of disbelief ‘I just thought it would not happen again’. This is similar to how Pruzinsky (1992) comments on parents reaction to the child needing surgery, how some parents resort to magical thinking, that it will be alright. There was also a sense of the child ‘not having to go through what I went through’. It is as if there is intergenerational transmission of trauma (Gardner 1999, Walker 1999). Freud and later Frenzi first referred to this phenomenon (Gardner 1999:298), she states ‘The concept of trauma is seen as the connection between a series of external events in the life of the person and the psychic consequences of such events’. Also when trauma is not spoken about there is preponderance for the phenomenon occurring. Although both Walker and Gardner draw on the experience of childhood abuse and survivors of the holocaust to illustrate the concept of how trauma may effect subsequent generations, it is suggested here there is a similarity with those with a congenital difference in that if the trauma is not talked about then it may be worked through in the next generation.

It is suggested here that if a person with a facial difference has not had the opportunity of finding a language to speak of their emotions, then their unconscious thoughts and feelings about their own difference may be ‘passed on’ to their offspring, in one of two ways, either by silent transgenerational trauma, or by projection of concerns onto the child, which the child then takes on board, through the process of introjection. Either way the child is coping with material that does not belong to them (whether or not the child has a facial difference). If the child does have a facial difference, then the groundwork is laid down for ‘history repeating itself’, for it seems difficult for them [the parents] to imagine it any other way; their experience becomes the template for living/coping with a facial difference.

Once a child is born with a congenital facial difference the comment ‘never had anymore children’ correlates with Walters (1997) view, that on the whole the child will be either the only or the youngest child in a family. The parents also had to cope with the reactions of others to their baby. It could be that prior to having a child with a facial difference, the parent had negative stereotypes surrounding difference, they may even have responded negatively to people with a facial difference. In essence the ‘tables have been turned’. These emotions need to be worked through and may
contribute to the fact that some parents adjust more readily than others (Bradbury 1997, Walters 1997, Bronheim 1994, Speltz et al 1990). These negative stereotypes are examples of sociocultural distortions in meaning making perspectives and the potential is there that without the opportunity of exploring their distortions, for the person to see it any other way.

How a parent adjusts and copes will impact on the attachment they have with the child (Ambler et al 1997, Hearst and Middleton 1997, Niederland 1965). Making emotional bonds with an other is fundamental for psychological wellbeing (Greenberg and Saffran 1987:164), and they credit the theories of Bowlby (attachment) and Fairbairn (object relations) as being ‘general explanatory theories that help us to understand the functioning of the emotional system in human beings’. According to Bowlby (1988) the person with whom one forms an attachment is said to create a secure base, and the relationship can survive separation; connection is maintained.

If a parent does not provide a secure base for a child, in the form of consistent positive care, then this can effect subsequent emotional development and ultimately influence relations with others. Bowlby comments that when a baby is disabled then there is a need to monitor how the mother bonds with the child. The parents in this study commented on their feelings of guilt at having produced a child with a facial difference, these feelings may subsequently affect the attachment between the mother and child. The child develops a concept of self based on this early care. According to Greenberg and Saffran (1987:164) ‘if these schemata carry hostile and negative representations of significant caregivers, they will serve as the source of continuing psychological trauma into adulthood’ [original emphasis].

The child with a cleft (the congenital facial difference that was spoken about in this study) requires surgery to correct the anomaly, therefore there will be periods of hospitalisation in the first three months, and subsequent years. The periods of hospitalisation can represent times of separation that may also impact on the relationship between mother and child (Bowlby 1988). This then can effect subsequent relationships through the process of transference. The therapeutic relationship can provide an opportunity of working through attachment issues; ‘It is the emotional communication between a patient and his therapist that play a crucial part’ also that ‘the therapist hopes to enable his patient to cease being a slave to old and unconscious stereotypes and to feel, to think, and to act in new ways’ (Bowlby 1988:139).

It would appear that a cycle of no-change is created when early experiences provide a template for future experience, in this situation, others will be rejecting and this will highlight difference, and as a result the person with a facial difference is left ‘still standing out’. As such there appears to be a cycle of repetition, for the person with a facial difference may anticipate negative responses from
others to their appearance, for example 'when I speak to people I wonder what they will think of me. I tend to stay away from people...then I won't get hurt'. This anticipation stems from previous experience 'I learnt that at a young age....I can still hear the names they called me'. There is an anticipation of re-experiencing the trauma in the present (Greenberg and Pavio 1997), and this anticipation creates anxiety, an anxiety that can impact on how the person responds to unknown others. For example 'when I am with other people, I go into myself. I instinctively expect people to reject me, and am surprised when they don't'. There is a closure to experiencing the new, for there is an anticipation/expectation of a repeat of previous experience, the other is feared; and there is a tendency to either physically or emotionally withdraw from experiences that may evoke the original anxiety. The above example is a form of emotional withdrawal, whereas, an example of a physical withdrawal is provided by the person who said, 'I used to walk about on my own during school break times, assuming that the gang would not want my company'.

Templates are created from these experiences that inform future experiencing, there is a tendency to ignore comments that do not meet with the template, for example, 'I'm told how people often don't notice for a while...but I don't believe them'. There is a sense that experiences that fall outside this template, may not be acknowledged for the template is the 'real' and current experiencing ignored in preference to the 'real' that is founded on distortions in perception. Without questioning and exploring the foundations to templates, there is a potential to remain closed to the new. To learn from experience, there is the need to reflect on experience (Mezirow 1990, Boud et al 1993). For through the process of reflection there is a re-looking at experience, a questioning of experience, and there is a willingness to be open to the new.

The cycle of no change is founded on previous experience, and revolves around how the person forms an image of themselves created by previous experience of others to them. This image and experiences of how people respond to them, informs how they respond to others. This response to others has the potential to inform the response from others, which has the potential to maintain the equilibrium; an equilibrium founded on distortions in meaning making perspectives. Therapy offers the potential to explore this repetitious cycle, and for it to be possible for experience to be different; to return to learning from experience.

Those who spoke of what they wanted from therapy were on the whole looking for certainty, 'to know what to expect', 'what to say to others'. There is a need to find a way of imparting this information without it being stated as the only way, failure do so would be to take away the experience of the person requesting the information. For it has been identified that parents need to be educated on how to speak to their child with a facial difference (Kish and Lansdown 2000, Charkins 1996). One way of introducing this from an early age is to use children's storybooks that
focus on the story of difference, for example *Show Time* by Clarke (1999b). In this book during show and tell sessions at primary school, Emma spoke about her 'burnt' arm and nose, and the scarring resulting from skin grafts. Without the opportunity to name and talk about difference, the child with a facial difference learns that certain aspects of experience are 'unspeakable', thoughts surrounding difference are thus not given a language and therefore not part of an individuals' personal language. Thus this information can be essential in enabling the child to talk about their difference, but what about the parents? How can they explore their thoughts and feelings around having to talk about difference to their child? Therapy offers the potential for this, however, there is a need for a willingness to embark on the process.

It would appear that there are a myriad of experiences, and a multiplicity of issues that contribute to the emotional world of a person with a facial difference, all have the potential to impact on how the person perceives their self. Early experiences can become a template for future experience, templates that inhibit a person to experience their experience.

3. **Analysis of exemplary portrait**

   The portrait of John embraces the main themes discussed. His mothers' reference to how his cleft was a 'punishment for something she had done', contributes to the feeling of guilt mothers can feel on the birth of her child with a facial difference (Walters 1997). Rumsey (1997) traces the cultural perception of facial difference and how in the early 1700's the King of Denmark, decreed that no person with a facial deformity should show their face to a pregnant women in case they passed it on. Rumsey makes the case that in some African countries this view is still held. In 2000, a mother who gave birth to con-joined twins blamed herself for this because she had looked at a book containing photographs of deformed children (Barton 2001). If the community also believes in this concept, then there is the likelihood that the family will be shunned. The difficulties of having a child with a facial difference may manifest itself in depression, which may be present soon after the birth, or may not become apparent until many years later (Niederland 1965). This appeared to be the situation for Johns' mother.

   John also retold how his mother responded when he wanted to ask a girl out, *'the girl might laugh at you – so don’t do it'*; from this he formed the opinion that no one would want to go out with him. This situation can be viewed from different perspectives. It could be that the mothers' inability to accept John's appearance was projected onto 'the girl' that perhaps as she [the mother] found him unattractive, therefore other women would feel the same. Another possibility is that John was uncertain whether he would be acceptable, and in checking it out with is mother, he has confirmation of that which was difficult for him to own. He subsequently does not go out with the girl, projecting the decision onto his mother, saving himself from possible/anticipated rejection by
the girl. Or it could be that the response was not related to his appearance, rather that the mother thought he was too young to go out with girls; or maybe she knew the girl in question and did not think her suitable for John.

There are various ways that the ‘event’ can be interpreted and meaning conferred, meaning that is context specific and dependent on the people involved and the interplay of their emotional schemata. According to Safran and Greenberg (1991) an individual encodes an emotional schemata as a result of experience. They also suggest that the original emotional response may be appropriate in a particular context, then become inappropriate/maladaptive in a new context. It is suggested here that if an individual is unable to experience their experience, then they will continue to use outmoded emotional responses. In the above example, Johns’ emotional response to his mother saying not to ask the girl out was to become a template for all future interactions with girls. He continued to have a lack of confidence around girls/women and subsequently his self-esteem was low.

Mruk (1999) suggests that there are three developmental stages to self-esteem, the first stage is pre-esteeem which takes place during early childhood, prior to the child being able to construct the concept of self-awareness. He suggests that this phase is influenced by how significant others react to the person. The first source of self-esteem is being valued by others. This valuing can be based on preconceived ideas the significant others bring to the infant. For example, in relation to gender and how this ‘announces a whole range of categories, values, expectations that others bring to the infant, who can only respond to them’ (Mruk 1999:172). The second stage is middle childhood when there is a growing recognition of the concept of self-esteem by the child. The third phase is in adulthood, when the person becomes aware of situations that can have an impact on their sense of self-esteem, and as such they have some control over the outcome.

Worthiness and competence are benchmarks for self-esteem; worthiness initially emanates from the quality of parenting. If there is unsupportive parenting then there is the likelihood of a decreased sense of worthiness, which can subsequently impact on competence which is determined in middle childhood, and the evaluations made in the realm of ‘motor, social, intellectual, personality, and behaviour characteristics’ (Mruk 1999:173). It is suggested here that low self-esteem may emanate from distortions arising in the pre-esteeem stage, which if unchallenged will continue to exert an influence into adulthood. It would appear for John, that therapy enabled him to challenge the previous distortions that created and contributed to his sense of having a low self-esteem.

Through the process of therapy he was able to explore his views on his appearance and speech. The important of speech and identity is acknowledged; ‘speech is not only a part of the total body image but also has a special role in establishing personal identity through the expansion of inner thoughts
and feelings' (Bronheim 1994:115). Thus Johns perceived difficulty in speaking also impacted on his sense of self; he talked of how he had to rehearse many times what he wanted to say before speaking to someone unknown to him. There is a sense that he was not present in the encounter, spontaneity was absent, and it was only post-therapy that he could initiate conversation — 'I have even started to initiate conversations with people'. Pre-therapy there was a fear of rejection based on his difficulty in communicating and his appearance, according to Kent and Keohane (2001) this fear of rejection can be both actual and anticipated. The anticipation acting as a barrier to interaction with others and this creates avoidant behaviour (Newell 1998).

The changes identified by Cell (1984:vi) as being an indication of significant learning are changes 'in behaviour, in interpretation, in autonomy or in creativity'. There are examples of these found in John's experience of therapy, 'I have even initiated conversations with people. Pre-therapy this was something I would not have contemplated' (an example of a change in behaviour and creativity); 'I have come to realise that we socially and emotionally set ourselves apart' (an example of a change in interpretation); 'my self-confidence has increased many folds' and 'gradually I have come to see that I am good enough' (two examples of a change in autonomy). These examples of significant learning, also encompass the element of a transformation 'Pre-therapy this was something I would not have contemplated'; and emotional restructuring with an increase in self confidence; how he feels about himself, and the recognition of emotionally setting himself apart from others. The learning implicit in Johns' comments on his therapy includes significant, transformative, and emotional learning. It is difficult to separate the forms of learning inherent to the process of therapy, rather the three elements are interdependent and intertwined. Therapy provides the opportunity for learning that can be either significant, transformative or emotional, and the potential outcome is a return to learning from experience.

Milioria (1998) suggest that people with a congenital facial difference have an avoidant personality and comments on her work with a person with a facial difference. She suggests there was a 'hide and seek fantasy' aspect to her clients behaviour; on the one hand she wanted to be seen, to have contact with others, however, this carried with it the risk of being seen, and in this seeing she would be seen as 'flawed', there was therefore a need to hide. She suggests that early losses and self-object failures contribute to the sense of being 'flawed'; 'the disfigurement predisposed the patient to narcissistic vulnerabilities and avoidant behaviour' (Milioria 1998:378). This view is supported by Niederland (1965) who suggests the presence of a congenital facial anomaly is a narcissistic injury; an injury that impacts on the ability to interact with others. For John, his sense of being 'flawed' was due primarily to his speech and appearance; he felt unable to be understood by others, he wanted contact, but feared rejection because he could not always make himself understood. Through the process of therapy, he was able to acknowledge that if he was not understood, he could repeat and it
would be ‘no big deal’. Pre-therapy Johns’ (in)ability to communicate was a barrier to him engaging with others.

Therapy is a form of ‘emotional work’ that provides ‘self-object functions including mirroring and idealizing as well as differentiation within containment’ (Milioria 1998:392). This appears to have been Johns’ experience, for his therapist ‘was a mirror’. However, it is suggested here that she was able to give something a mirror cannot, ‘the experience of another human being alongside her [him] at the level of her [him] internal feeling and experiencing’ (Kegan 1994:245).

The mirror is a metaphor that is used both in life and in therapy (Shipton 1999:183): ‘Looking in the mirror is the first step in a pact between a subject and object, tenuously connecting the me ‘over here’ and the me ‘over there’ in the mirror. In looking we project and introject our present and future selves and secure a kind of continuity’. The commonly held view is that the mirror reflects a persons’ image, so that the person gains a sense of how they ‘look’; however this look is an illusion and a delusion. For the mirror cannot reflect the self that others see, for this ‘look’ is mediated by the perception of the perceiver. Thus a person can be deluded by the illusion in the mirror. The mirror is not real, it is a ‘no place’, Shipton (1999) uses the term ‘heterotopia’ to encompass how the mirror is an ‘analogous place’ a ‘contrasting place’. It is neither objective nor subjective.

In relation to psychoanalytic theory, Winnicott (1967) refers to how the mothers gaze is important as through this the infant can gain a sense of self and of being valued. The gaze confers a template for how the child perceives ‘self’ and as such their place in the world. Lacan’s (1977) view of the mirror is fundamentally different to Winnicott in that he acknowledges the illusion of the image. Also he recognises that the mirror stage (six to eighteen months) is not just about forming an image of self, it is from this stage that ‘I’ is articulated, the self is created in and through language. The child identifies with an image outside self, with the ‘real’ mirror image; and is bound to the image by language. The words of the parents are important in assuming an identity: ‘The identity of the child will depend on how he or she assumes the words of the parents’ (Leader 1995:43). Language enables the child to symbolise and represent their self to others (Sarup 1993).

The ‘mirror stage’ is permanently being worked through, for it involves ‘accepting the reality of its unreality’ (Bowie 1991:23). According to Hill (1997) the mirror stage represents an alienation of the self from the real, where the real is the impossible to say. It is through language that the subject is constituted (Sarup 1993); however, language is found wanting, for we cannot always symbolise our experience. Hill (1997:49) is in agreement, and suggests that ‘language is a universal trauma or wound, taking a unique place for every subject’. He suggests that a trauma is an experience that belongs to the Lacanian category of the real: ‘it refers to an experience in a person’s life that he has
not been able to put into language' (Hill 1997:79). Therapy provides an opportunity to redress this trauma. For John it seemed important to him that ‘it was good to say what I wanted and to be accepted for who I am’. Part of this accepting was for his view of himself, as not being good enough, being challenged; initially being told he was good enough, and for him to realise this for himself. Being accepted for himself was a previously denied experience.

It would appear that ‘language constitutes us a subject’ (Sarup 1993:8). However, what if the language has a negative connotation? Did Johns’ sense of not being ‘good enough’ emanate from his early experiences with his parents? Was this compounded by further experiences? Does this initial response create and sustain a sense of marginalisation? It would appear so if we accept Sarup’s (1993:7) premise that ‘we cannot separate a person’s psychology from his or her personal history’.

Therapy can provide a reparative discourse for the exploration of the place a person takes up in the world, a place that is originally consigned due to early experiences and then taken up as the only place if there is an inability to learn from experience. Post-therapy John commented that he realised how people with a facial difference ‘socially and emotionally set ourselves apart’. It would appear that he came to realise that the self is created through relationships with others and he had a responsibility in how others responded to him.

4. Analysis of creative synthesis

The creative synthesis represents the researcher’s understanding of how therapy can be seen as a form of learning. This understanding emerged through the process of conducting this study, and reflecting on the understanding gained during the initial analysis of data, the presentation of findings and the location of findings in the literature on psychotherapy, learning and facial difference.

The learning that is intrinsic to the process of therapy draws on the theories and concepts of significant learning, transformative learning and emotional learning; it is learning that is personal to the individual. In keeping with the underpinning ethos of this study, whereby there is a privileging of humanness over science and technology, it is not possible to describe the specific nature of this learning, rather there is a recognition that the learning, that is intrinsic to the process of therapy, can enhance a return to learning from experience; where experience is an individual phenomenon known only to the person whose experience it is (Laing 1967).

The inability to learn from experience is dependent on previous learning experiences; for previous learning can create barriers to learning (Mezirow 1990, Boud et al 1993, Cell 1984, Claxton 1984, Rogers 1967). These barriers can inform how a person approaches learning, and the sense they make out of the potential learning experience. There is the potential to re-experience experience, based on
previous learning, as the previous learning can create a template or a standard, for evaluating further experience (Bowlby 1988, Symmington 1986, Casement 1985). There is a closure to experiencing experience; there is an inability to learn from experience.

This study focused on developing a conversation on therapy as a form of learning for people with a facial difference, and it has been possible to identify issues that can create barriers to learning from experience, and to acknowledge that therapy provides an opportunity for a person to explore and work through previous distortions in learning, to effect a change in perspective. A change that is cognisant with a return to learning from experience.

There is a sense that the label ‘facial difference’ can define the person, that it is difficult pre-therapy to separate the person from the label, experience is filtered through the lens of facial difference. Also, there is a sense that the facial difference is the cause of their difficulties in living, in relating; for it becomes the template for evaluating experience. Previous experiences, emanating in childhood sow the seed for the creation of a ‘lens’ to make sense of their experience, a ‘lens’ that is appearance focused, rather than person focused. There is a sense that this can be an intergenerational process, the ‘lens’ being handed down from significant others, who have difficulty in responding to the child with a facial difference, for they too may have an inability to learn from experience.

Therapy provides an opportunity to redress this imbalance, by providing an environment that is conducive to the exploration of thoughts and feelings surrounding their appearance and how they make sense of their world. Therapy can provide an opportunity to return to learning from experience: Facial difference does not need to define the person and therapy is a reparative discourse to enable a return to learning from experience.

Conclusion

The findings of the study were located in the appropriate literature; initially the themes that emerged from the data were explored. It was recognised that within the literature available there was a preponderance to theoretical concepts rather than people’s direct experience. This study addresses this apparent imbalance by focusing on people’s experience. The researcher identified the learning that was intrinsic to these experiences, and the discussion was informed by transformative, significant, and emotional learning approaches. It appears that significant learning could be an overarching term for the learning that can emanate through the therapeutic process; it is learning that is significant to the person. Intrinsic to this there is a transforming of beliefs and attitudes (transformative learning) underpinned by a recognition of feelings and how they inform behaviour (emotional learning).
Initially the themes that emerged from the data were discussed. There was evidence from therapist and client experiences of therapy that the reason for seeking therapy was usually related to their appearance together with their perceived difficulties in handling the reactions of the general public. The therapeutic relationship developed between therapist and client was deemed to be helpful in enabling a person to speak about their ‘difference’, to explore their distortions in meaning making perspectives, and through the process of therapy there was a change in perspective, therapy was a form of learning. There was evidence of significant learning, that the changes emanating through therapy were pertinent to the individual; transformative learning, for there was a freeing of previously held beliefs, and emotional learning for they were able to speak of thoughts and feelings about their difference and this had the potential to impact on their sense of self-worth. Therapy enabled them to return to learning from experience.

Of the experiences that can precipitate the need for therapy, from the parent’s perspective there was evidence of how giving birth to a child with a facial difference was a traumatic emotional experience. Feelings of guilt underpinned their reactions; there was a sense of how this may be transmitted to the child if not spoken about. Also there were ongoing concerns, related to developmental changes and surgical/medical intervention. For people with a facial difference there was evidence of a correlation in the stories they told about their birth, and the parent’s experiences. There was an indication of an intergenerational transmission of trauma, a sense of learning someone else’s way of experiencing; the parents ‘template’ for evaluating experiences becoming their way of evaluating their facial difference. Early socialisation experiences also have the potential to reinforce the view that facial difference defines the person, and further creates and sustains distortions in meaning making perspectives. These distortions have the potential to become barriers to learning from experience. Therapy could provide an opportunity to work through the distortions, and to return to learning from experience.

The composite depiction and exemplary portrait further developed the discussion on therapy as a form of learning, or the need for therapy as a form of learning. Therapy appeared to be about a shift from an external view of the problem, to an internal one, and in this process there was recognition of how the person with a facial difference has a role in maintaining the distortions in their meaning making perspectives. Distortions that have their foundations in childhood, templates are created that continue to inform how a person anticipates and evaluates experience. There is an inability to experience their experience, there is as such a repetitive cycle to experiencing. Therapy can provide an opportunity to break into this cycle and offer the possibility of a return to learning from experience.
The creative synthesis highlighted how facial difference need not define the person, and that therapy is a reparative discourse for a return to learning from experience. In the second cycle of interpretation required by the methodological framework that guides this study, these two phrases will be deconstructed; this secondary construction is provided in the next chapter.
Chapter Eight

Secondary Construction

Introduction

The aim of this chapter is to complete the second cycle of interpretation of the methodological framework developed for and being tested out in this study, and represents stages six and seven of the framework. This second cycle of interpretation culminates in a secondary construction, and is a deconstruction of the creative synthesis of the primary construction, and is representative of the researcher’s understanding of the question being explored by this study, is therapy a form of learning for people with a facial difference? Deconstruction is a term that is accredited to Derrida, and it is an exploration of hidden meanings embedded in the text. Derrida (1998) suggests that there is nothing new to be found, for there is always a building on of something else. As such previous knowing is the springboard for further knowing. Bennington (1994:4) suggests that a text is always historical, and includes ‘repression’s, exclusions and misreadings of all sorts’. Whereas, Howells (1999:3) suggests that ‘Deconstruction may set out to ‘read between the lines’ or even ‘read against the grain’, but it always attempts to read, and understand’.

The researcher is aware that she could deconstruct the whole project, from the title to the method chosen to guide this study, however, the intention is to demonstrate, or to provide an illustration of the multiplicity of meanings inherent in the findings that can emerge in a study. That the presentation of findings is but one interpretation, the second cycle of interpretation provides an opportunity for this demonstration of multiple meanings.

The following two issues that emerged in the creative synthesis will be deconstructed. Initially, ‘facial difference does not need to define the person’ will be explored, as this appears to be at the heart of the ability for a person to relate to, and with others. What does the label of facial difference signify for others? Where is this difference to be located, in the mind, or the body, or both? This is followed by an exploration of ‘therapy is a reparative discourse to enable a return to learning from experience’. What is reparative about the discourse of therapy? How can it be brought about? What are the implications for return to learning from experience?

The next section explores how therapy as therapeia (premised on the ethical relationship of responsibility to the other) can be developed as a model that promotes therapy as a means to learning. To conclude this section, there is a discussion of the overall findings of the research investigation.
1. Facial difference does not need to define the person

What is facial difference? The researcher selected this word, as this was the word that participants used when speaking of themselves that they were ‘different’. Why not stay with facial disfigurement? It would appear that there is difficulty in selecting another term, for in the literature review a range of words were used by the authors to ascribe meaning to those with a facial difference: only one author Solomon (1998:269) clarified why she preferred the term ‘facial distinction’, as it is a ‘non-pejorative descriptor’. Three other authors appeared to be acknowledging the need to use a word which was ‘neutral’, ‘visible difference’ (Lansdown et al 1997), ‘facial difference’ (Charkins 1996, Elks 1990). This contrasts with the remainder who used terms that inferred that the person with a facial difference was ‘less than’ the norm; ‘visible damage’ (Glover 1988), ‘impaired appearance’ (Hill-Beuf 1990), ‘facially deformed’ (Pruzinsky 1992) ‘facially marred’ ‘facially crippled’ (MacGregor 1984), ‘visibly handicapped’, ‘visibly stigmatised’ (Bull 1990).

In the book Facial Appearance (Bull and Rumsey 1988) used several terms e.g. ‘atypical appearance’ (page 185), ‘unattractive or disfigured end of the physical appearance continuum (page 217), ‘people who are considered by others to be ugly, or those who are disfigured or deformed’ (page 179). Hughes (1991) also used several terms; ‘not quite whole, not quite normal, or not quite acceptable’, ‘facially impaired’ (page 1), ‘distortion of appearance’ (page 505). It would seem that the authors were having difficulty in defining the other.

Language was first described as a social phenomenon by de Saussure, he stated that language comprised of two components langue, the pre-given, ‘rule governed abstract system’, and parole which is individual speech (Rainwater and Kearney 1998:290). Lacan develops this schema and advocates that the unconscious is structured like a language and is representative of langue, and consciousness is parole. Using this concept Lacan re-read Freud’s work and creates a topographical model which is premised on language. Lacan (1977) identifies the mirror stage as being when the infant leaves the imaginary (maternal) order and enters language and the (paternal) symbolic order. The third mode, is the real, the impossible to ‘say’ or ‘imagine’.

Feminists have contested Lacan’s paternal emphasis on the dominance of language, arguing that it in effect silences women’s voices. For example, Irigaray offers a feminist critique on discourses that privilege sameness over difference, and the inherent difficulties in representing and imaging femininity. She states:

‘Women’s social inferiority is reinforced and complicated by the fact that woman does not have access to language, except through recourse to ‘masculine’ systems of representation which disappropriate her from her relation to herself and to other women. The ‘feminine’ is never to be identified except by and for the masculine, the reciprocal proposition not being ‘true’ (Irigaray 1985:423-4).
For Irigaray it appears difficult for women to find a place from which to speak within the current system, for women will always be defined by a language that is masculine. A situation that could be seen to correlate with facial difference. For the same question posed by Irigaray of representing the feminine, can be used for representing facial difference 'If it were different what would it look like?' For it to be any other way seems 'unimaginable' for we are always subject to language. The language for facial difference is rooted in the dominant description of 'normality', any deviation from the norm is an inversion of the normal. The creation of binary opposites, where one term is privileged over the other, where one is subjugated over the other. However, do we need to be restrained within language? Can we come to a different understanding of self and situation? Can we find parity for self?

Possibly, Kristeva offers another way, for she had developed the concept of a 'subject in process', neither object nor subject but in between, the semiotic represents the in between, the tension between the paternal symbolic and the maternal imaginary; semanalysis is the recognition of the speaking subject (Kristeva 1986, 1980). Smith (1998:59) commenting on the work of Kristeva in her book *Speaking the Unspeakable*, states 'speaking the unspeakable, representing the unrepresentable are the premises of the work of psychoanalysts, of interpreting texts and of writing poetic fiction'. Where the text, is the discourse of the client and in the process of therapy beginning to explore the unspeakable, to find a language for the repressed material in the unconscious. The therapeutic relationship offers the opportunity for an exploration of subjectivity, for embodiment, 'language becomes embodied when it resonates with desires, hopes and fears for past and present' (Goldenberg 1993:3). Embodiment dissolves the mind/body split, the language of emotions uniting mind and body.

A further possibility about the use of different words to describe the phenomenon of 'facial disfigurement', is the representational system of de Saussure, where the *signifier* represents the object, the image, or the sound of the word, and the *signified* is the concept or meaning that is being named (Sarup 1993). The taken-for granted given is that the signified and signifier together create a naming of the real; but this is a myth, representation is founded on a myth, the myth of language (Barthes 1957). There is a difference between signifier and signified, there is a slippage and meaning is difficult to grasp (Derrida 1996). Meaning is open to multiple interpretations as language is open to multiple interpretations, at best it is an approximation to that which we ascribe meaning.

This approximation is evident in the attempt to ascribe meaning to the phenomenon of facial difference; 'There is one feature that is both necessary and sufficient in defining facial disfigurement, namely the strength of negative reaction by the possessor and others, to a particular facial feature, or set of features' (Elks 1990:37). He also suggests that without the negative reaction

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it would be a 'facial difference'. Thus implying that the difference exists in the minds of those who see it as something negative, and worthy of commenting on. As such it is society that defines the person with a facial difference, for the prevailing culture defines what it is acceptable in the 'beauty stakes' and therefore what are acceptable and non-acceptable forms of appearance. It is suggested here that a corollary can be drawn with the term 'women'; for as de Beauvoir (1949) suggests that one is not born a woman, it is an inscribed state conferred by society.

A person born with a facial difference is not aware that they are 'different' they will be ascribed a 'label' by society, firstly a medical label for a congenital anomaly (for example cleft lip) and a colloquial label by culture (for example hare lip). The label takes away from the person, the subject replaced by the object; a dehumanisation. The person takes on the label and owns it. An inverse of the designer label that the young must have, the label of facial difference becomes the must not have item. How can it be different? Are people with a visible difference the only ones who have an appearance that does not measure up to the culturally defined norm? What about the people who have been given the body dysmorphobia label? People whom although they do not have a visible form of difference, but to them their invisible difference is real (see Rosen et al 1995, Cash 1990).

Those with a difference that is visible to others can be defined by others (both medically and socially), and this somehow legitimises it; the difference can be named. Whereas, those with an invisible difference have a difference that can only be defined medically, within the social domain the difference does not exist, it is not legitimised. Yet to the person the difference in the mind is very real. There is a self-imposed label of difference. Whether the label is initially ascribed by others, then accepted by the person as a 'real' concept, or imposed by self; both labels have by implication, a taken-for-granted assumption, the person is less than.

Appearance related difference could then be said to be either in the body or in the mind. Thus difference is not the sole domain of those with a visible difference, for 'disfigurement' can be in the mind or the body, and the 'disfigurement' is in relation to emotional well being; how a person feels about their self image. The 'disfigurement' can become a block to social interaction, the other is feared, for they may see the 'disfigurement' and reject the person; respond negatively. There is a propensity to judge all 'others' as the same. There can be a zero tolerance to it being any other way, to embrace difference, and not to reduce all to what is known. Difference has a negative inference. This emotional template of being 'different' acts as both a barrier to, and a distortion to, being open to experience; to be open to their own experience. Metaphorically they become a slave to their template. There is an inability to learn from experience.
The mind body dualism is representative of a primacy to reason and facts, the scientific domain, a masculine way of knowing and the body represents unreason and feelings, the unscientific domain, a feminine way of knowing (Mies 1991). By deduction this implies that embodiment would represent Kristeva’s ‘subject in process’. There would be a return to feelings, and emotions as legitimate knowing paradigms. Romanyshyn (1990:240) suggests that phenomenology and psychoanalysis reject the mind body split, and accredits psychoanalysis as having ‘cautioned us to never assume the who or what of experiences’. He also suggests that ‘human experience is as such a given to be made’ (Romanyshyn 1990:244). However, this given may not be recognised; and therefore not made. For the person may be trapped in a cycle of repetition based on previous experience being the template for future experience.

They metaphorically get trapped in the ‘here is the one I made earlier’ culture. This phrase stemming from the children’s television show Blue Peter where on live television, the presenter rather than struggle and show all the stages in making an intricate model from recycled material, would get to a particular point (usually when they reached a tricky stage) and stop, utter the phrase ‘here’s one I made earlier’ and produce another model at the same stage of making, but with the ‘difficulties’ overcome, and begin working on the next stage, this would be repeated until the complete model was shown. The ‘difficulties’ were not shown. The illusion is created that you too can make this model if you follow the steps as demonstrated by the presenter. But the steps have been sanitised, the messy difficult bits, have been avoided, for example the trial and error attempts before getting it right; instead the perfect image/model is shown. How can this relate to experiencing our own experience? It may create and sustain ‘what you see is what you get culture’, the outer image, is all there is. Also life follows a predictable passage, that if you ‘do’ what is expected then the individual will move effortlessly along the predicted trajectory. Difficulties are not anticipated, and when they are it can be seen as a tragedy, for example producing a child with a facial difference.

The illusion of the perfect image, a surface with no depth, is as such a paradoxical situation, for postmodernism is about favouring surfaces rather than depth, and yet this surface, this image is not the real (Baudrillard 1984). Postmodernism is also about celebrating difference yet the term facial difference appears one difference too far. What does it mean to privilege the sur-face rather than depth? The preference to faces that are the same rather than different? If all we have are ever-mobile signifiers, then anything goes; but how does the individual mediate between the ‘real’ and the ‘imagined’?

‘Difference legitimises acts of inclusion and exclusion’ (Clarke 1999:23). He cites Freud’s book Civilisation and Discontents and how the capacity for love and harmony is dependent on their being a group that holds the aggression. As such there is a projection onto others what can not be owned
for the self. 'The product of paranoid projection is the stereotype, the transference of socially unpalatable thoughts from subject to object' (Clarke 1999:24). Klein's notion of splitting into the good introjected object and bad projected object is used by Clarke to demonstrate how projective identification creates a 'construction of the 'other' as a defence. The other is then responsible for the theft of our enjoyment, something we have imagined in phantasy and never possessed' (Clarke 1999:28). The 'other' may pick up the thoughts and feelings of the projection, and own them as if they originate in their self.

For the person with a facial difference, this could create an inverse form of prejudice, for the prejudice that they attribute to others can emanate from within, thus projecting out onto others that which they can own for themselves. How is the other construed if all negativity is projected onto them? And, what of the parents experience of producing a child with a facial difference? There is reference to how they need time to adjust, to mourn the baby they did not have (Ambler et al 1997, Hearst and Middleton 1997, Walters 1997, Bradbury 1993). Can the mother own for herself her feelings and thoughts surrounding the birth? Or does she project them onto others? For both mother and child there are a host of implications associated with conferring the erroneous label of facial difference on the child. An erroneous label, for as the above discussion infers there is no 'truth' in the term. But how to speak the unspeakable and think the unthinkable for the person to arrive at their own truth?

2. Therapy is a reparative discourse to return to learning from experience
This statement raises several questions, what does it mean to say that psychotherapy is a reparative discourse? What is learning? What is experience? What does a return to learning mean? An exploration of these questions is difficult, for there is a merging between the concepts, and as such there is a sense of which comes first, learning or experience, and where does therapy fit in? Is it that therapy is a form of learning? But then what is learning? What is experience?

Experience is only possible in the presence of an experiencer (Laing 1969), the experiencer recounts the experience via language and thought (Nicholson 1995); and this activity as such provides a structure and coherence to that which was experienced (Kegan 1994). Experience is as such a personal phenomenon, known only fully to the person whose has the experience (Laing 1969). In accepting this premise that experience is personal, there is recognition of how 'we ourselves actively give shape and coherence to our experience' (Kegan 1994:199). Subsequently people are considered by him to be 'the author of his experiencing, he writes the play the way he does' (Kegan 1994:254). This view could be seen to endorse the perspective of the modernist self, a self that is master of what it surveys, a self that is knowable and definable in a definitive manner. The self is thus at the centre
of the meaning derived from an experience. In contradiction to this is the postmodern self, the self created in communion with others; a de-centred self (Sarup 1993).

According to Sarbin (1993:xxi) this perspective, 'opens a possibility to study 'meaning' and 'meaning making' in particular, as a 'movement' between dialogical positions'. He also posits that the 'self' is a 'decentralised manyness of I positions that each have a voice and can tell their own stories about their respective me's' [original emphasis]. There is thus the opening up to the possibility of multiple selves (see Rowan and Cooper 1999). If the self is created in communion with others, each meeting then has the potential for a different self to emerge. The self, is as such not a once and for all known entity, rather it is an elusive concept, and the 'centre' of the self shifts from being within the person, to being located in the in-between, in-between the meeting with others. The self emerges in 'the gap' between the meeting of two people; a gap that is irreducible and thus the self as a known construct is beyond reach; for the self is in a process of becoming. All that can be known is a sense of the self as created through these meetings, however, in the recalling of the 'who' and 'what' this self is, there are limits imposed, for who is included in this telling? For the potential is there for the image of the self to shift depending on who is present in the telling.

It could be said that, there is a similarity with experience, for experience 'contains many ambiguities, it acts sometimes as a noun, at others a verb, and it is almost impossible to establish a definitive view with which to work' (Boud et al 1993:6). A view that could be seen to be cognisant with encompassing a postmodern perspective. Another, aspect that further confounds attempts at defining experience, is that in the re-telling of experience, there is as yet another experience. Therefore, experience can be said to be 'multifaceted, multilayered, and so inextricably connected with other experiences, that it is impossible to locate temporally or spatially. It almost defies analysis as the act of analysis inevitably alters the experience and the learning that flows from it' (Boud et al 1993:7). It would appear that Derrida (1996:83) reaches a similar conclusion, for he states; 'Human experience is inseparably entangled with our description of it'.

It is suggested here that the description is further confounded by the limits imposed by language, for language is an imposed given, we are socialised into the language of the prevailing culture; and enter the signifying chain as defined by Lacan (Sarup 1993). There is thus the further difficulty in the re-telling of an experience, because of the gap between the signifier and the signified. Another difficulty in re-telling an experience is that the self of the experience (the experiencer of the experience) also informs or has implications for, how the re-telling is spoken about, for the self has the potential, to be re-created in the experience of the re-telling of the initial experience. There is thus a gap between the experience of an experience and our ability to re-tell this experience to an other.
It can be seen that attempting to define experience is difficult when a postmodern perspective informs the discussion. Of postmodernism, Ainley (1998) suggests that within this ever changing landscape, the only constant is the ability to learn. But is this necessarily the case? What does this ability to learn mean/imply/infer?

Bergevin (1967) posits that the most important thing that we have ever learnt, is the fact that humans can learn. Learning as defined by Jarvis (1997:90) is ‘the process of transforming experience, of one kind or another into knowledge, skills, attitudes, values, senses, emotions, and so forth’. But how can this ‘transforming experience’ be determined, elicited? Especially when it is acknowledged that experience is an elusive concept, it is beyond reach, for there is an irreducible gap between the experience and the recounting of the experience. Is it that learning like experience is an individual phenomenon, and any attempt at defining it is an attempt to create a graspable entity? For it could be said, that ‘learning’ this ‘transforming experience’ may not be appropriated, it can only be apprehended in the moment.

However, within the scientific paradigm of modernism, it is possible to legislate for the outcome of this transforming of experience into learning. For there is the awarding of certificates for the attainment of specific standards of knowledge (e.g. general certificates of education, diplomas, degrees), as conferred by the educational institutions. Within the modernist paradigm, the grand narratives of knowledge create a definitive stance on what constitutes knowledge as the outcome of learning (Lyotard 1984). He suggests that within the postmodern paradigm, local narratives replace these grand narratives, knowledge then becomes personal and context specific. There is thus, a renouncing of primacy to science and technology, and a privileging of humanness. Jarvis (1997:64) appears to be mindful of the human element in learning when he acknowledges how Heidegger’s concept of Being, underpins learning and states:

‘human-ness remain a potentiality within human existence until it emerges from the mind and, eventually, as a self or identity. This initially occurs as a result of the learning processes – mostly non-reflective learning during the course of what sociologists regard as primary socialisation; later it occurs through a combination of non-reflective and reflective learning’.

This distinction between non-reflective and reflective learning is important in developing the concept of learning from experience, where learning is seen to be a process of ‘transforming experience’. Non-reflective learning could be seen to be the accretion of facts and figures, or alternatively it could be seen to be indicative of a repeatability in experience.

For as Cell (1984) comments, citing Zellner as saying that one can either have twenty-five years of experience, comprising of one year repeated twenty five times, or comprising of twenty five years of unique experience. In the first instance the person has not been open to the experience, rather
closure has been imposed, for the understanding gained the first time round has remained the ‘blueprint’ for all future encounters with the ‘same’ or ‘similar’ situations/experience; there is a sense of predictability, repeatability, certainty to an experience. Whereas, the second instance is about being open to experience, where each experience has the potential for providing new understanding; there is a sense of unpredictability, non-repeatability, uncertainty; and the potential is there for learning from experience.

Building on from Zellners’ notion of there either being a ‘sameness’ to experience, or an element of ‘difference’, the question that can be posed is why restrict the measurement of ‘experience’ to units of years, why not months, or days, or hours? Why impose a time frame at all? When the notion of difference is encompassed, the potential is there for experience to be a moment by moment phenomenon. It could be that by introducing time-scales there is an attempt to reduce this ‘transforming experience’ and the learning that emanates from this process into a pre-determined known entity. To impose some order, some certainty to the uncertainty that is created when learning from experience; for the learning cannot be appropriated beforehand, the learning that may emerge from experience is an unknowable entity.

Reflection on learning enables the learner to see the content of learning from a different perspective (Mezirow 1990, Colazzi 1973). von Eckartsberg (1998:98) is in agreement but also acknowledges how ‘each insight into something is accompanied by new areas of opacity’. It is suggested here to embrace the notion of opacity, is to give credence to how learning is an ongoing process, for experience is a precursor for learning, and experience is synonymous with life. Learning from experience can not be anticipated in advance. If learning is anticipated or there is an expectation of the outcome of an experience, then there is a foreclosure to the experience. This foreclosure to experience can be representative of a barrier to learning. The ensuing ‘learning’ can then be said to be non-reflective, where there is an element of repeatability to the experience, the learner is a passive recipient of the experience.

Jarvis refers to how early socialisation is a non-reflective process, implying that the learner is a passive recipient of experience; there is as such an imparting of knowledge from parents/significant others who could be said to take up the position of the ‘teacher’. When the teacher is seen to impart knowledge to ‘students’, a situation is created whereby the student learns someone else’s experience of the subject being taught (Laudrillard 1993). It is suggested here that another way of looking at this, is that it is the interpretative lens of the teacher that is passed on to the learner. There is the potential here for the lens, to incorporate the distortions in meaning making perspectives of the owner of the lens; perspectives that shape how a person construes/makes sense of their experience, experience that has the potential to be transformed into learning. It could be then, that a situation is
created whereby the ‘student’ learns the distortions in meaning making of the ‘teacher’, and assumes
that this is the way for them to interpret similar situations.

In the case of the parent/child interaction, there can be an intergenerational transmission of
distortions in meaning making perspectives. Prior to learning through socialisation, the child
experienced its own experience, there was no language for this activity, for language according to
Lacan introduces the child to the symbolic order (Sarup 1993). It could be said that this is
representative of pre-reflective knowing, where there is a coming to experience without prior pre-
supposition (Heidegger 1967). With the transition from the imaginary (pre-language) into the
symbolic, experience becomes something that can be named, brought into conscious awareness.
Through the socialisation process, the child learns the language of the parents, ‘things’ are ascribed
a particular meaning, also an image of the self is created in response to this entry into the symbolic.

Lacan, in developing his theory of psychoanalysis and the importance of language, drew on the
work of Freud, or rather he re-worked Freud’s theory of psychoanalysis; a theory that was based on
the discovery of how the unconscious informs human behaviour. In Lacan’s deconstruction of
Freud, he proposed that the unconscious be structured like language. That in learning a language
needs can be expressed, but that the underpinning desire gets lost into the unconscious, due to the
limitations of language (see Lacan 1988). Freud’s theory of how ‘material’ was relegated to the
unconscious was focused on the tensions between the pleasure principle and the reality principle.
Where the pleasure principle is representative of the persons desires, and the reality principle the
cultural norms, when impulses and desires are in conflict with the cultural norms, they are stored in
the unconscious, where they remain active and influence behaviour (see Freud 1915). Thus, as
learning from experience is influenced by previous experience, there is the potential that some
experiences may have been repressed (due to the tensions between the pleasure and reality principle)
and although these experiences can be unconscious to the experiencer, they continue to exert an
influence on the interpretation of current experiencing. The unconscious can therefore be
representative of a barrier to learning from experience.

It was acknowledged in the primary construction (analysis of findings in the previous chapter) that
barriers to learning, i.e. distortions in meaning making perspectives, can impinge on the person’s
ability to learn from experience, and that therapy may be required to work through these barriers
(Boud et al 1993, Mezirow 1990). However, with the recognition of the importance of the
unconscious and how previous experiences may continue to exert an influence on behaviour (for
there is a tendency for a repetition compulsion, we repeat what we do not understand; a return of the
repressed [see Freud 1915]); it is suggested here that some educators have overlooked this potential.
It could be that with the predominance of science and technology, where the teacher was seen as the
one who knows, and imparts their knowledge to the students (see Knowles 1984), and the students passive recipients of knowledge, their unconscious processes and how it informs their ability to learn from experience were not recognised.

Whereas, with the shift to student centred learning, and the role of the teacher being changed to a facilitator of learning (see Rogers 1983), the student becomes active in the learning process, and the facilitator is there to facilitate learning how to learn. The place of previous learning experiences are recognised, there is then the potential, at least, of recognising unconscious processes. The difference between the two approaches to learning can be found in the old Chinese proverb, you can give a hungry man a fish, and you feed him for a day, or you can teach him how to fish, and you feed him for life.

Conscious processes do not purely influence transforming experience to learning; rather there is an intermingling of conscious and unconscious processes. For there to be a return to learning from experience, there is a need to recognise how unconscious processes inform current experience; how these processes may provide a template to interpreting experience. It is about working through the barriers to learning from experience, and how in this process, the previously identified learning theories/perspectives that inform therapy as form of learning, can be seen in a different light when the unconscious is recognised as exerting a hitherto unnamed component of significant, transformative and emotional learning. Perhaps the suggestion of the need to refer a learner to a therapist if the barriers to learning are firmly entrenched (Boud et al 1993, Mezirow 1990); is a recognition of how the barriers may reside in the unconscious.

In commenting on learning in therapy Felman (1987: 76) comments that it does not proceed:

‘through linear progression but through break throughs, leaps and discontinuities, regressions, and deferred action, the analytic learning process puts in question traditional pedagogical belief in intellectual perfectibility, the progressist view of learning as a simple one-way road from ignorance to knowledge’.

The implications are that it can be difficult to isolate the forms of learning that are present in therapy, for there is not a linear progression. Also with the recognition of how the learning theories/perspectives of significant, transformative and emotional are seen in a different light when unconscious processes are recognised. It could be said that to ascribe a particular form of learning to therapy is a modernist stance, an attempt to provide closure to an experience by naming/prescribing the forms of learning. Whereas, to adopt a postmodern stance, would be to see therapy as a means to learning. Here there is openness to the learning that may emerge through the therapeutic process.

What then is reparative by the discourse of psychotherapy? Therapy is a process whereby unconscious material is made conscious (see Bateman and Holmes 1995, Symington 1986). Whereas, Gergen and Kaye (1993:257) suggest that ‘It is a process during which the meaning of
experience is transformed via a fusion of the horizons of the participants, alternative ways of punctuating experience are developed, and a new stance toward experience evolves'.

Therapy as deconstruction is about a shift from focusing on the problem, to questioning how that particular story came to be told, as opposed to another one, it is about a 'reflection on the way the therapeutic encounter is storied into being' (Parker 1999:1). It is about identifying the transition from meaning and power in the relationship to reflexivity and responsibility. Kaye (1999:34) appears to be in agreement when he suggests that there are two dominant discourses in therapy, the 'techno-rational repertoire' and the 'ethical discursive form'. Where the 'ethical discursive' is about the therapist taking up a stance of 'not knowing' (Kaye 1999), or 'not knowing knowing' (Lamer 1999:44). For Romanyshyn (1990:245) the stories in the life-world are 'symptoms of the soul' and 'when psychology attends to the life-world as cultural therapeutic, when it attends to the shadows and symptoms of culture, it performs the work of deconstruction' (Romanyshyn 1990:250).

Of the deconstructionist approach to therapy Kaye (1999:34) suggests that it is about examining 'the socially constructed discursive complexities and practices by which people are positioned or social conditions in which they find themselves'. There is as such an emphasis on how the self is socially constructed and how the self may differ dependent on the context. It appears that in this discussion we have come full circle; back to how the self, as the experiencer of the experience is influenced by previous learning, and how the telling of experience is shaped by the people present, together with the limits imposed by language.

The researcher is aware that the use of the term 'circle' implies a closure; however, it is a circle that cannot be closed if we are to remain open to experience, like the hermeneutic circle (Gadamer 1967). If we remain open to experience, there is the sense that the understanding gained from previous experience may be available as pre-understanding when we next encounter a similar situation, and through reflection, the previous experience informs the next experience. Gadamer (1967:41) also posits that 'hermeneutical reflection plays a fundamental role' in psychoanalysis. For it is here a link is made with how the 'the unconscious motive does not represent a clear and fully articulable boundary for hermeneutical theory'. He goes on to say that 'psychotherapy could be described as the work of "completing an interrupted process of education into a full history (a story that can be articulated in language)"', so in psychotherapy hermeneutics and the circle of language that is closed in dialogue are central'. He also made reference to how his reading of Lacan, had been influential in shaping his views that therapy and education are inextricably linked.

Loewenthal and Snell (1998:334) are interested in therapy as a form of teaching and learning and state: 'where there is trauma in our lives and there is restriction we cannot learn. In trauma the world
does not make sense to us. There is a war between ourselves and others rather than rapport'. It is suggested here that trauma is an inevitable outcome of early socialisation, for there is, drawing on the work of Freud, a denial of the pleasure principle, and drawing on the work of Lacan, the mirror stage represents a break into language, the symbolic, there is rupture between what the child desires and what can be spoken about. There is through this socialisation process an abnegation of self; there is as such an interruption into the process of learning from experience. Therapy can provide a reparative discourse to enable the repression(s) that emanated from early non-reflective learning to be made known, a knowing that has the potential to enable a return to learning from experience.

It could be that through the process of therapy, the patient is introduced to him or her self (Symmington 1986). Reaching a similar conclusion, Holmes (2001:89) states:

‘Therapy provides an opportunity for the patient to begin to see himself from the outside; to forgive parents as well as to blame them; to see and own his contributions to circumstances, rather than to view himself as the helpless victim; and to recognise that there are occasions in which fate deals us cards over which we have no control’.

Within this quote, there is recognition of the need for the client to make a shift from seeing things in either black or white, ‘to forgive parents as well as to blame them’, in a sense to embrace the binary opposites, for a blurring of perspectives, to be more open to multiple meanings. It is neither one thing nor the other, but a combination of a multiplicity of factors. There is also a recognition of how the client assumes some responsibility in maintaining the status quo; to own the distortions in meaning making perspectives, that informs their way of knowing. There is also a sense, of accepting the things that cannot be changed.

How can the therapist provide an environment that is conducive to creating a learning milieu that has the potential to enable a return to learning from experience? An environment that is ‘ethical discursive’ as opposed to ‘techno-rational’ (Kaye 1999). Larner (1999:44) suggests that an ethical relationship is a ‘tolerance difference’; perhaps this is one way of viewing therapy as a reparative discourse for a return to learning from experience. Lowe (1999) suggests that in ethical therapy there is a sense of ‘not yet’ for there is a sense of staying outside the binary opposites, there is as such an embracing of the notion of multiplicity of meanings and I positions. He states, there is ‘an openness to the contents of discursive binary forms in which subject positions are constituted’ (Lowe 1999:97).

Levinas (1947) in an attempt to explain this ethical relationship of responsibility for the other critiques Buber’s I-It, and I-Thou relationship. The I-It relationship represents a relationship between a subject and a passive object. Others are therefore objectified, it is as such a narcissistic relationship, a relationship with one self; notions of the other are not recognised. To move away from this place there is a need for ‘self-forgetfulness as the first abnegation’ (Levinas 1947:39).
In preference to this I-It relationship is the I-Thou relationship and there is a sense of mutuality between two subjects. Levinas suggests that in this relationship there can a sense of social communion, a dialogue. However, there is the tendency for the other to be reduced to what is known. To ascribe a meaning in advance to the meeting, to posit that the other can be known is to already provide a foreclosure to the other. What Levinas is advocating is a relationship that is asymmetrical, where the I has responsibility to the other, but the Thou has no responsibility to the I. For the I to take up a responsibility for the Thou would be to make the relationship symmetrical, and it is this that Levinas questions. It is as such a difficult relationship to conceptualise, for in essence it is found in the unconscious, for it is pre-reflective knowing.

Levinas does acknowledge for there to be a meeting between people, there needs to be an element of ‘sameness’ for it is this that facilitates a dialogue, however there is a need for the concept of ‘difference’ to be privileged. It is in this difference, that the asymmetrical relationship can emerge. Emerge, for to suggest that it will is to already subscribe some element of knowing in the meeting with the other.

A relationship based on reciprocity has the potential to totalise, to reduce the other to what is known, to ascribe a meaning for and to the other; to define the other; to know the other prior to the face-to-face meeting. Whereas, he suggests that the asymmetrical relationship that he prefers, is for there to be an openness to the infiniteness of the meeting. He implies that in Buber’s I-Thou relationship, the I is subjective, and is a knowing self. Whereas, Levinas refutes this because for him it is about being. A being founded in mystery, like the mystery of death. Death is unknowable, and the ethical relation with an other is unknowable for ‘the relationship with the other is a relationship with a mystery’ (Levinas 1947:43). We can never grasp the other, it is not a possibility, for the ‘Other is in the future’ like death (Levinas 1947:44). Accordingly he suggests that it is difficult to conceptualise this meeting with the other, for any attempts at conceptualising is an attempt to provide foreclosure to experience. Can we meet in the face-to-face and be open to the experience?

Critchley (1992:4) drawing on the work of Levinas suggests ‘The domain of the Same maintains a relation with otherness but reduces distance between the Same and the Other’. There is thus an attempt to close the ‘gap’, a ‘gap’ that cannot be closed if we maintain a responsibility to the other. A closure of the gap is to create a symmetrical relationship, founded more on the principle of Buber’s, I-Thou rather than Levinas’s face-to-face. Gans (1997) used the phrase ‘responsible relatedness’ to refer to this asymmetrical relationship.
The ethical subject according to Critchley (1999:186) is not a conscious subject, 'for consciousness is the effect of an affect and this effect is trauma' [original emphasis]. Thus through trauma we become a conscious subject, and yet this very act of becoming conscious imposes a boundary on learning from experience. There is relegation to unconsciousness of the elements that are too painful for the nascent ego to comprehend, to admit to awareness. We are thus caught in yet another 'gap' the 'gap' between consciousness and unconsciousness; to return to learning from experience there is a need to 'bridge the gap', to be open to experience. But how can this bridging take place?

How can the therapist provide a therapeutic relationship that is premised on 'responsible relatedness'? This is the focus of the next section, where notions of good practice will be suggested for providing therapy as a form of therapeutic, premised on the concept of 'responsible relatedness' in the face-to-face encounter with another.

3. Therapy as therapeia

The deconstruction of therapy as a reparative discourse to enable a return to learning from experience highlighted the inherent difficulties when the postmodern paradigm informs knowing, for there is a shift to multiple meanings. That experience, and the learning emanating from it emerge in the in-between, between the therapist and the client (Felman 1987, Symmington 1986). There are limitations imposed on the re-telling of the experience due to the boundaries imposed by language. To speak of a return to learning is to embrace the notion of an interruption in learning from experience, due to trauma. The initial trauma being the transition to a conscious subject, other experiences may then build upon this trauma, for experiences that are too traumatic for the conscious self to acknowledge or to 'know' are repressed. The repressed material in the unconscious continues to exert an influence on behaviour. The repressed material may form a barrier to learning from experience, for it can inform how future experience is anticipated and evaluated. Thus previous experience informs current experience; there is an inability to learn from experience.

One way for therapy to be seen as a reparative discourse is to enable unconscious material to become conscious, there is a sense of redressing the original trauma. As an adult, there are choices; there comes a recognition of the many juxtapositions involved when binary opposites are reworked, and there is a blurring of boundaries between the 'either' and the 'or'. Or as Derrida (1998) suggests it is about speaking from a non-place; to metaphorically be on the outside looking in, another position from which to speak.

Therapy becomes a place to speak the unspeakable, and think the unthinkable, there is a sense of the process enabling an 'awakening to thought' (Heaton 2000). For this to occur there is a need for the therapist to be open to the experience of the other, to not provide foreclosure to the meeting by
reducing all to that which is already known in an attempt to favour sameness in opposition to difference. There is a need for the therapist to create an environment that is mindful of the face-to-face meeting.

Building on from the work of Levinas (1947) and his critique of Buber's I-It and I-Thou relationship, it can be possible to identify how these relationships may take place in therapy. According to Williams and Gantt (1998) there is the potential for all relationships to be seen as 'therapeutic' as the meaning of the word refers to 'service' or 'attendance'. Drawing on the findings that emerged in this study, the researcher proposes a model for opening up further conversations as to how therapy is a means to learning.

The givens to the therapeutic relationship in therapeia constitute the setting, the contract agreed between therapist and client, the timing of sessions, payment and confidentiality, etc., aspects that Feasey (1999) considers under the heading of 'good practice'. There is an assumption made that the therapist will be qualified, and to have had a training experience that prepared them to take on the role of a therapist. In providing an environment that is premised on the Levinasian notion of responsibility to the other in the face-to-face, there is a need for the therapist to acknowledge the theory and techniques of therapy, but to lay this aside, for there to be an opening up to difference (Larner 1999). He also poses the question 'can we as therapists deconstruct ourselves so as to allow others to speak?' (Larner 1999:46).

Perhaps there is a need for the therapist to have had had the experience of being a client, to have experienced therapy as therapeia. Perhaps there is also the need to have supervision from a therapist who has also experienced therapy as therapeia. Perhaps these experiences may facilitate an opening up to difference.

With the aforementioned in mind, the givens of therapeia, are the environmental/contractual issues, and the training, therapy and supervision experiences of the therapist. The intention of stating these givens is to set the scene for therapeia, for what happens in therapeia cannot be appropriated beforehand, for to do so is an attempt to provide a foreclosure. And afterwards, any attempts to translate the 'saying' in the moment, becomes the 'said' and a reduction to the same. The 'moment' emerges in the in-between, in-between the therapist and the client, an unconscious in-betweeenness.

According to Larner (1999:47) 'the therapist in ethical relation to the other creates an abode or space for encounter and conversation'. Whereas, Gordon speaking of therapy as ethics, suggests,

'It involves an ability to be truly open to the other, not to try and fit him into any preconceived model or theory. It requires an ability too to learn from experience, not in the sense that one knows more facts but rather that one's conception of and thoughts about the
world have broadened... It is a position which does not tolerate unknowing or uncertainty, for that implies a passing phase, something to go through or got over, but which welcomes such unknowing and uncertainty as the ground from which something worthwhile might emerge.' (Gordon 1999:160) [original emphasis].

There is, as Gordon, acknowledges a need for the therapist to learn from experience and his use of the word ‘too’ implies that there is an intention that through the process the client may learn to learn through experience. This factor is also acknowledged by Loewenthal and Snell (2001:30) ‘As psychotherapists we can be ethical only if we see the other as someone we can serve and learn from. This is ethics as practice’. The use of the term serve is cognisant with Freidman’s (1989) definition of therapeia, as one that encompasses service to the other. Thus therapeia is ethical practice; a practice premised on learning. For Levinas, teaching is the ethical relation to the other, ‘the other that precedes me is my teacher: the law of the other is that I must learn “my” past which is given to me through another’ (Beardsworth 1998:75). But how may this learning be recognised? How may the practitioner be mindful that learning from experience is taking place?

It is suggested here, that there can be an imaginary continuum to represent different forms of therapeutic relationships, at one end there is the ‘I-It’ relationship whereby there is no recognition of the other, the other is objectified, the self too may be objectified, the self may be referred to by an impersonal pronoun. The next relationship is the ‘I-Thou’ relationship, here there is a recognition of the other, and the relationship is symmetrical. The relationship with the other is founded on a mutuality. At the other end of the continuum is ‘responsible relatedness’, an asymmetrical relationship premised on the responsibility of the therapist for and to the client. A responsibility that is apprehended in the moment.

Examples of statements from the client, that could be seen to be indicative of non-reflective learning, in the ‘I-It’ relationship, it is always that way...you know it will be that way because. An example from the data that emerged in this study ‘you just know that people are going to reject you’. Whereas, in the ‘I-Thou’ relationship there may be signs of reflective learning, willingness to question, to explore, it may be this way, or it maybe that way, or I feel that at times I have prejudged situations. An example from the data ‘I realise that I did not give people a chance to be different’. Here there is a sense of being able to reflect, to recognise their role in maintaining the status quo. It may be possible in the ‘I-Thou’ relationship to determine significant, transformative and emotional learning. In ‘responsible relatedness’ it is a pre-reflective state, it is as such a felt sense, an unconscious knowing; therapy as a means to learning.

It is not possible to legislate for the type of learning that may take place in therapeia rather it is about welcoming uncertainty and not knowing, as the underpinning ethos to the practice of ‘responsible relatedness’. It may be possible through reflective processing, for the therapist, to
identify the types of therapeutic relationship formed. But it is not possible to enunciate the ethical relationship; this being in the moment with the other, for it is not graspable, it is beyond reach.

Conclusion
Through the process of initially deconstructing ‘facial difference need not define the person’ there was recognition of how the term ‘facial difference’ is erroneous. It is a term conferred by society. This ‘difference’ may be in the mind or in the body; the effects on the person are for them to be perceived as ‘less than’. There is a sense of marginalisation. The suggestion that therapy may be a reparative discourse to enable a return to learning from experience, highlighted the difficulty in defining experience and learning within the postmodern paradigm. There are limits imposed by language and unconscious processes. To ascribe therapy as a form of learning, creates the possibility of identifying learning theories/perspectives that may inform the ‘lens’ for looking at therapy as a form of learning. But in recognising the role of the unconscious in the first trauma (entry into language) that interrupts the process of learning from experience, it is not possible to define the form of the learning; rather therapy becomes a means to learning.

With this recognition, therapy as therapy was explored; a concept that embraces the ethical relationship of responsibility for the other and is premised on pre-reflective knowing. It is therefore a phenomenon that happens in the moment, it cannot be appropriated. A model was proposed, to enable practitioners to open up further conversations, on therapy as a means to learning. It is acknowledged that the very use of the term model, may imply/infer a step by step process for therapy as therapy, however, the term is used here in its loosest sense, and is mindful of the need to encompass difference in preference to sameness. Levinas acknowledged that the ethical relationship is premised initially on an element of sameness to enable a dialogue to commence, and it is in this vein that the model is provided, as an element of sameness to open up a dialogue, how the dialogue develops is premised on difference, a difference that cannot be apprehended, for it is in the moment.

The next chapter concludes the final stage of the methodological framework developed and tested out in this study; a critique of the research process.
Chapter Nine

Critique of the Research Process

Introduction
The aim of this chapter is to complete the final stage of the methodological framework, to critique the research process, and is representative of stages eight and nine of the framework. The aim of the study was to develop a methodology for exploring psychotherapy as a form of learning. A research paradigm was created following a review of other paradigms. The intention was to provide a paradigm that was informed by the researcher’s interpretative lens, and would be mindful of the tensions inherent when re-presenting the other, where subjectivity (humanness) was privileged over objectivity (technical). Knowing is achieved through communion with an other; it is an interactional subjective activity (epistemological perspective). The meaning emerges in the in-between, created in the moment and known to the interlocutors involved (ontological perspective). The possibility of meaning is generated through a reflexive and dialectical process (methodological perspective).

The methodological framework that guided this study will now be critiqued to elicit whether it does privilege humanness over science and technology. There are six phases to the critique; (1) research design and method; (2) data generation; (3) data analysis; (4) primary construction; (5) secondary construction; (6) review of the research process; each will be discussed.

1. Research design and method
The design emanated from the purpose of the study, an exploration of therapy as a form of learning with particular reference to people with a facial difference. The question posed by the study ‘Is counselling/psychotherapy a form of learning for people with a facial difference?’ The first step was for the researcher to operationalise the meanings of the terms in the question, literature reviews were conducted on counselling/psychotherapy, learning and facial difference. A review of the literature allows for ‘a historical perspective on the topic as well as a source for further interpretations of the data’ (Garman 1996:21). Whereas, Fink (1998) suggests that a review may inform a researcher of previous studies and assist with developing the research question. In this study the reviews on counselling/psychotherapy and facial difference enabled the researcher to be clearer on what previous research had been carried out and the methods employed; and the review on learning clarified the domain of learning that correlates with therapeutic practice.

An area of opacity found in the research reviewed was that the decisions that informed the selection of the research method(s) was on the whole omitted. Consequently, the reader is left to make an assumption as to how the method correlated with the chosen research paradigm. Overall there was
an absence of the humanness of the researcher; there was an emphasis on the 'doing' of the study. The method as such is viewed as a 'set of instructions' and if correctly applied/followed then an assumption is made that sound results will be produced, there is privileging of replication/repeatability. There is a foreclosure to humanness; for subjectivity is erased in deference to objectivity. The subjectivity of the researcher becomes negated in the name of scientific rigour.

The sharing of the researchers interpretative lens is one way of making more transparent the researchers’ subjectivity and it is suggested here that it is representative of a privileging of humanness. The hermeneutic approach may help science methodology by ‘making transparently clear the guiding pre-understandings in the sciences thereby open up new dimensions of questioning’ (Habermas 1962:39). This seems to be an invitation for the researcher to share their interpretative lens, however, can we make something transparently clear? To whom? Possibly the researcher, but for unknown readers it is an impossibility for there is a presupposition that the reader will reach the same point of clarity. None the less this should not deter the researcher from explicating how they make sense of the research process. By defining the ontological, epistemological and methodological perspectives that inform the research process, the researcher makes known to the reader of the research text (report) how a particular meaning(s) emerges from a particular study. It as such adds to the credibility of a study (Sword 1999, Thorne 1997).

In this study, the sharing of the researcher’s interpretative lens included the theories and perspectives that inform her knowing, it would be naïve to suggest that in this telling all is revealed to the unknown reader, for can we make it all known to ourselves? For what of the unconscious processes? Perhaps all that can be said is that this is how it was at that moment in time, this was the then current state of understanding. However, in light of further experience it may be changed. This does not take away, or lessen the achievement at the time, rather it is to give credence to how meaning is not a fixed, static entity, for it is in a state of flux; like the human state.

Is it possible to be mindful that the meaning created belongs neither to the researched or researcher; it lies in the in-between? Can we re-present for the other this in-betweeness? Can we capture the ‘saying’, or will there always be something that is not graspable? This difficulty is acknowledged when trying to capture the ‘saying’ in the therapeutic relationship (Gordon 1999). From a Levinasian perspective, the ‘saying’ is in the moment and there is the potential for an openness to the other. Any representation of the ‘saying’ becomes the ‘said’ and there is a closure to the meaning that emerged with the other. Meaning is reduced to something that is other than what occurred in the moment. How does the researcher account for this without doing violence to the other? Should we conduct research, if research becomes a totalising move, an attempt to reduce to all that is known? What are the alternatives? Perhaps what can be shared is the struggle with the
inherent tensions of embracing an approach that privileges humanness in preference to science. This very ‘sharing’ demonstrating the difficulties in not reducing all to what we already know, and to be mindful that the meaning generated is a situated meaning. Batchelor and Briggs (1994) suggest that this sharing enhances an awareness of potential ethical dilemmas.

The selection of the research method was influenced by the researcher’s intention for the research to focus on people’s the lived experience, to hear the participant’s story; thus the heuristic method was chosen to guide this inquiry primarily as it is a phenomenological research method and the focus is on ‘lived experience’. The relationship of the researcher and the research participant is acknowledged, and the researcher needs to have experience of the phenomenon (Moustakas 1990, Patton 1990). There appears to be a privileging of humanness; there is the intention to conduct the study with participants or co-researchers as opposed to on them (Scheurich 1997, Lather 1991). Also the method correlates with the ontological (relativist), epistemological (interactional subjectivist) and methodological (reflexive and dialectical) perspectives of the research paradigm that informs this study.

The selection of one method appears to contradict the recommendation, for multiple methods to guide research that encompasses postmodernism (Scheurich 1997, Reinharz 1992, Lather 1991). The researcher believes that heuristics can be seen as an eclectic method, for the four stages of representing the findings encompass elements of grounded theory (the content analysis of the individual depictions); case study method (exemplary portrait) and discourse analysis (analysis of transcripts. It could be said that multiple methods have been employed. Another possible way of looking at this piece of research is to acknowledge the multiple stories told; the stories of the participants, the story the researcher made from the analysis of transcripts which drew on the words of the participants, the story the researcher made of her understanding of the phenomenon following conducting the inquiry (the creative synthesis). The research report is yet another story; and as Scheurich (1997) suggests there are only partial stories; we never arrive at a full story, for in the telling of one story, one story or one voice is privileged.

The humanist stance of heuristics where the self (of the researcher) is at the centre of the meaning making process is in opposition with the decentred postmodern self, where the self as a phenomenon exists in relationship with others. We are all subject to (Sarup 1993). The methodological framework that guided this study, incorporated a second cycle of interpretation and offered the potential of reviewing heuristics from a post-phenomenological perspective; and to consider the implications of being subject to, and an opening up to the possibility of multiple meanings. (This will be explored further in the review of the research process that concludes this chapter).
2. Data generation

The telling of the lived experience was shared either through face to face interviews or telephone interviews, or via e-mail and written documents. Apart from the written documentation, all participants were concerned that the information given was what the researcher wanted to hear. This correlates with the view that people like structure in an interview so that they know that they are giving the right response (Acker et al 1991). But is this necessarily so? Or is it a cover story on behalf of the researcher to maintain control of the situation, thereby ensuring that they 'get' the right data to answer the question they pose? Already there is a closure implied to the meeting with the other and hearing their lived experience. Both West (1998) and Sussman (2001) when conducting heuristic inquiries used a pre-determined set of questions to guide the generation of data. The questions selected by West became the headings of the themes that allegedly emerged from the data. Whereas, Sussman (2001:93) states ‘while dialogue cannot be planned, some areas of inquiry must be outlined in advance’ [researcher’s emphasis]; she does not however elaborate why. But must we? Is the must more about a structure to ensure that the researcher ‘collects’ data to answer the research question the way in which the researcher has decreed beforehand?

Somehow by using a structure there is an element of certainty created to temper the uncertainty created when meeting with an other. Can we meet with an other when conducting research and be open to the experience? To not reduce the story told to that which we already know, or presume to know? Hence the questions to check out the presumption. Do we only hear the story if it resonates with our own story, our take on reality? Gerrish (2000:920) recognises how the ‘researchers own values also impact upon collection and interpretation of ethnic data’ for as such we interpret from our own culture. But it would seem that this sentiment is pertinent to all research, why single out ethnic data? If all researchers were more transparent about their personal interest in a study, and the methodological, epistemological and ontological aspects were also shared, would there be a need to raise this as issue?

An experience that occurred in the process of this study has reinforced the researcher’s belief in letting people tell their own story in their own way. Nearing the end of the data analysis, another potential participant made contact, wishing to join in with the study. The initial thought was that it would be good because the emerging themes could be checked out, who was imposing a structure now! The second thought on including another participant stemmed from the fact that the person was interested in being involved, had experience of living with a facial difference, was a therapist and had experience of personal therapy. The challenge would be to not structure the interview as per the emerging themes.
However, at interview, the person was not happy with the researcher asking only one question; ‘you say what you want and I will respond’. This posed a dilemma; to respond to the research participant’s needs appears more in keeping with the underpinning ethos of this study. However, to respond in the way asked would be to skew the storytelling, under the scientific remit the interview could be seen to be ‘null and void’ for there would not be parity with the rest of the data collection.

There is a tendency for research conducted guided by the ethos of subjectivity, to be evaluated by objective methods (Koch and Harrington 1998, Thorne 1997, Denzin and Lincoln 1994, McCutcheon 1990) therefore there is a need for new ways of evaluating the validity and credibility of the findings. One way is for the researcher to share their struggle when re-presenting the other (see Kitzinger and Wilkinson 1996).

With this in mind the interview proceeded, the themes that had emerged from the data thus far, guided the open-ended questions posed, for example, ‘what was the most helpful aspect of therapy?’ ‘what is your experience of meeting new people?’ The content of the responses was similar to what others had shared. However, the process was different, there was a ‘deadness’ to the story, it was a more of a ‘matter of fact’ answer, a story told that followed a linear trajectory. Which contrasted with, the spiralling trajectory of the response that emerged through the process of participants telling of their experience. It is possible that the person needs the questions as a framework to ensure that they would be heard? For ‘The subject in the act of speaking constructs an interpretation of experience which is consonant with what the researcher wants to hear or risk not being heard’ (Crowe 1998:342).

The generation of data represents a paradoxical situation for on the one hand the focus of the study was on the face-to-face encounter (the exploration of the therapeutic process), and on the other hand the main route for data generation was face-less (either telephone conversations or written correspondence). This paradox could have been avoided had the researcher focused on the experience of therapy from the perspective of the therapist. For instance, she could have used an approach similar to Granfanki and McLeod (1999) who recruited people to their study on the helpful and hindering aspects of experiential psychotherapy, by offering twelve free sessions of therapy to people, on the understanding that they were participating in a research project. Thus data would have been generated in the face-to-face, and transcripts from actual therapy sessions could have been analysed; and the learning intrinsic to this elicited. However, what would have been missing would have been the uncovering of people’s stories of their experience of therapy and peoples opinion of therapy. Stories that enabled a picture to be developed of the issues that may precipitate the need for therapy as a means to learning, and reflections on the outcome of therapy that illustrated the effects of the learning that had emanated through therapy. A multi-dimensional story could be told, where there was an exploration of more than one perspective.
For the researcher, the face-to-face encounters raised issues of meeting others with a facial difference, of somehow belonging to the same "club", in essence there was the potential for a reduction to sameness. Belonging to the same group as the research participants can provide an access to minority groups, however there is a need to be mindful of the 'seduction of sameness' (Hurd and McIntyre 1996: 78). They suggest that sameness can diminish critical reflexivity, and that one voice may be privileged over another. But is this not the case with all research? Rather there is a need for researchers to be aware of this inherent tendency, perhaps the inclusion of a deconstruction of findings is one way of demonstrating the privileging of one voice, one view over the other. A deconstruction is a way of blurring the boundaries between the either or stance; and this could be representative of the messy texts of research that Lincoln and Denzin (1994) refer to.

The place of the researcher in the study needs to be acknowledged (Bola 1996), she suggests that the researcher should identify whether or not they belong to the same group as the participants, and to explore the implications of either stance. In this study the three different modes of data collection facilitates this exploration. In the face-to-face encounters there were visible cues of belonging to the same group, and one person contributed to the study because it gave them the opportunity to meet with another person with the same facial difference. In telling of their story, there was a sense of isolation, a sense of the difference being accentuated because of not having had the opportunity of talking with someone else with a facial difference.

In the telephone interviews, there was no face to scrutinise, just the sound of a voice to determine sameness or difference. For some people, they would have preferred to have met, but geographical location prevented this, and for some the fact that the interview would be via the telephone was a contributory factor in taking part in the study, for they would not have to meet with an unknown other, a situation which was extremely difficult for them. On the one hand this method of data generation appears impersonal, and yet on the other it enabled the telling of the story to an unknown and unseen other, like a confessional. Skinner (1998) comments on this when speaking about unstructured interviews, and it would seem that with telephone interviews, there is a need for the researcher to be mindful that in not being seen this could have the potential to open the floodgates for telling one's story. Getting it off one's chest without having to worry about the impact on the other person. As Levinas (1947) suggests it is more difficult to do violence to the other when looking into the face of an other.

One way of handling this potential situation is to keep the focus on the research question, to bring the person back to the purpose of the interview. In essence to place boundaries to the story telling, without this there could be the potential for the interview to become more like a therapy interview (Hart and Crawford-Wright 1999, Etherington 1996); the research interview unlike the therapy
interview does not take place within an ongoing relationship. There is thus the need for the researcher to be aware of the need for support, (Barnitt and Partridge 1999) suggest that follow up interviews may be necessary when covering sensitive issues. In this study, none of the participant’s requested support, this could have been due to the researcher staying within the boundaries imposed. An example of needing to impose the boundary was when there was one instance of the person wanting to off load her views on how awful people were to her, by intervening and restating the aim of the interview was to hear of her experience of therapy, the off loading stopped. On the one hand there is the invitation for people to share their lived experience, and on the other hand there are boundaries imposed; boundaries that are premised on ethical considerations (Punch 1994).

The e-mail correspondence, was another face-less method of data generation, this time there was no voice to determine sameness or difference. Kralik et al (2000) suggest with pen-pal correspondence there is a need for the researcher to be thoughtful of how they respond to the stories shared, for the written word can be re-read, and the potential is there for it to be miss-read. However, this can also the case with face-to-face encounters. The dilemma is how to respond to this miss-communication, with the written word there is no personal contact. In this study, it was for this reason that the person participated, and shared how it was much easier to write of her experience than to speak it with another person. My responses to her, followed the same as in the other interviews, to respond to questions posed, and to seek clarification, for example she had said that therapy had not been helpful, and in response to the invitation to say more, the unhelpful part was that she had been disappointed at the slow progress, and that she could not express her feelings in the way that she thought the therapist wanted her to. Most people did not ask questions, but those that did (three people), these were in relation to my own experience of having a cleft (e.g. had I been teased), these responses were in the vein of yes, I had had a similar experience, and then to focus back on the research participants lived experience.

The choice of data generation, either face-to-face, telephone or written correspondence, provided people with a choice (for some, geographical location, reduced the choice to either telephone or written modes of data generation). For some this choice was instrumental in their decision to take part, perhaps there is a need for researchers to consider different methods of generating data, rather than relying on one method, as this may limit the number of stories told.

3. Analysis of data

Once the data is collected, Moustakas (1990) advocates the researcher immerses themselves in the stories, so much so that it fills every waking moment. West (2001:128) suggests that this stage involve ‘synchronous occurrences when opportunities arise in chance meetings with people to explore our research question’. It is during this immersion that the individual depictions of the
research participant stories are read and re-read for the emerging themes; similarities in experiences are recognised and grouped together. This need for themes may be foregrounded during the generation of data, and contribute to how the telling of the story at interview may be structured by the researcher to ensure they get the answers they were looking for (Crowe 1998, Reinharz 1992). Whereas, Smagorinsky (1994:xii) appears to reach a similar conclusion, but from two differing perspectives, he poses the question 'to what extent had the method itself shaped the data?' And also comments on how 'the researcher's hypotheses and theoretical framework affect the interpretation of the results' (Smagorinsky 1994:xvii). As such it appears impossible for the researcher to abnegate from the process. Rather there is a need for the researcher to be more transparent in the research process, by sharing their interpretative lens and questioning their taken-for-granted assumptions surrounding research. Garman (1998) refers to this as questioning the stereotypes surrounding research, and raises the question of the use of personal pronouns instead of ‘the researcher’. This represents one of the tensions inherent to this study, on the one hand wishing to use 'I' instead of 'the researcher', and on the other hand recognising that within academia this is not as acceptable (Reinharz 1993), also that this could be indicative of the researcher positioning themselves at the centre of the meaning making process, a process that is not possible without a relationship with and to another. Thus it becomes not just the case of re-presenting the other, but also how to re-present the self of the researcher.

To invite people to share their experience of a phenomenon was a struggle, for on the one hand there was the need to make comparisons between the individual stories told, so that a collective story could be told, as such there was the temptation to ensure sameness by asking some questions to structure the stories. And on the other hand there was the dilemma of trusting the process, to let each participant tell their story in their own particular way, and hope that there would be an element of sameness, that would enable a collective story to be told. There was another possibility, if all the stories were so diverse as to not find consistent commonalities for a collective story, the story of diversity could have been told. Research that endorses humanness, needs to remain open to the experience of conducting research, and to be open to what emerges, to tell the story as ‘how it was’ rather than impose closure and tell it ‘how they thought it should be’. If the researcher knows the answer before conducting an inquiry, and skew the data generation and interpretation to meet with this ‘ready made answer’, why conduct the research? Is research carried out under this guise not a form of violence to the other?

Another potential violence to the other, is to not hear the others story and to generalise from own (Reinharz 1992). But how difficult or easy is this in practice? For is there not the potential to reduce all that is known to that which we already know; as such there is a closure to the experience of the other if it does not fall within our interpretative lens. Can we allow for our horizons of knowing to
be expanded? An inherent difficulty when conducting heuristic research is the notion that ‘it is a process that encourages the researcher to make a personal connection and relationship to the topic which leads to depictions of essential meanings and its significance to the researcher’ (Etherington 2001:122). Thus the researcher’s understanding of the phenomenon is expanded; their own experience being their pre-understanding that they bring to the study, and through the connection with the research participants, their pre-understanding is transformed into understanding. But what of the research participants understanding?

West (2001:130) compares grounded theory and heuristic research, and suggests that the understanding in the two approaches is significantly different; ‘In grounded theory it comes from a study of the people researched and the data gathered, in heuristic inquiry it is to be found within the researcher and elucidated by an intuitive and tacit process of knowing’. However, can the subjectivity of the researcher be eliminated in grounded theory? Can the researcher claim that the understanding comes from the researched? For is it not the researcher who codifies the transcripts, in much the same way as in the first stage of heuristics. How else can the themes emerge? The self of the researcher is involved; previous experiences cannot be erased in the name of objectivity.

To illustrate this point, a study by Churchill et al (1998) gave a group of researchers the same interview generated data to codify, the researchers were all involved in the study, and had attended the same workshop on how to codify the data. Each presented a different thematic analysis, which is not surprising as you cannot eliminate the subjective, each has their own way of processing information and conferring meaning, their own perception, their own take on reality. So how can it be that the understanding gained in grounded theory differs from heuristics? Is it more that in heuristics the personal tacit dimension is more foregrounded? Whereas, in grounded theory there is an attempt to hide behind technical know how?

Another dilemma appears to be in how the data is presented, both West (1998) and Sussman (2001) whose heuristic inquiries in the field of psychotherapy were published, only represented the creative synthesis as the findings. The stages in how they had reached this were omitted, and this researcher believes that these stages need to be included to demonstrate how the meaning that emerges in the study is co-created with the research participants. This omission places the researcher in the centre with the potential for the participants lived experience as surplus to requirement.

In writing we objectify (Acker et al 1991). When we sort data into themes we also objectify. Where does the researcher’s responsibility to the other begin and end in the research process? Whose lived experience is reported on? How can we maintain contact with the subjective? Is it something that is only achievable during the meeting with the research participant? In writing can we be mindful to
re-present their voice in a way that does not dehumanise? It is difficult to re-present the other without imposing our template of knowing; perhaps in recognising this there is an openness to the possibility.

Following on from immersion, is incubation, when the researcher leaves the data alone for new insights to enter awareness (illumination). It is at this stage that the researcher needs to trust the process (Etherington 2001, West 1998a). There can as such be no time scale to this; it can not be forced. The researcher agrees, but also suggests that what is not emphasised is how the researcher may be affected by hearing the stories, perhaps further sanitisation of the research process accounts for this; for this can be another messy part. For if it is included does it not become more evident that there is yet another story inherent to the research process, a story that if untold, removes the humanness from the process. Re-reading the transcripts of the research participants was at times a very moving and at times ‘just too much’. There was a sense of doing violence to the other, by selecting just a snippet of their story to include in the study. Research appeared at times seemed to be a violent process when drawing on the work of Levinas; for people shared their stories and then I as the researcher would make some sense of it, a sense that would fit within an established framework for research and the stories told being different from the encounter, the encounter that can never be re-told, for there is a gap a unbridgeable gap.

There was at times a rawness to the stories told, people were in pain, like the mother whose son had the same facial difference as she had, and who had difficulty in coping with him, that he spent four days a week in foster care. These experiences were painful to hear, but yet there was also a sense of being privileged to hear them. On the one hand to not be moved by these stories would have been to take up the position of an objectified observer, and on the other hand to be moved was to be open to the possibility of meeting with the other. To not know in advance what may emerge in the conversation, to be open to possibility is to be subject to the unconscious. For the study to be enriched by unconscious processes (that cannot be appropriated beforehand) rather than contaminated by it (where attempts would be made to objectify the process). Breathing life into research process requires the researcher to become involved, to engage in the process, to be open to the many tensions inherent when struggling to re-present the other.

At times when conducting this inquiry the researcher felt as if she took two steps forward and six back, oscillating between yes this is what it is, then no, it is not so. It was difficult to grasp the thoughts, to create a sense from the bits of jigsaw as they emerged. It was tempting to place the pieces together in a picture that resonated with ‘me’, a bit like when a young child is doing a jigsaw and they are determined that the piece in their hand will fit the gap in the picture, and they spend ages forcing it into place, miss-shaping the piece in the process. The involvement of others (e.g.
academic supervisor, colleagues) in the process of identifying emerging themes and the subsequent analysis can minimise researcher bias (West 1998, Rose 1997), and make known unconscious processes (Rowan and Reason 1981); and enhance the study's credibility (Thorne 1997).

A journal is advocated by Moustakas (1990) to record of thoughts and feelings that emerge in the process of conducting a heuristic inquiry. The journal maybe referred to in the data analysis (Koch and Harrington 1998, Bungay and Keady 1996); and informs the discussions of the research process with others. The researcher's journal recorded her struggle to stay with the participants stories and to not interject 'that it does not have to be this way', the researcher acknowledges that this would be imposing her frame of reference, rather than hearing their stories. Personal therapy became an important venue for exploring my need to interject, and the effect the stories were having, some resonating, some providing food for thought. What if a forum for these types of discussions is not possible? Or what if there is no recognition of this potential need? How then does the researcher stay with the struggle of accepting the stories of the other? Perhaps when this is difficult the researcher resorts to structuring the way the story is told, so as to protect themselves from the unknowing that may emerge in the process of exploring the phenomenon of a study. Perhaps the use of the word explore, should be more prevalent in research rather than questioning which implies an answer that may be partially known in advance, whereas exploration is an invitation to discover.

4. Primary construction
The presentation of the findings that emerged in the study (themes, composite depiction, and exemplary portrait) represent the many layering of understanding gained during the analysis of the data; it was a back and forth process. What was interesting was that although the participants had shared their experience in response to the one question posed 'can you tell of your experience of...' there were commonalities in what they spoke about, all the themes were represented in some form in each individual depiction. There was a difference in how the stories were told, people who had had therapy, appeared more philosophical about their experience, recognising how they influenced interactions with others, how it was not all down to the other person. This contrasted with people who had not had therapy but were expressing their opinion of therapy, and in so doing shared their experience of either living with a facial difference or having given birth to a child with a facial difference. These stories focused more on how it was the other people who created the problems, it was the others who needed to accept them. Possibly projecting onto others what they were having difficulty with themselves; in consequence the other seemed hostile, not there for them.

The selection of dialogue to represent how the themes emerged from the data, was difficult. By taking a section out of context, the potential is there to change the meaning, for 'all language can always be read as saying other than intended by the speaker' (McQuillan 2000:314).
Even the reading of the transcripts and notes was open to this dilemma, for the text is open to multiple interpretations (Howells 1999, Bennington 1994, Norris 1982). Does the researcher read into the text that which is not there? One way of eliminating this was to share the individual depictions with the participants. Another way is by being mindful of potential contradictions in representing the other, and by sharing these with the unknown reader, it is a way of being more transparent, and supports the recognition that the meaning derived from the study is the best approximation of the ‘truth’ as it was for the researcher at the time of the study.

This approximation can also be extended to the generation of data, for example, interviewing participants on a different day, a different story may be told. Change the interviewer, and yet another story may be told, these possibilities become thinkable, speakable when we acknowledge that meaning making is difficult to grasp, for it is not a commodity, it exists in the minds of the interlocutors involved. When humanness is privileged over science, it is a messy process that cannot be packaged as a repeatable product. There is an aliveness to the process, a willingness to explore and engage in the process. Perhaps this is why Moustakas (1990) suggests there is a need for the researcher to be passionate about the phenomenon of the study.

The creative synthesis is representative of the researcher’s understanding of the phenomenon, the sense she made from hearing the stories of the research participants. Moustakas (1990) suggests that there is a need to rely on tacit knowing, intuitive knowing, and for this to emerge there is a need to ‘switch off’, he refers to this stage as incubation. There is a need for the researcher to trust the process (West 1998) it cannot be hurried. The sharing of the ‘felt’ sense the researcher was making of the data generated, enabled her to recognise when she was providing closure, reducing to what was already known, rather than staying with the uncertainty, and questioning and exploring the meaning making process.

This process has the potential to be infinite, for when does a researcher stop? What if the researcher had stopped when she first had a sense of a ‘this is it’? It is difficult to put a time-scale to this activity (West 1998a, Moustakas 1990). How does one know when enough is enough? Difficult questions, without definitive answers. Although the data has been analysed and presented, there is thus the supposition made that it is complete, however, this is not necessarily the case. For what of the interplay of unconscious processes, in our ability to make sense of our world? To state that the definitive has been reached, is to ignore the unconscious. With further experience, there is the potential for a different reading to be made. By including another cycle of interpretation, there was the opportunity for the researcher to further expand the understanding of the phenomenon by presenting a secondary construction.
5. Secondary construction

This stage of the research process was undertaken following a further period of incubation. There is no method for deconstruction (Burman 1998, Derrida 1996), the researcher chose to look at two key phrases from the creative synthesis and to unpack them, and in so doing see the phrase in a different light. The process was an exploration of the taken-for-granted assumptions surrounding the phrases. The first phrase was ‘facial difference need not define the person’ and the second ‘psychotherapy is a reparative discourse for a return to learning from experience’.

By focusing on language there is recognition of how there is always a gap between the terms ‘signifier’ and ‘signified’; for they do not represent a concrete entity, rather they are abstract, and each person will ascribe a meaning to them. This ascribing of meaning first occurs during the process of socialisation, the child learns the language of the parents. However, this learning is premised on the parents learning experience of language acquisition. The child prior to the entry into language can experience their experience; however, with the entry into language there is an interruption to this process, for experience is mediated through language.

Through socialisation the child learns someone else’s experience of the world; there is as such an interruption to learning from experience. During this process there is a relegation to the unconscious the tensions between the reality and pleasure principle; tensions that the ego cannot tolerate. Consigned to the unconscious they remain unknown at a conscious level, however, these tensions continue to exert an influence on behaviour, there is as such an interruption to learning from experience. Through the process of therapy, the unconscious influences on behaviour can be made known, and worked through. Therapy can provide a reparative discourse to enable a return to learning from experience; for in the process of therapy the person relearns their personal language, and the sense they make of their experience. A key issue for the person with facial difference is the recognition that the term is erroneous, for it exists in the minds of people. Therapy provides people with the opportunity of exploring their meaning making perspectives, and working through distortions in meaning making; to return to learning from experience.

As a process, deconstruction enabled the researcher to further explore the meaning generated in the primary construction, to identify the taken-for-granted assumptions and to gain a different perspective. The author concurs with Butler’s (1990:xi) view, that when exploring the meaning of a text there is ‘no guarantee that unravelling would ever stop’. For each exploration has the potential for new meaning to emerge. Through conversation with other people about this study and the sharing of the sense I was attempting to make of it, also provided opportunities for new meanings to emerge, sometimes there was a clarification of ideas, or the uncovering of another perspective to the study. Research, as an activity should not take place in isolation.
Each exploration has the potential for a different story to be told, in this study, the inclusion of two cycles of interpretation, provides the possibility of at least three different stories being told. Firstly, there is the meeting of the researcher with the research participant, secondly the primary construction is the story of the researcher’s sense of the data, and thirdly there is the story of the secondary construction. It could be said that all research is about narrative, if a narrative is taken to be stories about action (Bruner 1990, Polkinghorne 1988). With encompassing an interactional subjective perspective in the paradigm that guides this study, the view of Botella and Herrovo (2000:417) would seem pertinent, for narratives encompass ‘the relationships we constitute and that, in turn, constitute us’. Narrative then become context specific, the research process is a narrative grounded in the sense the researcher makes of conducting a research inquiry. An inquiry that has the potential to produce multiple narratives, for ‘stories are multiple; there is always more than one story’ (McQuillan 2000:3). It is to be hoped that the stories told here have not ‘remained dependent upon ever the same old stories’ (Booth et al 1999:273). For do so would to not be open to exploration, questioning, for to embrace the notion of multiple meanings is to remain open to the possibility of infinite interpretations. Rather than reach a definite conclusion, a tentative conclusion can be drawn; research, as a process is infinite. For the story told is a partial story (Schurich 1997); it should always be work in progress; work that will never arrive at a definitive destination; just a temporary respite.

The next section is the review of the research process, another story integral to this research process; one that builds on from, and concludes the story of the research critique.

6. Review of the research process

The development of a methodology to conduct this study, formed a major strand to this study, it could be said that without it the findings may not have come out the way they have. The question that the researcher now considers is why was there a need to develop a research methodology for this study, why not pick up a ready formulated methodology? A good question, for on the one hand there is a sense of how this could have made the study a lot easier, for the prevarication’s on which and what method to choose at this moment in time seems infinitely easier than what took place. So what did take place?

A key aspect to the study was how to represent the other, and how to be mindful of the inevitable gaps that occurs in the process of translating the ‘saying’ to the ‘said’. How to speak of the tensions inherent in this process? How to privilege humanness over science and technology? Where humanness is about embodiment, and the reconciliation of the mind body dichotomy. That embodiment is neither one nor the other, but a blurring of the boundaries. The process of psychotherapy is an inherently human activity, one that is premised on the relationship developed
between the client and the therapist. How can this meeting be represented for unknown others? Usually it is a private activity, but with the increase of professionalisation and evidence-based practice, the practitioner is called to account for their practice. This very human activity has been, at times, reduced to mechanisation, technologisation in the name of scientific rigour, to determine the efficacy of such practices. Whilst the researcher can at one level acknowledge the need for some form of regulation of practice, and consideration of how research may inform practice, the question explored was how to study this intrinsically human activity, without reducing it in the name of scientific rigour to a mechanised activity. Where mechanisation would be to focus on repeatability, predictability, in a sense a de-humanisation. How to breath life into the process of research? To re-humanise research, an activity that involves acknowledging intersubjectivity.

How to bring in humanness and for it not to be seen as the poor relation; that this is not ‘proper’ research? How to challenge the dominant voice? A theme that informs the concept of facial difference, a minority group. In both cases it is the dominant group that claims the authority, that legitimises its position over the minority. For example, the positivistic research paradigm informs how research per se should be measured, or defines what constitutes research (see Guba 1990). The post-positivistic paradigm has flourished, is flourishing, is expanding (see Denzin and Lincoln 1998, 1994), and yet the ground on which arguments and discussions are premised are within the language of the positivists.

There is a corollary here with how the person with a facial difference, is defined, assigned a place in the community by comparison with/against those with non-facial difference, those without the label facial difference, are the standard against which the minority group is measured. In the attempt for sameness, for parity, the majority voice is heard, the minority voice silenced. It is those without facial difference who name the difference, or legitimises their position in deference to the minority.

The practice of psychotherapy could be seen be mirror this, for whose voice is privileged? Does the therapist assume the stance of the one who knows? Their professionalisation and studying placing them in a powerful position. In deconstructing psychotherapy, Parker (1999) acknowledges the need to shift from looking at the ‘problem’ of the client, but rather to be open to exploring why they tell the story they way they do, what has influenced the story being told that particular way. Larner (1999) talks about the issue of power and the need for the therapist to debase themselves of this, or to question the how and why of taking up this stance of knowing. This appears to be particularly so with postmodernism there is a sense of never knowing; that knowing is the wrong question; it is about being open to the possibility of uncertainty.

How to work with these tensions between the positivists and post-positivists positions of research? The view of Stanley and Wise’s (1993) is particularly relevant here, for they suggest that there is a
need to work with the blurring of the boundaries of the binary opposites, that it is neither this not that, but a blurring, a merging. In a sense, this merging could be seen to be what emerges when a different stance is taken, when there is an exploration of the majority and minority perspectives. Whereas, Fine (1998) refers to the need for reworking the hyphen, in a sense there is an exploration of the in-between, the position between 'it' being neither one nor the other.

In relation to research, it could be said that positivism represents the mind, and post-positivism represents the body, the question becomes how to embody research? Whereby there is a situation created where it is not one nor the other, but a blurring of the boundaries. Or put it another way to not throw the baby out with the bath water, where the 'baby' is the dominant voice in the research community, i.e. science. However, the privileging of the minority voice is not at the exclusion of the majority, for this stance perpetuates the either or stance, rather than embracing a blurring of boundaries. Leicester (2000) refers to the blurring of boundaries in the field of education as post-postmodernism, whereby there is a recognition of both traditional teaching and the grand narratives, and of facilitation and local narratives.

As Derrida (1998) suggests there is nothing new, something always builds on something else. There is a need, the researcher suggests, of identifying the building bricks to the new, so that the new is seen as a progression. For research to be seen as a process as opposed to a product; that the practice of research is not premised on taken-for-granted assumption on how research should be carried out, rather there is a need for the process to be deconstructed, and the components, the constituents of research made known. From this knowing, research is re-visioned, knowledge of the process is foregrounded rather than assumed.

Prior to undertaking research, or perhaps the first step in research should be an exploration of how the researcher makes sense of their phenomenal world. For this perspective informs the research paradigm. A paradigm that comprises of three interdependent elements, ontological, epistemological and methodological perspectives. The ontological perspective, considers issues/concepts of reality. From a Heideggerian perspective this would be the nature of Being, or Daesin, our being in the world. Whereas from a research perspective, the view of Guba and Lincoln (1994) is that ontology is the nature of reality, as if it is something removed from the person, that reality exists possibly outside of us, that we can in essence remove ourselves from reality for we are not a part of it; possibly this is the scientific take on ontology. For Levinas ethics precedes ontology, for there to be a question of being, we are already 'being' for there is a consciousness, whereas, ethics as preceding ontology is an unconscious state, a pre-reflective state. It is suggested here that there is a need for the researcher to grapple, to struggle with this phenomenon, what is their take on reality? How do they perceive the relationship between the knower and what can be known; the epistemological
perspective of a research paradigm. Is it an objective stance (positivism) or subjective stance (post-positivism)? It is argued here that the subject cannot be totally objectified in the name of scientific rigour, for the subject selects the research question, the research method, and writes up the findings.

Can we in essence offer a mechanised view of what we apprehend? Descartes postulated that man could separate out the mind and body, where the mind became the rational discourse and the body the irrational, where the mind is masculine, and the body feminine, where consciousness is rational, and unconscious is irrational. Man in his quest to know, castrated himself from knowing in the feeling domain, he became a machine, there was an attempt to reduce everything to what could be explained, rationalised. Any questioning of this was rejected due to the dominance of the scientific discourse. The film A.I. (artificial intelligence) currently on release, is premised on how man created the ultimate machine, a robot that was capable of feeling. But man created his own demise, the machines took over the world. Science had gone a step to far, annihilation. A stance that can be seen in a comment by Nietzsche (1882:36) ‘thirsty for reason, want to look at our experiences as fixedly in the eye as a scientific experiment, hour by hour, day after day. We ourselves want to be our own experiments and vivisectional animals’. In essence we wanted it all.

How can we know what we know, is the domain of the methodological perspective. Positivists appear to focus more on the methods of a study, rather than the ontological, epistemological and methodological perspectives, these are as such taken-for-granted assumptions. To a lesser degree it could be said that the post-positivists also focus on the methods; there is however, the recognition of how the self of the researcher impacts on the subject/topic studied. One way of looking at this is Buber's conceptualisation of relationships, the view of positivists is the ‘I-It’ relationship, the researcher as ‘I’ objectify the other in the name of scientific rigour. The post-positivists is the ‘I-Thou’ relationship, where the researcher as ‘I’ meets with another subject, and is influenced by, and influences the encounter. There is a tendency for it to be a symmetrical relationship based on notions of modernity, the self at the centre of the meaning making process.

The blurring of the boundaries between positivists and post-positivists is messy, for it is suggested here that the relationship is premised on the postmodern de-centred self. Where the self is not a known entity, but rather emerges in the in-between, where there is an interplay of conscious and unconscious processes. The known self is a misnomer with postmodernism, rather there is a multiplicity of selves, dependent on ‘who’ the self is interacting with.

The intention of this study was to privilege humanness over science and technology, and that part of this process was for the researcher to make known previous experiences, experiences that inform her interpretative lens, from this it could be made known how this lens informs the development of a
research paradigm to guide the research process. A methodological framework was developed to be
tested out in this study, a framework that is supported by the research paradigm; they are thus
mutually inclusive.

The methodological framework in keeping with the ethos of embracing a multiplicity of meanings,
includes a second cycle of interpretation. There is the potential for the understanding generated in
the primary construction to be re-interpreted with the second construction. There is also the potential
for the selected research method, to be re-interpreted from a postmodern perspective. In this study,
the heuristic method is expanded to include a deconstruction of the meaning generated in the
creative synthesis. There is a shift from meaning generated by the modernist self, the self at the
centre of the meaning making process, to considering the de-centred self, a self that is subject to.
Heuristics is viewed as a post-phenomenological method, and is as such post-heuristic.

With a post-heuristic method there is a move away from the researcher's understanding as the
central focus of the meaning generated to recognising how the researcher is subject to the meaning
that evolves; the meaning/understanding emanating from/within the in-between of the researcher
and the researched; researcher and the data; researcher and the text. In sharing their process of
meaning making via a critique of the research process, a researcher can increase transparency, and
demonstrate the tensions inherent when representing the other.

In this study, the research was undertaken with a 'knowable product' the heuristic method premised
in modernism, and the researcher viewed it from a postmodern perspective; there was thus an
element of an unknownness to the process; there was a need to be open to what might emerge in the
process of exploration. But is this just another cover story? For did not the researcher find what she
was looking for — that therapy is a form of learning? On the one hand the answer is yes, for it was
evident in the lived experiences shared that therapy had changed a person's perspective of their
situation, thus therapy was a form of learning. And on the other hand the answer is no, for therapy is
not a form of learning rather it is a means to learning. A subtle difference, the first implies that there
is a 'form' a knowable/definable product to learning; in this study it was in the domain of
significant, transformative and emotional learning. Whereas, a 'means' is an unknowable/indefinable
process of learning, what can be established are the givens to this learning, i.e. the therapeutic context. The unknown is the meeting of the client and therapist in the moment with each other.

To make a preference for either 'form' or 'means' to learning, would be to privilege one term over
the other, and be a replay of the binary opposites, either product vs. process, or process vs. product;
whereas, a blurring of the boundaries would be representative of a process - product - process.
Where the process is the saying (the in the moment experience between client and therapist) and the product is the said (the re-telling of this moment; naming this moment as learning). However, the said is also a process when premised on the notion of a multiplicity of meanings, for each 'said' has the potential of being formed/created through another form of 'saying'; thus a blurring of boundaries is represented by process - product - process - ad infinitum.

A post-heuristic approach to research can represent a way of looking at lived experience that is mindful of the multiplicity of meaning and the need to work with the binary opposites where there is a temporary privileging of one term. In re-presenting the researcher's saying (the experience of the research exploration) there is a translation to the said (the naming of the understanding gained during the research exploration) there will always be a remainder, a gap that cannot be bridged. However, a researcher that is mindful of this gap can work with it rather than denying it. A post-heuristic research approach is one way of acknowledging and working with this gap. A critique of the research process is another way of working with this gap, for in the process the researcher shares their struggle of re-presenting the other.

Conclusion
This critique followed the stages of the methodological framework developed for and tested out in this study. Initially the research design and method was explored, this was premised on humanness and the question of how can a researcher conduct research that is mindful of the other, and not to reduce what is apprehended with what is already known. Humanness is subjectivity, but it can be erased in deference to objectivity, and the subjectivity of the researcher negated in the name of scientific rigour. The research paradigm developed for this study is cognisant with the researcher's interpretative lens; the creation of meaning is a dialectical and reflexive activity; it is an interactional subjective process and the meaning generated is context specific. This paradigm informs the methodological framework developed to guide the research process. A process structured on the heuristic method, a method that provided coherency to the data generation and analysis.

In acknowledging the multiplicity of meanings that can emerge through the process of research, the methodological framework comprised of two cycles of interpretation, this provided an opportunity for the heuristic method be explored further, and expanded to a post-heuristic method. A method that includes a deconstruction of the creative synthesis (the final stage of a heuristic analysis); to read between the lines, to identify which term/voice is privileged (in the text) and which is marginalised (relegated to the margins). There is thus a temporary privileging of one term/voice, temporary for it to be permanent is to maintain the status quo, a recreation of binary opposites.
A critique of the research process offers a further potential to demonstrate that the meaning generated through the research process is open to further interpretation, further meanings. The research report is representative of the researcher's understanding of the phenomenon of a study at the time of writing. There is an openness to research as being work in progress. The methodological framework developed and tested out in this study supports this view; and there was a privileging of humanness.

A summary of the study as work in progress is provided in the next chapter.
Chapter Ten
Summary and implications of the study

Introduction
The aim of this chapter is to provide a summary of the study, firstly the three main areas of the study will be reviewed; research methodology, therapy as a means to learning and facial difference. The implications arising from the study are also included in each of the three sections. Areas for further study are then identified. The researcher’s personal experience of the phenomenon of the study was shared in chapter four as this was integral to the interpretative lens she brought to the study; as such this was her pre-understanding that informed the research process. In this concluding chapter, I (the researcher) will share the changes to this personal knowing as a result of conducting this research inquiry; my current understanding. A summary of the study concludes this chapter.

1. Research methodology
As discussed in the previous chapter, the researcher developed a research paradigm for this study; one that is cognisant with the researcher’s interpretative lens. A lens that was premised on the theories and perspectives of phenomenology, hermeneutics, psychoanalytic theory, postmodernism, feminism and ethics. Phenomenology encompasses the concept of the lived experience and description (Spinelli 1989), whereas hermeneutics includes interpretation. An interpretation based on how understanding is generated through a reflective process, whereby previous understanding is the pre-understanding that underpins the next cycle of interpretation, from which new understanding emerges. This then becomes the pre-understanding to the next cycle of interpretation. There is thus the potential for expanding the horizons of knowing (Gadamer 1989).

Psychoanalytic theory can provide a way of looking at relationships, and how relationships are premised on both conscious and unconscious processes (see Bateman and Holmes 1995, Symmington 1986). Relationships are dependent on transference (Freud 1915), we transfer past feelings and thoughts onto future situations; in a sense there is a questioning can we ever meet in the moment? Or are we destined to re-create the old, the familiar? Can we be open to experience? Where to be open is to welcome uncertainty and exploration, an exploration that may lead to a temporary answer, temporary, for when an openness to experience is embraced, there is the potential for this answer to be subjected to further revision/amendment in light of future experience.
A postmodern perspective incorporates the notion of a multiplicity of meanings (Robinson 1999). Modernism is premised on a knowable subject, whereas, postmodernism embraces the concept of an unknowable subject, for we are always subject to (Sarup 1993). A feminist perspective challenges the male dominance of society, how in language there is a privileging of the masculine, and a silencing of the feminine (Reinharz 1993, Lather 1991, Stanley and Wise 1979).

The ethical stance of Levinas, is premised on the responsibility to the other, an ethics that precedes ontology, it is a pre-reflective knowing, an unconscious knowing (Peperzak 1993, Bernasconi 1988). Can we meet with the other in the face-to-face encounter, and acknowledge our responsibility for the other? Can we be open to the other and not reduce to the same? Or to put it another way, to not evaluate the other against what we know, but to be before the other without presupposition. To not interpret, where to interpret is to reduce, to categorise.

All the theories and perspectives support a preference for understanding to be an in the moment experience, also there needs to be an openness to the experience of the other. Meaning making emerges in the in-between, and known to those present. Any attempts at recounting this moment of in-betweeness is an attempt to reduce to what is already known; in the translation of the ‘saying’ to the ‘said’ there is always a remainder, that which cannot be spoken about (Peperzak 1993, Llewelyn 1988, Blanchot 1986, Cohen 1986). The implications for research is that meaning making is context specific, and there is the need to be mindful of meaning emerging in the in-between. There is a need for a research approach that privileges humanness over science and technology.

The researcher’s interpretative lens informed the research paradigm developed for this study. The paradigm comprised of an ontological perspective of relativism, whereby reality is context specific. The epistemological perspective was interactional subjective, meaning is created through a relationship, there is a relationship between the subject and knowing; knowing is not independent of the person. The self of the researcher is involved and subject to, the meaning making process. The researcher exerts an affect on the meaning generated. The methodological perspective was reflexive and dialectical, in that meaning making is possible through reasoning and achieved through a back and forth process. A process that promotes the emergence of meaning in the in-between.

There was a blurring of the epistemological and methodological perspectives, in that the meaning emerges in-between subjects. There was also a blurring of the ontological
perspective, for meaning is created within a context, the meeting of the researcher and the researched and emerges in the in-between, through a reflexive and dialectical process. Each perspective is mutually interdependent, there is a multi-layering of perspectives.

The incorporation of a double cycle of interpretation, of the methodological framework supports the notion of the situatedness of meaning generation; together with meaning emerging in the in-between, through a dialectical and reflexive process. The first cycle represented the meaning that emerged in-between the researcher and the research data. Prior to this analysis of data, there was a relationship between the researcher and the research participant; meaning generated in that in-between created the generation of 'data'. The data was analysed by the researcher and the meaning that emerged was represented in the primary construction. That meaning became the pre-understanding of the second cycle of interpretation, which was premised on a relationship between the researcher and the text. A deconstruction of the findings was undertaken, in an attempt to question the privileged voice (Howells 1999, Derrida 1996, Bennington 1994). The secondary construction was generated by a deconstruction of the creative synthesis from the primary construction.

The deconstruction was premised on language and the impossibility of the message sent being the one received, for there are 'gaps' in the generation of meaning; we are subject to the limits of language. The deconstruction attempted to make known some of these 'gaps' or slippage's in meaning. There was as such a re-working of the binary opposites inherent in the text. The cycle of interpretation could have been repeated infinitely but to bring the study to closure, a critique of the research process was provided. The intention of the critique was to make more transparent the researcher's understanding gained during the process of inquiry, to highlight the inherent tensions when re-presenting the other. Also it was an attempt to demonstrate how research can become work in progress, and how the researcher attempted to remain open to this exploratory process.

Heuristics was the research method chosen to generate data for analysis. An approach from the modernist frame, whereas, the inclusion of a second cycle of interpretation through a deconstruction of the text, locates the approach within the postmodern frame. Subsequently, the method employed was post-heuristic, and the self of the researcher is not at the centre of the meaning making process, they are subject to it. A critique of the research process is an integral component of post-heuristics as this provides the opportunity for exploring and questioning the research process. To make known the tensions inherent in the process of attempting to re-present the other.
The development of a research paradigm and methodological framework for this study, enabled an exploration of some of the taken-for-granted assumptions that underpin the research process. In making more open this process there is a sense of an increase in credibility; the study speaks for itself, there is as such no need to elaborate on the issues of validity, reliability, repeatability, generalisability. For these are the tools of making the opaque transparent in a scientific way. When a study embraces humaness over science and technology there is a need to explore different ways of determining ‘trustworthiness’ (McLaren and Kincheloe 1994, Reinharz 1993, Lather 1991).

The implication of postmodernism for research is that there is a need to recognise how knowledge is generated within a specific context. Therefore there is a need for a change in how a researcher approaches the research process. There is a need for researcher’s to make known their interpretative lens, together with an exploration of the ontological, epistemological and methodological perspectives that inform the research paradigm within which a study is situated. To share how the research process unfolds, with the privileging of humaness and subjectivity, there is also a privileging of transparency over opacity.

2. Therapy as a means to learning

The intention of this study was to open up a conversation of therapy as a form of learning. One way of establishing this was to ask people to share their experience of therapy and from this to elicit the learning experiences. To speak of their learning experiences would have provided foreclosure to their experience, rather the aim was to elicit the lived experience (heuristic approach) and from this the researcher would identify the learning experiences. To assist with this identification, there was an exploration of approaches to learning that were considered to be cognisant with the underpinning ethos of the study, a privileging of humaness. The three approaches to learning that the researcher considered correlated with the intentions of therapy were significant learning (Rogers 1967); learning that is relevant to the person, they are active in the meaning making process. Transformative learning (Mezirow 1990), whereby previous learning is transformed through the reflective process intrinsic to this form of learning, distortions in previous learning experiences can be uncovered and worked through. Emotional learning whereby a language for speaking of emotions is considered helpful for forming relationships with others, and for informing decision making and problem solving activities (see Bar-On and Parker 2000, Quigley and Barrett 1999).

It was possible to identify elements of learning in the analysis of the data generated. This identification was located within the researcher’s frame of reference, and on the one hand,
this appeared to be in contradiction to the ethos of the study, whereby meaning emerges in the in-between the researcher and research participant, it is their experience of the phenomena not what the researcher thought happened. But on the other hand, had they been asked to share their learning experiences it could be that their interpretation of learning could be more situated in the modernist, traditional frame of learning, whereby the teacher imparted knowledge to the students, and translating this to therapy could be how the therapist taught them. Also there is a view that learning is synonymous with life experience and how a broader picture of learning could be established if the word was not used.

The first cycle of interpretation demonstrated how therapy can be seen to be a form of learning; where previous learning experiences can create templates for evaluating future experience. Distortions in meaning making perspectives were created, and these became barriers to learning from experience. Through the therapeutic process, there is an uncovering of barriers to learning, and a dismantling of them, to enable a return to learning from experience. In this process there was evidence of significant, transformative and emotional learning. Therapy offers the opportunity to return to learning from experience (Loewenthal 1999).

The second cycle of interpretation demonstrated how learning also encompasses conscious and unconscious processes; processes that cannot be appropriated by naming a particular theory. Therefore, therapy is not a form of learning, rather it is a means to learning; for a return to learning from experience. The first interruption to learning from experience, takes place with the entry into language, the speaking subject (see Lacan 1988, 1977). Through this socialisation process the subject learns another person’s (initially the parents) way of experiencing the world. They learn to interpret their experience dependent on the experiencing of the other person, there is thus the potential for an intergenerational transmission of distortions in learning. The ability to think one’s own thoughts and to experience one’s experience is subjugated in the name of the dominant voice. There is as such a marginalisation of their own experience; and there is an interruption to learning from experience. Therapy enables the minority voice to be privileged and offers the potential for a return to learning from experience.

A model was developed to assist others to look at therapy as a means to learning. It was acknowledged that it was not possible to come up with a definitive view, for this was a contradiction to privileging humanness. However, what could be identified were the parameters, the givens of the therapeutic encounter. This then allows for the potential of a space being opened up, a space for meaning to emerge in the in-between, in-between the
therapist and the client; for a return to learning from experience. The given are the contractual issues pertaining to the therapeutic relationship, (e.g. time, venue, cost) and the therapists training and experience of providing and receiving therapy as a means to learning. The name given here for this kind of therapeutic experience was therapeia. In the meeting of the client and therapist, the outcome of the encounter cannot be known beforehand, or afterhand, for it can only be apprehended in the moment. In the recounting of the experience there will always be a remainder that cannot be elucidated. If there is no remainder, then therapeia has not taken place.

Within the therapeutic relationship it is possible to determine a continuum of relationships; the therapist may be ready for an ethical relation but is the client? Can the client enter into a relationship with the therapist? Or do they relate to self and others as objects? Perhaps there is a need for clients to first learn how they relate with self and others before the ethical relation is possible. Buber's (1965) concept of relating can be a helpful way of exploring how the client relates to the therapist and how they relate with others. The ‘I-It’ relationship is premised on relating to the self and other as an object; the ‘I-Thou’ relationship the self and other as subjects. The next stage would be a ‘subject to’ and the recognition of a multiplicity of meanings.

The therapeutic relationship can be identified as a learning milieu that may provide the potential for a change in how the client perceives their self and how they relate with and to others. In the early stages the transition from an ‘I-It’ relationship to an ‘I-Thou’ relationship it may be possible to identify aspects of significant, transformative and emotional learning; to recognise a shift from non-reflective to reflective learning. The shift from reflective to pre-reflective learning is learning that cannot be named but apprehended in the moment. Therapeia provides a possibility for therapy to be a means to learning; a return to learning from experience.

The model developed as a way of viewing therapy as a means to learning may generate further conversations with therapists, between therapists on the implications for their practice when positioning therapy as a means of teaching and learning. When knowledge creation is recognised as being context specific, there is the potential for therapists to be acknowledged as creators of situated knowledge (Kvale 1992); knowledge that could be made known to other practitioners so that it may inform their work (see Rowland and Goas 2000, Horvarth and Greenberg 1994) this may generate further conversations about the nature of therapeutic knowledge.
3. Facial difference

Within the field of facial difference it is acknowledged that there is no correlation between
the size or cause of the disfigurement and the level of psychological difficulties encountered
(Robinson 1997a, Bull and Rumsey 1988, MacGregor 1984). Counselling/psychotherapy is
recognised as being an approach that may enable people to cope (Turner et al 1998,
the specific nature on what a person may bring to therapy, hence the specific nature of their
difficulties, or the experience of therapy from people with a facial difference is lacking in the
literature available. This study therefore provides new information and adds to the body of
knowledge on facial difference and the implications of therapy as a means to learning.

The intention was to explicate the lived experience of therapy for this client group, and from
this to discern the learning experiences inherent to the process of therapy. As the population
size of this group was an unknown entity, it was decided to include additional perspectives;
from therapists working in the field of facial difference, and people with a facial difference
who have not had therapy but have an opinion on the place of therapy, likewise people living
with someone with a facial difference may also have experience or opinion of the place for
therapy. There were thus two broad areas of focus, therapist and client experience of therapy,
and experiences that may precipitate the need for therapy.

The perspective gained from interviewing therapists (working in the field of facial
difference) and clients (people with a facial difference) provided hitherto unreported
information on the presenting issues of this client group. There was a correlation between the
therapist and client’s perspectives on what a person with a facial difference may bring to
therapy. Overall it was recognised that therapy was initiated following some event that
brought into focus their difficulties in coping with their appearance and the reactions of the
general public to their facial difference.

The experience of therapy provided people with an opportunity to explore their thoughts and
feelings surrounding their appearance and the responses from others. The therapist was
identified as being interested in hearing their concerns, providing support and providing a
place where they could talk. Through this process there was a change in perspective; previous
distortions in perception emanating from previous learning experiences were challenged and
worked through. Thoughts and feelings about their appearance were spoken about for the
first time; there was evidence of significant, transformative and emotional learning. The
learning aspect of therapy was not just restricted to the clients, the therapists also commented
on how their perspective on 'disfigurement' had changed, being with the client had affected a change in previously held beliefs.

Experiences that may precipitate the need for therapy were sub-divided into two main areas, the parents and the person with a facial difference. From the parents perspective, there was evidence that giving birth to a child with a facial difference was a difficult emotional experience, one that was not anticipated, and generally generated negative feelings within the extended family and from strangers. The label of 'difference' appeared to define the child. The parents concerns were perceived to be ongoing and each developmental stage created a new set of potential difficulties.

The people with a facial difference exhibited an inability to learn from experience, for it appeared on the whole that previous negative experiences became the anticipated norm for the next experience of meeting a similar set of circumstances. There was as such an inability to experience their experience. Reactions from others, informed their response to others and these had implications for the perceived effects of the facial difference; effects that were unique, and premised on previous experiences. It was recognised that there was a potential for an intergenerational transmission of trauma from mother/parent to child, this may be either unconscious or conscious, and the implications for the child is that facial difference becomes a defining label, and there is an interruption to learning from experience.

When this phrase was deconstructed in the second cycle of interpretation, it was recognised how this term is conferred by people without a facial difference, the dominant voice. The term is located in language and has multiple meanings, it is an erroneous concept for it exists in the minds of people, it is a label that may define the person. Through the process of therapy it may be possible for the person to challenge the label and become more open to the experience of difference; to challenge their distortions in meaning making perspectives. Distortions premised on previous experiences that may have perpetuated the myth that facial difference defines the person.

Overall there was a recognition of the need for therapy as a means to learning, to uncover the distortions in meaning making perspectives, and to relearn to experience their own experience. The need for therapy extended to both those with a facial difference, and parents of a child with a facial difference. Therapy may facilitate a transition in how a person perceives facial difference; it need not define the person. Therapy may enable a person to explore their sense of marginalisation; the sense of being different, and how early experiences can create a sense of difference and how further experiences reinforce this view,
there is as such an inability to learn from experience. Therapy as a process may assist with a return to learning from experience and thereby address marginalisation at an individual and possibly societal level. Through the process of therapy and the telling of one’s story and the learning emanating from this process, there is also the potential for an increase in mental well-being; an increase in self-esteem (Keyes 1998, Zika and Chamberlain 1992).

The information on people’s experience of therapy and experiences of what may precipitate the need for therapy may be beneficial to people with a facial difference, and for people working in the field of facial difference. The information provided here may enable them to gain an insight of the potential needs of this client group and their families.

4. Areas for further study

In the field of facial difference, this study seems to be indicating that there may be an intergenerational transmission of trauma, and this merits further study. Is there a difference if the parent has had therapy? What of the fathers perspective? How important are early experiences in mediating the effects of facial difference? Would a comparative study undertaken with people who acquired the difference in later life and those born with a congenital difference provide further knowledge on this phenomenon?

Therapy as a means to learning, was identified in relation to people with facial difference, what of other client groups? Or is labelling the client group a misnomer? Would it be helpful to explore how these ‘groups’ construe and own the groups’ label? Could the findings presented here be replicated in another group? What of therapy as a means to learning for couples in therapy? For therapeutic groups? The training implications for offering therapy could be another area that merits further study, how can the neophyte practitioner be introduced to providing therapy as a means to learning?

Could these findings be a springboard for developing a more quantitative study, acknowledging that this study has temporarily privileged the minority research voice. A larger study may provide further evidence on therapy as a means to learning. Alternatively a similar study could be carried out with clients in therapy, like Granfanki and McLeod’s (1998) study. There are many potential opportunities for developing this study, the methodological framework could be applied to other studies, to other methods. When research is viewed as work in progress there is an opening up to the possibility of meaning making being an infinite process.
5. Personal learning

As the study progressed I began to reflect on experiences as a therapist, identifying within the therapeutic relationship changes in client’s perspectives, and began to see these as evidence of learning. There were examples of how people were feeling different, initially positioning themselves in a rigid framework of ‘it’s always been that way’ then a transition to ‘well it could be different’. This transition was dependent on the exploration of barriers to learning from experience. There was a gradual uncovering of how these barriers had been formed, followed by a working through of the distortions in meaning making perspectives. Through this process, there was a making conscious of previous unconscious material, material that exerted an influence on behaviour. There was a change in perspective, an increased ability to learn from experience. The trajectory of this change was not linear, but ‘all over the place’, a trajectory that was unique to the client, and unique to each therapeutic relationship; it could not be anticipated in advance. For there is a need to remain open to the process, to be with an other in the relationship. To create a space for the generation of new meaning.

The continuing experience of being a client, enabled me to recognise my own learning through the process of therapy. As such there was a recognition of my distortions in previous learning. Through the therapeutic relationship I began to recognise my own role in maintaining this status quo; a status quo founded on facial difference defining me. There was also a realisation that the status quo was founded on misconceptions and misperceptions, and that during childhood, socialisation experiences had been contributory factors in creating distortions in my meaning making perspectives. The distortions became entrenched with further experiences that reinforced this early learning. Therapy provided an environment that was conducive to exploring the distortions, to recognise how they were created, and then to challenge the beliefs and attitudes behind them. There was a freeing, a letting go of distortions, a return to experiencing experience; therapy was a means to learning.

The experience of interviewing people with a facial difference was also thought provoking, there was a sense on the one hand of belonging to the ‘same club’ and this may have somehow influenced the sharing of people’s experience (Bola 1996). Yet when speaking to parents there was a sense of hearing it from the ‘other side’, a side that as yet I have not encountered. But who knows what the future holds, with the potential of being either a grandmother or great aunt to children with a facial difference. Perhaps this concern has been an unconscious influence (Walsh 1996), behind the inclusion of people in the study who live with someone with a facial difference.
There has been an increase in my understanding of the implications of postmodernism for research. My style of writing changed as the study progressed, it became more questioning in the latter chapters as I gained confidence with the concept, and the making known of the struggle to represent the other. A struggle that is ongoing, for the study’s conclusion represents an ending, an in the moment ending. The learning emanating from the study has the potential to be ongoing, for meaning making is a lifelong process.

Conclusion

A key aspect to the study was in relation to developing a methodology to explore the question posed: Is counselling/psychotherapy a form of learning for people with a facial difference? Exploration of the question is favoured over answering the question, where to question implies that a definitive answer will be reached. Rather the intention was to open a conversation on therapy as a form of returning to learning from experience. An exploration that was premised on the principle of a multiplicity of meanings, and the need to remain open to experience; for there to be an embracing of humanness over science and technology. Where science and technology was seen to be about repeatability, certainty and sameness; humanness was seen to be about uncertainty and difference.

The research paradigm (relativist ontological perspective, interactional subjective epistemological perspective, and a reflexive dialectical methodological perspective) informed the development of a methodological framework to guide this study. The method selected to guide the study was heuristics, however as the methodological framework incorporated a second cycle of interpretation, plus a critique of the research process, consequently the method can be viewed as post-heuristic.

The meaning generated through the process of this study was premised on therapy as a form of learning. The primary construction supported the view that it was possible to identify elements of significant, transformative and emotional learning; therapy was a form of learning. However, the secondary construction enabled further meaning to emerge, to recognise the role of unconscious processes in meaning making, therapy is a means to learning. Where the potential outcome is a return to learning from experience; for the person to experience their own experience.

In relation to people with a facial difference, the findings provided evidence of how previous learning experiences can create distortions in meaning making perspectives; distortions that are barriers to learning from experience, for they provide a template for the evaluation of experience. Therapy provides an opportunity for the uncovering and working through of
distortions to enable a return to learning from experience. For the person to experience their experience. Facial difference pre-therapy is a label that may define a person, post-therapy there is recognition of how the label does not need to define the person; there is a return to learning from experience.

A model was developed to enable further conversations to be opened up on therapy as a means to learning. The model was premised on Levinas' ethical relationship and Buber's 'I-It' and 'I-Thou' relationship. Therapy as a means to learning can represent a transition from an 'I-It' (non-reflective) to an 'I-Thou' (reflective). To a responsibility to the other relationship (pre-reflective), and each transition offers the potential to return to learning from experience; to be more open to experience of the other.

The trajectory of this research inquiry, has been presented here in a linear format, however, it should be noted that the process in action can be difficult to plot for on the one hand, there was a sense that the trajectory was 'all over the place' and on the other hand, that the trajectory was sequential each stage building on the next. This paradox is representative of the dilemma when translating the saying (in this case doing the research) into the said (recounting for the other the meaning generated in the many in-betweens identified in the research process). In the translation there is an inevitable gap, for we know more than we can tell, in attempting to describe for the other that which took place, or the meaning that emerged, there is an irreducible element.

When there is recognition of this inevitable gap, there is an opening up to the possibility of multiple meanings; research becomes work in progress, and the researcher concurs with Fine's (1998:140) sentiment:

'Our work will "never" arrive but always must struggle "between" '.
References


Batchelor, J.A. and Briggs, C.M. (1994) Subject, project or self? Thoughts on ethical dilemmas for social and medical researchers, soc. sci. med (39)7: 949-954.


