A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation into

'Supervision and Risk: A grounded theory approach'

By

Miriam Geraldi

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Statement of Anonymity

Whilst considerable attention was given to ensure that the personal accounts and contextual information of clients, placement colleagues and research participants retain their original meaning, in the extracts provided below, all identifying material has been altered to protect the privacy of those involved. Pseudonyms were used to refer to clients and research participants in order to ensure confidentiality.
Acknowledgements

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INTRODUCTION TO PORTFOLIO

The aim of this portfolio is to provide a collage of my work during the three years of my doctoral training in Psychotherapeutic and Counselling Psychology. The selection of papers included here depends partly on personal choice and partly on what is required by the course guidelines. However, I have assembled this ‘collection’ with special care because I want this portfolio to deliver something more than just my academic, professional and research pursuits. In essence, I would like it to offer a personal narrative of my development throughout this course and, hence, contextualise the choices of topics I have decided to explore and my interests throughout this course.

As evident on more than one occasion throughout this portfolio, I often make use of metaphors and quotes. Both probably originate from my love for reading, a source of relaxation but also a source of knowledge about other people’s stories and experiences. Somewhere I read that metaphors ‘encourage interpretation’ and this suggests that both the writer and the reader are engaged in the dance of meaning-making. This is what I would like to achieve: that the contents of this portfolio be dynamic and co-created. Hence, for once more, I will make use of a metaphor in order to reflect on how I came to choose the papers included in this portfolio.

I have the image of myself in front of an empty photo album after a long three-year journey. I am surrounded by a number of photos, each of which, I took myself, depending on the scene, angle and light (which represent the context of the topic of choice, my personal interest in the subject and the theoretical milieu, respectively). On this album I would like to relate my experience by choosing particular snapshots, which I believe, will represent more who I am and what scenarios have attracted my attention throughout. In order to do this I will first introduce myself and some of the experiences which have contributed to my decision to follow this profession. Then I will proceed to introduce each of the dossiers contained in this portfolio.
Background

Still nowadays, many people are curious about why I chose to embrace a career which brings me so close to other people’s suffering. People’s looks and comments after they hear about my professional choice are different. Some have almost bestowed me with saintly virtues assuming that I have decided to do this job out of some intrinsic and pious goodness. Others have looked at my choice condescendingly, and remarked about how ‘bizarre’ it was that one should expect to be paid simply for ‘listening to others’; something that we should all do anyway. Furthermore, coming from a medical family background, many people (including myself) have probably expected me to follow the path of other family members and become a medical practitioner.

Indeed, deciding to choose psychology over medicine was not an easy choice. However, I was always fascinated by people’s ability to connect with others and their emotions. Becoming a medical practitioner would not have quenched my thirst in this area. Hence, I decided to read psychology at university, a subject which I imagined, could give me some answers. Two experiences in that period were especially significant for my later decision to become a counselling psychologist. One of them involved working in a correctional facility and the other, involved working in the psychology and family therapy service in a drug and alcohol rehabilitation programme.

My work in the correctional facility came as a summer university job shadowing the forensic psychologist and conducting assessments. I decided to take this job notwithstanding the disbelief and fears of my friends and relatives who, over-protectively, assumed that I could be in serious danger working there. This experience provided me with the first glimpse of the amazing quality of human contact that transcends life experiences and culture. Here I was working with a few amongst the most dangerous criminals. Yet, apart from the initial shock of working actually within the prison quarters, I realised that there was no insurmountable
obstacle and that, being able to connect and be with them, was no more different than connecting and being with any other person in need. Shedding away the natural tendency of judging them for what they had done was not easy but, very enlightening. It was there that I started realising what, Strawbridge and Woolfe (2003) described as two basic elements of counselling psychology: 'the acceptance of the subjective world of the client as meaningful and valid in its own terms' (p.8), and, 'the need to negotiate between perceptions and world-views without assuming an objectively and discoverable truth'. Hence, I learnt the subtle difference between accepting the world of another without necessarily condoning it and understanding one's perception without judging it as true or false.

In my final undergraduate year at university, my clinical placement took place in an out-patient service for the rehabilitation of drug and alcohol addicts. Here, I had the possibility of observing individual and family work. Having the opportunity to experience the development of a therapeutic relationship was very interesting. The amazing combination of levels on which the client and the therapist would be talking, was intricate and captivating. Besides, if both therapist and client were motivated, the 'dance' and movement in the session were smooth and fluid even though not necessarily easy. During this period I was also invited to participate in a reflective team in a systemic family therapy service where I could witness the ripple effect that, such a problem as addiction, could have on other people in one's environment and how the latter contribute, in their own way, to this pattern. In addition, I also started to appreciate the co-dependence of certain processes and the circular function of most behaviour. This provoked my interest in systemic family work, which is still fundamental to the way I try to understand others and myself nowadays.

As you will notice, most of the rest of the journey is further described in the clinical paper in the Therapeutic Practice Dossier. However, for the purposes of this introduction I cannot ignore the question about why I chose counselling psychology as a career over other professions (including family work). Indeed, being a strong
believer in the human ability to change and develop, I have always valued the work of one-to-one therapy. Perhaps reflecting a person-centred philosophy, I believe that as human beings we have the ability to actualise ourselves in the appropriate context and individual therapy could be one of these contexts. The value base of counselling psychology reflects this perspective whilst advocating the subjective experience of clients and the engagement with their world (Strwbridge & Woolfe, 2003). This resonates closely with my own perspective about the work of being with another. I also had a specific reason for choosing an integrative course. As a person, I value integrity and congruence. Yet, I question the usefulness of extreme positions. Hence, as reflected even later on in this portfolio, I value highly an integrative stance in the practice of counselling psychology as compared to more pure positions, since it is my belief that human nature is so diverse and therefore necessitating different perspectives.

The dossiers

The portfolio consists of three dossiers which combine together a collection of interests and curiosities during this three-year course. Each dossier focuses on a different area of my development. The academic dossier assembles essays on different subjects of personal interest from different theoretical perspectives. The therapeutic practice dossier contains a summary and discussion of the four placements held during the three years and the final clinical paper which has instigated my thinking think about who I am as a developing professional. Finally, the research dossier combines the research work conducted during the three years. I will now proceed to introduce each of them in turn.

Academic dossier

The academic dossier contains essays from each of my three years of training. My first essay explores children’s understanding of death and anticipatory grief. The interest in this topic stems primarily from my four years experience of working with children and adolescents (prior to joining this course) and also from a personal
curiosity about the role of grief in their lives. Indeed, since I was mainly working with looked-after children and children on the Child Protection Register, I have often encountered issues of loss in my work with them. This has urged me to tackle the subject further. Unfortunately, throughout this course I did not have the opportunity to work with children in a therapeutic context, something which I have missed a lot. Considering that I have written this essay in my first year, I wonder whether this was an attempt to bridge the gap between my previous identity of a professional working with children, and the current one of working predominantly with adults. I decided to include this essay as a testimony to my previous work with children and also because it represents my hope to be able to work with them again in the future.

The choice of my second essay, entitled 'Psychoanalytic perspectives on bisexuality: implications for the therapeutic relationship' combines my curiosity about sexual identities in therapy and my interest in the psychodynamic perspective of such identities. In this essay, I explore the theoretical position of bisexuality from a psychodynamic perspective, which has historically labelled it as pathological and as a sign of immature development. This position lays in stark contrast with my own values. Most probably, the choice of this essay reflects my position in relation to psychodynamic approaches at this time of my professional development. In fact, as reflected in the essay, although I appreciate the insight added by psychodynamic theory in my understanding of clients, I am more interested in the recent developments of the model which, in my opinion, tend to be less judgemental and more humanistic.

My third essay explores the role of homework in cognitive behavioural therapy (CBT). This essay gave me the opportunity to explore the meaning of homework in the light of the therapeutic relationship in CBT. Initially, in my practice, the idea of utilising homework assignments in therapy sounded very strange to me. However, the clients I was meeting in my practice appeared to benefit from it and I later came to realise that whether they choose to adhere or not and the way they chose to do so, suggests important information about our therapeutic relationship as well. I feel that
this essay was very important to enhance my understanding about the benefits of the CBT approach and its use of homework assignments.

Therapeutic practice Dossier

As suggested by the title itself, this dossier contains information about my therapeutic work during the three years. The bulk of my experience in these last three years has been in primary care. Working in this sector has given me an opportunity to work with a different number of clients and, hence, to utilize the respective theoretical models with different clinical presentations. Thanks to my supervisors, throughout the three years, I was also able to extend my work with some of my clients for longer-term work depending on their therapeutic needs. This has given me a snapshot of short-term and longer-term work with the three different models. In my second year, I also formed part of a reflective team in a tertiary care placement working with people of different age-groups suffering from moderate to severe mental health issues. In this placement I was able to utilize the knowledge and skills acquired during my two-year diploma in systemic practice, obtained prior to enrolling on this course. The descriptions of the placements include an explanation of my responsibilities, the client groups and the main theoretical perspective adopted in each. This dossier also contains a clinical paper about the development and progress of my skills throughout the three years. I believe that, in the preparation of this portfolio, the clinical paper has been an essential guide in grounding the narrative of my development throughout the three years.

Research dossier

As I think about this dossier, I remember my initial anxiety and reluctance about narrowing down my interests to a specific topic for research. Settling on a subject that would probably be the hub of my research interest for three years felt scary and difficult at first. I finally decided to jot down the main areas I was interested in and to try to find a common thread that could sow them together in a meaningful subject. Finally I came up with the four areas: counselling psychology, health, identity
formation and adolescence. The subject of my literature review developed by time as I considered different aspects of these areas. Owing to a specific experience I had with a particular client in the past and my curiosity about how I could have improved my interventions with her, I decided to tackle the topic of altered body image in adolescence. The literature review identified a lacuna in the current knowledge about body image since there appeared to be no information about the role of an unwanted change of body image on the adolescent's identity.

In my second year I decided to continue investigating the topic through Interpretative Phenomenological Analysis. It was a topic I had grown very fond of and I was looking forward to understand more about the individual experience of such a physical change. However, the pursuit of an appropriate sample was not successful. Due to time constrains I had to give up on finding the sample I had initially identified in my initial proposal: of adolescents with two different types of changes in body image. Hence, I decided to focus on acne and investigate it in relation to the adolescents' identity. Thankfully, I managed to find an appropriate sample late in the year. Coupled with a build-up of frustration at my recurrent unsuccessful attempts to find my original sample, the resultant lack of time (due to course deadlines) available to adequately develop my understanding of the data collected, had some implications for the quality of my second year research project. For the aims of this portfolio I decided to leave the report relatively unchanged in order to represent my development in the research domain in the following year.

Being aware of the difficulty of finding an appropriate consenting sample to continue my investigation of the topic from the previous two years and of the hectic nature of the third year, I decided to shelf the topic for a while hoping that I would be able to return to it at a later stage. Again, I went through the process of trying to find something that was appealing and interesting to me. As a professional working with children and especially after two years working as a counselling psychologist in training I had become quite interested in issues around risk in psychotherapy. Hence, for my third year research I decided to investigate this topic in relation to
supervision. This subject was appealing also because, in my practice, I had come in contact with a number of suicidal clients. In view of this and possibly owing to my own anxiety about risk, I decided to investigate this subject in relation to supervision; a space where the practitioner is supposed to discuss these issues in safety. As a supervisee myself, I had always wondered about the position of the supervisor in these situations. This curiosity served to fuel my interest in the investigation of the topic in my final third-year research project.

Both my empirical essays are of a qualitative nature. The choice of the methods is mostly dependent on the aim of my investigations. On both occasions, I attempt to understand something about a process and about the participants' actual experience of the topic. Having had experience of quantitative research in the past, I am aware of its benefits but the topics addressed here, necessitated a qualitative approach, especially since both are quite exploratory in nature. Choosing this methodological perspective was not difficult for me especially since I truly believe that qualitative methods manage to join together the tidy pathway of pristine scientific research and the murky ground of real and often puzzling human experience.

Conclusion

Returning back to the metaphor I mentioned in the beginning of this introduction. I feel that now I have chosen the photos and placed them in the album. I will now leave it up to you to sift through the pages and consider the different snapshots of my work. All the three years have had an impact on my life and on who I have become. The pictures (essays) are there to stay as memoires of my experience, but hopefully, also as catalysts for future work and exploration.
Reference

INTRODUCTION TO ACADEMIC DOSSIER

This dossier includes three selected essays submitted throughout this course. They all discuss aspects of the role of the counselling psychologist in relation to specific topics. The first essay explores the way children understand death and the way they cope in the process of anticipatory grief. Hence, a discussion of important aspects pertaining to this subject is included with a special focus on the role of the counselling psychologist. The second essay is concerned with the concept of bisexuality from a psychoanalytic perspective and the possible elements that may play a part in the client's development and in the therapist's position within the therapeutic space. Finally, the last essay discusses the role of homework in cognitive behavioural therapy and the implications of this technique for the therapeutic relationship.
Discuss children's understanding of death and their process of anticipatory grief. Specify what role a counselling psychologist might play in helping children face the imminent death of a significant other.

Weeping willow with your tears running down, why do you always weep and frown. Is it because he left you one day, Is it because he could not stay? On your branches he would swing. Do you long for the happiness that day would bring? He found shelter in your shade. He thought his laughter would never fade. Weeping willow stop your tears, there is something to calm your fears. You think death as if you forever part, but I know he'll always be in your heart.

Abstract taken from the movie 'My Girl' (1991)

The above quotation is taken from a movie about an 11-year-old girl called Vada. She writes the above abstract after the sudden death of her closest friend Thomas J, a neighbourhood boy with whom she spends long hours of summer vacations. His death leaves Vada shocked, horrified, angry and inconsolable and it takes her a long time to cope with the realization that he had left. Her words appear to be significant for the topic of this essay since they retain a childlike quality that allows for an easier conceptualization of the topic. This essay focuses on a slightly different subject: that of children who are aware of the imminent death of a significant other. Their experience is often mistakenly believed to be equivalent to that of adults. However, different factors come into play when children are involved. Their well being in such circumstances is marked by the interplay between their understanding of the situation and their environmental circumstances. The role of the counselling psychologist is necessary when children need support and when the people surrounding these children need some help in understanding and communicating with them. This essay includes a discussion of some salient issues for children in their understanding of death and the process of bereavement according to their developmental stage and in relation to the expected loss.
of a significant other. It also takes into account the ways in which counselling psychologists might be involved in such situations.

**The meaning of anticipatory grief in children's lives**

The process of grief that takes place before the death of another is referred to as 'anticipatory grief' (Rosenheim & Reicher, 1986; Worden, 1991). Abrams (1999) associates the process of anticipatory grief with a 'rehearsal' of what is expected to happen when the person actually dies. It is a period pregnant with feelings of insecurity and apprehension. During anticipatory grief children usually have to adjust to a lot of changes (Sølvi & Ulfsæt, 2003). However, in many cases they are not provided with explanations of what is going on possibly because they are believed to be oblivious to what is happening around them. In fact, literature has also indicated that children are often inadequately informed about illness possibly because many adults are under the inaccurate impression that children are unable to understand or that they are too vulnerable to cope with pain (Nelson, Sloper, Charlton, & While, 1994). Indeed they have often been described as the 'forgotten mourners' (Smith & Pennels, 1994). A number of studies have focused on this area and they have shed some light on the psychological processes that children may experience in these circumstances.

Psychological distress is very common among children who expect the death of a loved one (Beswick & Bean, 1996; Kroll, Barnes, Jones, & Stein, 1998; Sølvi & Ulfsæt, 2003). The distress emerges from different factors related to the illness including the prospect of death, the physical distancing from the dying person and the interference that the illness brings in the roles and lifestyles of all who are involved (Compas, Ey, Worsham & Howell, 1996). The preannounced death of a significant other is also believed to bring a lot of insecurity, fear and a sensation of lack of control for children (Compas et al. 1996). This also leads to further anxiety about their own mortality and that of other significant people (Hurd, 2004). In their study Compas et al. (1996) discovered that children's emotional state is often correlated with that of the dying person. These authors investigated the cognitive appraisals and coping of 134 children whose parent had been diagnosed with cancer. The results indicated that children depended on their terminally
ill parents' stable periods in their illness to feel tranquil themselves. This highlights children’s capacity to empathise and absorb the feelings of others and possibly their need to mirror the behaviour of trusted adults in unfamiliar situations. In fact, in another study conducted by Sølvi and Ulfsæt (2003) children admitted being frequently anxious and worried whilst being completely unaware of the actual source of their distress because they had been left unaware of the actual source of the significant person's distress.

Further studies have confirmed that there are a number of reactions that children experience in cases of bereavement, including: outbursts of anger, somaticisation and guilt. Other authors (e.g., Black, 1978) also suggest that there is a potential for long-term psychological difficulties associated with deaths in the family. An understanding of children’s feelings and reactions is important for the role of counselling psychologists who may be asked to intervene either directly with the child or indirectly with older adults responsible for the child. However, they would also need to take into account the children’s developmental stage and cognitive abilities.

**Understanding children’s needs in light of their development**

Children’s learning and reasoning hinges upon their social interactions and their communication with others. Echoing a ‘constructionist’ perspective, contemporary literature in child development sustains that children are active in the construction of their knowledge about the world (Thompson & Payne, 2000). The depth of children’s understanding of the circumstances surrounding the death of a loved one depends on many factors including their support system and any previous experience of death (such as that of a pet). However, one needs to remember that other underlying factors such as their developmental stage and cognitive abilities also play a role in their understanding of the implications of illness and death.

In the preschool years children are not yet able to distinguish between logic and fantasy (Rauch, Muriel, & Cassem, 2002). They are also unable to understand the lasting nature of death. At the same time they believe that they are the main cause of events. Thus, children at this stage of development could interpret a terminal illness as being caused by
them or by something they have done. It is imperative for adults to constantly remind children that this is not true. At this age children are also very curious and they repetitively ask 'why' questions (Rathbone, 1996). Children need to receive meaningful and coherent answers to these questions from trusted adults. Occasionally, the latter, who are experiencing anticipatory grief themselves, may overlook this. Counselling psychologists may be involved at this stage. They need to help adults understand the importance of such clarification for the child or else provide the coherent story themselves if working directly with the child.

Between the ages of seven to twelve children are believed to be in what Piaget called the 'concrete operational stage' (Bee & Boyd, 2004). At this age, children start grasping the concept of death: its inevitability, permanence, and finality (McEntire, 2003; Worden, 1996). Hence children may be overwhelmed by the newly acquired knowledge about the fate of the significant other. However, they may be unable to explain themselves. This has been acknowledged by a study carried out by Wetton and McWhirter (1997) where they discovered that although by the ages of seven and eight children can identify with different emotions, they may not have yet grasped the vocabulary needed to express themselves. Consequently, adults may fail to estimate the extent to which children are being affected by the imminent loss of the significant other (McWhirter, Wetton & Hantler, 1998). If someone is not available to discuss these issues with them and enable them to describe their feelings, children may feel more confused and isolated. Consequently, in absence of a verbal medium for expressing their pain and confusion, they may start to act out their feelings behaviourally. In these cases, counselling psychologists may be able to offer a non-judgemental space for understanding these behaviours. Additionally, they can help them by offering other creative means of communicating (e.g., through play or drawing) or by providing them with vocabulary in order to express their feelings.

Adolescents often get caught between the urge for independence and their family's expectation for them to be closer. Indeed, they are frequently given more responsibilities such as taking care of their younger siblings especially when parents are ill or hospitalized (Rosenheim-Borus, Weiss, Alber & Lester, 2005; Wells, 1988). When the
illness of the significant other or relative is contagious (such as AIDS), adolescents are likely to experience stigmatization and thus may end up isolated at a stage of their life when the support of peers is so important (Rotheram-Borus et al. 2001; Rotheram-Borus et al. 2005). Indeed, ‘being teased at school and feeling ‘different’ seem to be particularly common’ for them (Thompson & Payne, 2000; p. 94). Such situations and the emotional distress that accompanies the approaching death of a significant other may again lead to a lot of challenging behaviour on their part where they can become disruptive and abusive. Kübler-Ross (1984) maintains that at this stage adolescents “need the extraordinary understanding of a non-judgemental person who can see their actions as defence against the fear of impending loss” (pp. 77). Whilst fulfilling this role, counselling psychologists could also help adolescents vent their feelings anger and mistrust towards others and cope with them. By being honest and available for them, counselling psychologists could operate as a safe base for support and containment.

Coping with the prospective death of a significant other

The process of bereavement has been a special area of interest for various authors (e.g., Kübler-Ross, 1973 & Worden, 1991) in the last decades. However, many of the studies are mostly focused on adult bereavement processes and, as claimed by Thompson and Payne (2000), ‘research on childhood bereavement lags behind’ (p.75). There appear to be two main perspectives on the function of grief for the bereaved. Some focus on its role in helping the bereaved gain closure by helping them detach themselves from the deceased. Whereas others suggest that it is mostly related to enabling the former to relocate the role of the deceased in their lives. The following is a discussion of one of the models proposed by Worden (1991) about the tasks of grieving. This model if not specifically related to children. Hence, an attempt is made to apply it to this age-group in a bid to understand more about their coping cycle.

According to Worden the first task of mourning involves accepting the loss of the significant other (Worden, 1996). Children are very sensitive to changes in their environment and may sense that something is wrong even if adults try to conceal the truth. This is why it is important for children to be informed as soon as possible of the
expected loss of a significant other (Elsegood, 1996). It is likely to form the basis for them to be able to accept the physical separation from their significant other. In order to do this, they require an “accurate age appropriate and timely explanation” (p. 419) of the dying person’s condition (Shepherd Johnson, 1997). Ideally the most suitable person for the task of sharing such information is the one closest to the child and the person with whom they will remain in contact (Elsegood, 1996; Jewett, 1982). This person would ideally be a parent. However, parents may also be confused as to how to prepare children and what information to give them. Besides, they may also be preoccupied with their own distress. The study by Solvi and Ulfset (2005) highlighted the fact that sometimes, parents find the task of informing the child ‘challenging’ because they find it difficult to gauge what to tell them in light of their children’s level of understanding. Consultation with counselling psychologists, who have an understanding of developmental stages and of such skills as active listening, might prove beneficial for such parents to understand better the amount and type of information that children need. If parents still find this difficult, the counselling psychologists themselves might be able to talk directly to the children. In the latter scenario, it may be important for psychologist to consider that the present turmoil may already encourage children to be less trusting of an unknown person and that they may be overly suspicious of them (e.g., thinking that they will take the dead person away permanently). Hence it would be important for a trusted adult to introduce the child to the psychologist and that this person is open and clear about the role of the latter. In any case, the news about the imminent death of a significant person should be shared with the child in a comfortable environment and in presence of the most significant persons in his or her life.

The second task of mourning involves facing the pain and emotional aspects of the impending death (Worden, 1996). Counselling psychologists can offer information and assistance to adults about the emotional and behavioural reactions of children. They may also be able to identify children’s reactions to the situation which may remain unnoticed to the untrained eye of other adults in the family. For instance, a common reaction of children in anticipatory grief is the acquisition of physical and psychosomatic symptoms. Amongst the most typical of these symptoms one finds changes in the children’s eating and sleeping patterns, regressive behaviour, phobic reactions and so forth (Shepherd
Johnson, 1997). For example, in the movie mentioned above, Vada's father is a funeral director and he manages his funeral home service in their home. Vada is very obviously affected by this and is portrayed as a hypochondriac constantly seeking medical attention, because she imagines herself as suffering from a variety of ailments, all of which are inspired by the fatal illnesses her father's "clients" have passed away from. By treating children as individuals and by providing them with the necessary psychological space, counselling psychologists may be able to create the necessary context for them to discuss their feelings and to acknowledge that their emotions are significant and common in such situations (Corey, 2001). Indeed, a major aspect in this therapeutic alliance is to offer empathy, congruence and unconditional positive regard (Rogers, 1957). These skills are essential in this field of counselling psychology and are clearly necessary when the child and the surrounding adults are going through so much psychological pain and stress. Literature stresses the importance of addressing childhood difficulties and of allowing children to grieve in such circumstances. If ignored, these difficulties may be detrimental for the child's psychosocial development (Abrams, 1999; Shepherd Johnson, 1997). Another reason for involving counselling psychologists is that they can take a more objective stance in contrast to other adults whose vision may be too obscured by their own psychological distress. The counselling psychologist provides a space for the child to face the circumstances with someone who is not overwhelmed by pain. In the process, children may also learn healthier ways to express themselves and face another task.

The third task for children in these circumstances is that of starting to adjust oneself to an environment where the deceased is absent (Worden, 1996). This may become more evident for children when the sick person starts to withdraw further from the usual interaction with them and when the sick person's physical deterioration becomes more obvious (Worden, 1991). At this point, children benefit a lot from being involved in what is happening around them and the changes that take place around the sick person (Hallam & Vine, 1996). In this way they have the opportunity to start working through the process of grief. Children may even want to visit the dying person in hospital. Rauch et al. (2002), claim that this may be very important for the child. However, they also explain that good preparation needs to take place for this to occur. The counselling
psychologist, in this case, needs to guide the parents in preparing children for what they may encounter in these situations (including the altered image or psychological state of the hospitalized person) and also to be prepared for questions and comments that may ensue later from the child. Through this preparation children also have the opportunity to say goodbye to the person who is dying. Whenever possible, children should be encouraged to voice anything that they feel towards the dying person. The counselling psychologist at this point may help the child face this difficult task. The dying person may also want to say something to the child and this should be clearly stated and repeated until the child grasps the information (Rauch et al. 2002). If however, this is not possible the child should be encouraged to say goodbye symbolically, for example, at the funeral.

Many adults face the dilemma about whether or not they should allow or encourage a child to attend the funeral of a loved one. Funerals and other rites can help children to part with the deceased in a more serene environment. This may also help in the fourth and final task of mourning which involves “relocating the deceased and move on with life” (Worden, 1991, pp. 16). In this regard, it may be worthwhile mentioning the work of Walter (1996) who suggested that grief is not simply about letting go but also about a ‘construction of a durable biography that enables the living to integrate the memory of the dead into their ongoing lives’ (p.6). This is believed to be important for them to continue the grieving process. If Walter’s contention is true and sharing information about the deceased in order to achieve a ‘durable biography’ is a necessary component of grieving, funerals and other ‘community rites’ may represent an excellent opportunity to start this process. Literature suggests that children should be given a choice to attend funerals and have the opportunity to be involved after the death (Holland, 2004; Kübler-Ross, 1983). If children decide to attend, it is imperative to let them know about what is likely to happen during a funeral (e.g., that many people will be crying). Counselling psychologists are in a position to offer this information to the child without being overly dramatic about it. They could encourage the child and other relatives or friends to remember incidents and anecdotes that capture the spirit of the dead person whilst providing continuous reassurance that others will still be available and present in their lives.
Conclusion

The experience of death and bereavement brings a lot of psychological upheaval. Children experience this both directly and indirectly. Various aspects become important depending on the children's needs and their stage in development. The role of counselling psychologist is that of dealing with the issues that arise with the child in the context of the complex dynamic that takes place with other family members and the impending loss of a significant other. Notwithstanding the great preparation that the child may have, one needs to consider that the death of a loved significant other is always difficult to accept. As Abrams (1999) explains:

Even when there has been plenty of 'warning', death remains unimaginable and largely impossible to prepare for....You know it will be dreadful, but before it actually happens you know it with your head rather than your heart (pp. 39)

As adults and as professionals involved in such instances we need to keep striving to transform this difficult experience into one of growth and development for children by taking into considerations their needs, their fears, in conjunction with their emotional and cognitive development.
References


PSYCHOANALYTIC PERSPECTIVES ON BISEXUALITY:
IMPLICATIONS FOR THE THERAPEUTIC RELATIONSHIP

I've liked both sexes for as long as I can remember. When I was an adolescent I was in love with a girl from my class, but I was also excited by a few boys in the school gym. But that kind of desire was not common and usual in my time.... So I got married.... It was not long ago that I heard of bisexuals. I was happy when I realized that I am not as special as I thought I was.

Djura (n.d.)

The above words are taken from a personal account published on a website dedicated to bisexuals. It portrays a reality that the middle-aged author has had to face and the decision that he has made earlier on in his life as a result of social pressure and lack of recognition from the environment. Bisexuals are individuals who can feel physically attracted and are capable of physical intimacy with both men and women (Shechter, 2004). Many people believe that they are uncommon and therefore few show interest in their needs and desires. Faced by this lack of acceptance, bisexuals often get lost in the crowd when they decide to follow the less threatening path that society lays out leading to monosexual identity. Notwithstanding the confusion that is often stirred up by this topic in social conversations, professionals in the fields of counselling psychology and psychotherapy need to be available and understanding with the ever-increasing numbers of clients presenting with issues around their sexuality and especially in relation to bisexuality (Limentani, 1999).

The aim of this paper is to focus on the social landscape as it embraces the concept of bisexuality in a bid to understand more thoroughly the individual's struggles and needs. Since, one of the first arenas recognizing the existence of bisexuality was the psychoanalytic field, especially owing to Freud’s interest in the subject matter, a

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1 A monosexual is a person who is attracted to only one sex or gender (Monosexual, n. d.)
discussion of the main themes surrounding bisexuality from a psychoanalytic perspective will ensue. Consequently, it is also believed necessary to focus on issues pertaining to the therapeutic relationship. This will be tackled in the second part of this paper.

**Bisexuality in the social context**

Bisexuality is often believed to be an aberration from the more socially acceptable heterosexuality and homosexuality. People who identify themselves as bisexuals feel outcast by society at large (from both homosexual and heterosexual circles). A very interesting phenomenon has been observed recently when the movie Brokeback Mountain was released in public cinemas in 2005. Even though the main characters in the movie are depicted as bisexuals, most discussions about the movie have portrayed it as a gay movie. This can possibly be a reflection of society’s tendency to dichotomize and generalize issues around sexuality (Brod, 2006). Given this scenario, it is not surprising that people who identify themselves as bisexual get caught in a maelstrom of self-crisis and, therefore, decide to conform to social norms often denying their own sexuality.

Most often bisexuality lays hidden in the confusion surrounding sexuality. Bisexuals are often misunderstood or categorized as ‘different’ and ‘unsettled’ (Oxley & Lucius, 2000). The lack of recognition they receive from the community ‘makes it more difficult to maintain and validate these preferences than heterosexual identities, which are supported continuously by socio-cultural institutions, or homosexual identities, which are recognized and reinforced by institutional arrangements within the homosexual community’ (Troiden, 1988; p.82). Unfortunately, this stereotype and bias is often held by the professional clinical community as well (Purdie, 2000). The ambiguity associated with bisexuality is often not tolerated and it is often seen as a sign of pathology. Schechter (2004) explains that many professionals perceive bisexuals as people who fail to recognize and acknowledge their homosexuality or who experience difficulties in relation to their heterosexuality. Such beliefs are mostly embedded in the development of psychological theory about sexuality and from the inheritance of psychodynamic concepts and theories. As psychotherapists and psychologists we are invited to help our clients to foster sound relationships notwithstanding their personal lifestyle and sexual
identity (McDougall, 1993; Shechter, 2004). Psychoanalytic theory has an important contribution to make to this area with its emphasis on the unconscious and psychosexual development early in life.

**Bisexuality in Psychoanalytic theory**

Historically, psychoanalysis has equated any divergence from standard heterosexuality to disorders or problematic development. Resting at the basis of psychoanalytic theory of sexuality is the underlying assumption that people are innately attracted to a person of the opposite sex (Burch, 1993). This happened notwithstanding the fact that Freud (who was one of the foremost pioneers in the areas of sexuality and psychoanalysis), included bisexuality in his theory of psychosexual development.

Freud explained that all humans have a bisexual predisposition and speculated that bisexuality is at the basis of psychosexual development (Fox, 1995; Freimuth & Hornstein, 1982). He conceived of bisexuality as 'the norm in infancy and seeing the child as gradually conscripted into the rigid norms of heterosexual sex' (Oxley & Lucius, 2000; p.117). He laid bisexuality exactly at the mid-point on a continuum of sexuality ranging from masculinity to femininity. In his writings, it is apparent that the concept of bisexuality has a dual meaning in relation to the equilibrium of object relationships. On the one hand, it reflects a biological tendency of the human organism - he sustained that human beings are not genetically differentiated in infancy (Freimuth & Hornstein, 1982). On the other, he sees it as a necessary prerequisite for both psychic and sexual integration (Bott Spillius, 1993). Thus, Freud incorporates bisexuality in the concept of the Oedipus complex and states that the successful resolution of the Oedipus complex is paramount for the development of heterosexual identity. He acknowledges earlier psychological bisexuality that comprises of an ‘unconscious identification of both parental images in the positive and negative oedipal constellation’ (Kernberg, 2002; p13). Thus, prior to the resolution of the Oedipus complex, the child does not distinguish between genders and is ‘primarily focused either on autoerotic activities or on the mother (because she is the primary parent...)’ (Valverde, 1985).
On the whole, Freud saw bisexuality as a stage of sexual immaturity that would, at a later stage, develop into one of the monosexual (heterosexual or homosexual) identities. Notwithstanding the importance that Freud attributes to bisexuality in psychosexual development, he struggled to understand the actual definition of bisexuality or what it consists of and struggled with the ensuing vagueness related to the term. His position was interpreted as suggesting that clients, who identify themselves as bisexual, are somewhat fixated in their psychosexual development. In today’s socio-political context, this notion of bisexuality is likely to sound somewhat narrow, rigid and judgemental. Yet, as explained further on, many future psychoanalysts adopted this pathologising stance (Izzard, 2000). Nevertheless, Freud’s theory has two important and valuable implications (Freimuth & Hornstein, 1982). Firstly, it is apparent that in his understanding, gender is to be conceived as multidimensional incorporating both biological and psychological variables. Secondly, according to his theory, gender cannot be conceptualized through dichotomous criteria but as laying on a continuum.

Regrettably, the psychoanalytic community after Freud did not inherit his ambiguous stand in relation to bisexuality. Few authors discuss bisexuality in a positive light. Amongst these few, we find Wilhelm Sketel who goes to the other extreme by stating that bisexuality is inborn and that monosexuality is unnatural (Storr, 1999). Conversely, many psychotherapists and psychoanalysts still consider bisexuality as a reflection of denial on the person’s part to accept their homosexuality. Ruitenbeek (1973), for instance, claims that bisexuality is not real and he also suggests that it is potentially dangerous for clients who are attempting to make a ‘genuine sexual choice’ (p. 204). The same pathologising sentiment is shared by Kernberg (2002), who implies that most of those who are ‘chronically’ bisexual ‘have significant character pathology’ (p.17). According to Kernberg, this pathology is evident from the fact that these individuals cannot limit themselves to one gender as object choice. Similarly, Limentani (1989) equates bisexuality to a perversion and states that the treatment of bisexual patients is more complicated because they have borderline traits with a tendency to act out and be more prone to transference. Such ideas around different sexualities have led sexual minorities to be denied membership in psychoanalytic circles. With the consequential exclusion of gay, lesbian and bisexual people from formal psychoanalytic training, it is
scarcely surprising that the theories pathologising homosexuality and bisexuality received scarce criticism in this area. As argued by Izzard (2000), for a long period, most of the literature about these areas 'has been written by analysts writing from their clinical experience, rather than their personal experience' (p. 110).

The term bisexuality suggests a dichotomy between homosexuality and heterosexuality. It also denotes that there are two genders and raises the question of whether the 'bi' refers to the 'person's object choice or to his or her own psyche' (Storr, 1999; p. 11). Some authors in the field, such as Shechter (2004), go as far as to suggest that from their clinical experience, clients presenting with issues around bisexuality eventually drift towards either homosexuality or heterosexuality because, 'once their psychic conflicts are ... resolved, happiness is possible in a sexually consistent world' (p.273). Although this scenario might represent reality for a number of therapists and clients, such a perspective also seems to suggest that bisexuality is often and basically a transitional experience. Thus, denying the experience of people who feel bisexual throughout their lives. Due to these situations, bisexuality has seldom been studied as a distinct and revealing form of sexuality and hence, has received little credit (Oxley & Lucius, 2000).

Valverde (1985), comments on Freud’s theory and expresses her disagreement about his assumption that we are born bisexual. She draws a difference between infantile 'bisexuality' and bisexuality as is manifested later on in life. She explains that in infancy, sexual instincts are triggered regardless of gender. Bisexual adults, on the contrary, relate to their partners by acknowledging their gender as well. This concept is reflected even in the Jan Clausen's (1990) paper where she explains her own experience and confusion about being bisexual. Clausen, who discovered her bisexuality after having identified herself for a long time as feminist lesbian, comments that the partners one chooses are always 'sexed individuals'. This statement clashes with some people's beliefs that sexual attraction or the choice of partners for bisexual individuals may not be related to gender (e.g., Burch, 1993; Freimuth & Hornstein, 1982). On another note, Valverde (1985) criticizes Freud in his contention that bisexuality is associated with childhood innocence whilst heterosexuality is assumed to be a by-product of sexual maturity. She explains that as long as some sexual choices are seen as natural or else as a result of
maturity, there will still be prejudice and belittling of other people's choices which obfuscate our thorough understanding of these individuals' reality.

A new perspective

In recent years a shift has been observed within psychoanalytic theory in relation to the understanding of sexuality (Izzard, 2000). Under the influence of feminism and postmodernism, psychoanalysis is undergoing a change in the way it envisages and conceptualizes homosexuality and bisexuality. Therefore bisexuality is increasingly becoming accepted and acknowledged on its own without pathologising comparisons with heterosexuality. However, this is a lengthy process and, as implied above, there are still diverging views around it. Indeed a lot of attention is being given to the dichotomy suggested by the term itself. In their respective papers about the practice of psychoanalysis with issues of sexuality, Ellis (2005), and Izzard (2000) address the limitations of classical psychoanalysis and call for a change in the theory and practice of psychoanalysis. Although they still acknowledge and celebrate the contribution of psychoanalysis to our understanding of what lies beneath the sheet of consciousness and for providing us with the tools to do so, both authors call for a change in our approach to sexuality. This change should aim, for instance, at reducing the assumptions around bisexuality that equate it to developmental failure. Indeed, different studies about psychological adjustment of bisexual individuals have failed to find evidence of psychopathology or maladjustment amongst this group (e.g., La Torre & Wenderberg, 1983). Ellis encourages therapists to listen more openly to clients and to refrain from 'generalizing' their experiences. She also highlights the benefits of self-reflexivity and invokes a conscious awareness of the context informing our beliefs. In this way, we are encouraged to become more aware and sensitive to transference issues.

Ellis (2005) highlights the importance of language in the psychoanalytic relationship. She sees it as a resourceful bank of meaning and possibilities available to the therapist in order to connect in a meaningful way with the client. In her discussion Ellis, is influenced by her interest in phenomenology. Therefore, she focuses on the 'descriptions' of experiences rather than on the causes. In her endeavour to encourage therapists to pay attention to the clients' own story and individual reality, Ellis echoes
Foucault’s (1976) focus on language and context in giving meaning to particular issues. In fact, the latter sustains that the body does not have any meaning outside a context of history and social discourses. This is particularly relevant in relation to bisexuality because such a topic is closely related to the body and the inherent instinctual feelings. Following this argument in their reciprocal discussion, Ellis (2005) and Izzard (2001) advocate neutrality on the part of the therapist to let go of assumptions and theoretical beliefs in such a way as to be able to listen to the clients’ descriptions of their experiences. In this respect, Ellis’s perspective conflicts with Freud’s and with his belief that the therapist should gain a thorough understanding of the patient’s repressed material. Izzard (2000) also challenges the contemporary movement for affirmative therapy. She reaffirms the arguments of other authors in the field and contends that neutrality is more important and helpful. Otherwise one runs the risk of colluding with some social currents that have originated as a ‘reaction to’ rather than as a ‘working through’ model.

The therapeutic relationship

As with other clients presenting for therapy, people with a bisexual identity come with their individual difficulties and their own story. Although not necessarily evident in all cases of bisexuality the difficulties of those who identify themselves as such include feelings of isolation from family and friends who don’t know how to define them and a misinterpretation of presenting problems by professionals who assume difficulties in their psychosexual development. Furthermore, as explained by Valverde (1985), on a daily basis, people who are bisexual have to resist both ‘fronts’ in society: the primary and widely accepted heterosexuality and the oppositional force of homosexuality. This is likely to make them feel more vulnerable and isolated (Shechter, 2004).

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Inherent in the work of psychotherapy is the necessity to understand the individual story and the individual pain as presented by the client. Clients presenting with issues around sexual identity may have unique life experiences in comparison to those who are considered within the 'norm'. Definitely, aspects of transference and countertransference insinuate themselves into every course of therapy. They are modulated by our meaning making and by the way we communicate our ideas and beliefs. These phenomena involve both therapist and client and are also related to the way we embody and conceptualize sexuality. As therapists we need to be aware of this and also of the social prejudices that may seep through our own clinical judgement and the therapeutic relationship we are likely to offer. Such issues can easily play a part in the therapeutic relationship on an unconscious level in the therapist's own defence mechanisms and countertransference. Brauner (2000) recommends a thorough investigation of the therapist's own guilt, shame and defensiveness around sexuality especially with regards to issues of homophobia and biphobia. For instance, Khan (1997) warns that, when clients explore topics that are rather disturbing for the therapists, the latter may respond from their countertransference. Indeed, if the therapists have not yet come to terms with the meaning of bisexuality, they may share their clients' anxiety and discomfort.

Paying attention to beliefs, fears and tendencies about sexual minorities is also important for practitioners in order to avoid ending up in a double-bind. In fact an impasse can easily be created if the therapist gets stuck between wishing to be neutral with the client (which may collude with the client's other experiences in a society where bisexuality is ignored) and taking a more accepting stance (which may be interpreted as if the therapist
is 'trying too much'). At the same time, this double-bind may also be a reflection of projective identification. Given, the lack of social acceptance and social modelling available for bisexual individuals, they may be projecting their own uncontainable fear and confusion related to their sexual identity on the therapist. Casement (1985) describes projective identification as 'a form of affective communication, the projector has a need (usually unconscious) to make another person aware of what is being communicated and to be responded to' (p. 81). In this case, clients (the projectors) are unable to manage their feelings of confusion and possible disbelief about their sexual identity. Hence, they communicate them to the therapist (the recipients). Ideally, the latter is able to contain and manage these feelings. If this is achieved, the clients will be able to take back their feelings which are likely to feel more manageable 'because another person has actually felt them and has been able to tolerate the experience of those feelings' (Casement, 1985; p.82).

All this suggests that the therapeutic relationship is a significant aspect in the therapeutic endeavour. Paying attention to one's own understanding of bisexuality and the theoretical position that one adopts is necessary for the therapist who works with such issues. The greater the awareness of the therapist, the more likely he or she will be able to understand the clients well and to avoid problematic and persecutory therapeutic situations.

**Conclusion**

Bisexuality attracts various reactions in professional and social spheres. It is not unlikely to equate it sarcastically to this golden status of sexual identity under the impression that the bisexual person can get the best out of the two worlds (the heterosexual and the homosexual worlds). Others look down on bisexuality and perceive it as a perversion. There is also evidence suggesting that in other sexual minorities, such as homosexuality, bisexuality is frowned upon as well. This suggests that the bisexual person may encounter difficulties in expressing his or her bisexuality and possibly even in defining himself or herself as such.
Psychoanalytic theory has initially equated bisexuality to perversion or to maladjustment in one's psychosexual development. This has led to a relative distrust in the model. However, a shift in theory is becoming evident. Ideally with its focus on the relational dynamics within the room and the attention given to unconscious processes, psychoanalysis can recover the relationship that has been severely damaged by the apparent association of sexual minorities to pathology. Possibly if clients find the space to be free from prejudice within the room, they are likely to find solace and support in psychoanalytic therapy. Being recognized and being accepted can help people understand and feel comfortable with themselves. Therapy can help them find a niche of understanding and of realizing that they are not alone.

...I found out about other bisexuals. It was a relief. Not that I now have the heart to tell my innocent wife the truth, but anyway it is much easier now when I know that people like me exist.  

Djura (n.d.)
References


Reflections on the role of homework in CBT: considerations for the therapeutic relationship

I have found that many of my patients do not complete diaries or other homework tasks, and that this is the case even when the patient has agreed that the task is reasonable and its completion desirable.

(March, 1997; p. 461)

Cognitive behavioural therapy (CBT) has been found to be beneficial for treating a different array of disorders and different studies have suggested that clients respond rapidly to this kind of treatment (Wilson 1999). In many cases the original model has been adapted into different protocols for different client presentations. Yet, these adaptations appear to share similar underlying principles, values and techniques (Beck, 1995). One of the core technical features of CBT: one that appears to transcend differences in protocols and adaptations of the original model is homework. In this context, the terms 'homework' or 'homework assignment' are being used to refer to any assignment agreed upon during therapy for the client to practice between sessions (Detweiler & Whisman, 1999). Homework can take different forms including, self-monitoring, thought diaries, food diaries, behavioural experiments, and so on. In collaboration with the client, the therapist decides which assignment is most appropriate depending on the stage of therapy, the client's presentation and the latter's ability to comply with the job. Consistent with one of the main aims of cognitive behavioural therapy, homework is primarily assigned as a means towards cognitive restructuring. Practitioners may utilize different labels to refer to the same technique depending on their own values, their client's needs or the context of their work.

Recent economic forces and social demands for a higher accessibility of short-term psychological interventions have amplified the popularity and dissemination of homework assignments because they are presumed to aid in enhancing the amount of change that clients experience during therapy (Detweiler-Bedell & Whisman, 2005).
However, as suggested by the quote above, clients often do not adhere to their homework assignments. The author of this quote observes that notwithstanding the frequent use of homework assignments in CBT, problems in homework completion appear to be very common (Helbig & Fehm 2004; Kazantzis & Shinkfield, 2007). Although the awareness of the prevalence of this problem is somehow consoling on a personal level, it is still concerning within a model that utilizes homework assignments so regularly. In such cases the practitioner may need to consider the implications of this behaviour on the therapeutic relationship and on the development of therapeutic change. The aim of this paper is to discuss the role of homework in cognitive behavioural therapy especially in the light of the therapeutic relationship which is one of the primary concerns for counselling psychologists (Strawbridge & Woolfe, 2003). I shall start by giving a brief overview of CBT in order to contextualise its' use. Consequently, I shall try to explore issues around homework in the light of the therapeutic relationship.

The cognitive behavioural approach

The cognitive behavioural approach views the person's experience as a by-product of the interaction between cognition, emotions, behaviour, the environment and bodily processes (Beck et al. 1979; Beck, 1995; Wills & Sanders; 1997). This approach was developed in the 1950s to challenge psychological conceptualizations primarily based on the role of the unconscious (Davison & Neale, 1997). However, in its own way, CBT acknowledges the strength of material which is not readily accessible to our conscious mind. It focuses on changing the apparent automatic relationship built between negative thoughts and feelings that are believed to be responsible for dysfunctional behaviour. Even though the cognitive behavioural approach has often been associated with a cold and mechanical way of conducting therapy, it 'is actually all about reaching and working with client's salient feelings' (Wills and Sanders, 1997; p.9). This model holds that every emotional state is characterised by a particular thinking pattern. Therefore, CBT attempts to uncover the clients' dysfunctional thoughts since these are believed to be very closely related to emotions and to hold a pivotal role in maintaining unhelpful moods and behaviours (Padesky & Greenberger, 1995). This approach views psychological
problems as resulting from erroneous beliefs that rule people's life (Bemnger, 1997). The aim of therapy is to reveal, appraise and change ineffective cognitions. It is believed that this may have a ripple effect and that, in turn, clients may find it necessary to change their environment and behaviours if the vicious dysfunctional cycle between thoughts, emotions, and behaviour is broken.

Cognitive behavioural therapists are traditionally associated with working solely in the present and to underestimate the role of past experiences. However, since its origins, the main authors in CBT (e.g., Beck et al. 1985; Beck et al. 1979) have acknowledged the role of the person's past in creating the presenting problem (Safran & Segal, 1996). This approach presumes that 'resolution and/or a more realistic appraisal of situations that are currently distressing, usually lead to symptom reduction' (Beck, 1995, p. 6). Whilst considering the history of dysfunctional thoughts and behaviour, therapy helps to reassess people's beliefs by collecting the evidence in the present. Homework assignments are one of the means at the therapist's disposal to reach this end. They are practical aids that enhance change whilst setting in motion three essential mechanisms (Safran and Segal, 1996):

1. 'Decentering' – where clients become aware of their own potential to construct reality;
2. 'Experiential disconfirmation' – where clients are able to disprove their dysfunctional assumptions about themselves and others through new experiences; and,
3. 'Accessing action-disposition information' – where clients learn about aspects of the self that have remained hidden from consciousness.

The Role of homework in Cognitive Behaviour Therapy

The use of homework as a therapeutic technique is not an exclusive prerogative of CBT. Various types of between-sessions assignments have been utilized by different therapeutic orientations as a way of engaging clients in the process of change outside the therapy hour (Freeman, 2007; Helbig & Fehm, 2004). Nevertheless, the reference to homework during therapy is most often associated with the cognitive behavioural model and many CBT practitioners would agree that homework is a core and integral element of
cognitive behavioural therapy (Beck et al., 1979; Kazantzis & Shinkfield, 2007). In fact, a study by Kazantzis, Busch, Ronan & Merrick (2007), with a sample of practitioners from different therapeutic orientations indicated that CBT therapists reported utilizing homework more frequently than practitioners and that they are more structured and systematic in the way they utilize it. This structured and systemic element appears to be beneficial for treatment. In fact, another investigation by Detweiler-Bedell & Whisman (2005) concluded that there appeared to be a positive relationship between the degree of specificity and systematization of the assignments and the rate of clients’ improvement.

Homework assignments are also beneficial because they provide clients with an opportunity to monitor themselves, an element which is likely to enhance their sense of self-efficacy and control (Bandura, 1989; Carroll, Nich, Ball, 2005; Rees et al., 2005; Wilson, 1989). Many therapists agree that ‘clients are more likely to improve if they apply the skills learned in treatment to situations outside treatment’ (Kazantzis & Lampropoulos, 2002, p.578). Indeed, Freeman (2007) claims that no matter how well assignments are planned, they are never infallible and that by having to face unpredicted reactions from the environment, a patient will be able to concretely assess the value of the new skill (e.g., assertiveness). Therefore homework assignments compliment in-session therapeutic work. For instance, role plays which are extensively used in therapy encourage clients to experiment with new ways of being. The therapist is often the one providing feedback to the client in such situations. However, the therapist may feel inadequate to respond as powerfully or as aggressively as a real person in the client’s environment. Hence, if particular skills are not practiced outside of the therapeutic session clients may find themselves unprepared for real reactions and consequences from other people in their environment.

Research has also indicated that homework adherence and therapeutic outcome are positively correlated (Helbig & Fehm, 2004). For instance, a study by Burns and Sprangler (2000) investigated the effect of homework adherence on clients with depression. The results suggested that the consistent adherence to homework assignments led to improvement in the clients’ conditions. Compared to another group of clients who did not comply with homework assignments, those who did, recovered
more steadily. Interestingly, this study also suggested that compliance to the assignments was not related to the type and severity of the depression symptoms thus giving more weight to the hypothesis that homework assignments carry a high therapeutic value. In another study, Kazantzis, Deane and Ronan (2000) concluded that clients who receive homework assignments during therapy are more likely to have a better therapeutic outcome than those whose psychotherapy does not involve homework. In addition, a study by Rees et al. (2005), also suggested that different assignments could be responsible for the actual positive outcome and that not every type of homework is necessarily conducive to change. Indeed their research indicated that whilst behavioural activities were related to improvements in depressive symptoms, they were not related to progress on anxiety measures. Being able to discern the correct timing and form of homework to assign to clients is very important. Therapists need to gauge their input and monitor closely their clients' progress in the context of their therapeutic relationship.

It is therefore imperative that homework is discussed between therapist and client before and after it takes place (Burns and Sprangler, 2000). The clients' observations about the assignment are discussed during the therapeutic hour; thus providing a safe arena in which clients 'calibrate' their new beliefs or behaviours. On their part, therapists will need to keep in mind the formulation of the clients' difficulties and encourage them to assess their progress without being limited by their usual dysfunctional thoughts and avoidance strategies. This is one example of the evidence-based nature of CBT where the client is encouraged to make changes according to which aspects are 'evidently' more functional and helpful (Padesky & Greenberger, 1995). This aspect of 'practicing' or 'testing' skills or beliefs as homework has implications for the work of the counselling psychologist as well. It appears to bear resemblance to the role of the counselling psychologist as a scientific practitioner (Strawbridge & Woolfe, 2003). Through homework assignments, the CBT model allows therapists to evaluate their practice and the progress of their clients. From these 'tests' in the real world, practitioners are able to assess the clients' progress in therapy, the usefulness of the newly acquired skills for them and the latter's propensity to use them. This, in turn, continues to inform the conceptualization of the problem, the clients' engagement with the model whilst indicating future directions and necessary modifications to treatment (Garland & Scott,
2002). For instance, one of the clients that I was working with has appreciated the fact that we devised assignments together rather than suggesting everything myself. Paying attention to her initial reluctance to stick to her work uncovered her sense of distrust whenever she felt ‘constrained’ to do something by someone else. This continued to inform our work together. Consequently, her motivation and sense of self-efficacy increased accordingly and she became increasingly willing to comply with the job.

The therapeutic relationship in CBT

Rudd and Joiner (1997) observe that ‘few relationships offer the potency and intensity, regardless of duration, as does the therapeutic encounter’ (p. 236). My experience as a therapist with clients and as a client myself in personal therapy lead me to agree with this statement. However even though many contributors to the field of cognitive therapy mention the therapeutic relationship, they appear to fail to focus on the details of building and strengthening the relationship. Hence, for instance, most therapists remain ignorant about how to foster the relational aspect of therapy whilst integrating homework effectively in their work or how to gain feedback about the therapeutic alliance from the client’s use of homework assignments (Detweiler-Bedell & Whisman, 2005). Possibly these aspects support the stereotypical portrayal of CBT as a cold and mechanical way of conducting therapy (Wills & Sanders, 1997). Undeniably, if true, these characteristics contrast starkly with those of counselling psychology, a profession which emphasizes the empathic engagement with clients and the importance of the therapeutic relationship in facilitating therapeutic work (Strawbridge & Woolfe, 2003; Woolfe, 1990).

Although the stereotypical perspective of CBT appears to suggest otherwise, different CBT authors (e.g., Beck 1979) have challenged the perception of this model as one which underestimates the importance of the therapeutic relationship. In fact, they explain that since its origins CBT always advocated the centrality of the therapeutic relationship. Yet, it appears as though literature has suggested that although vital, the therapeutic relationship ‘is a mere container in which to do the real work’ (Sanders & Wills, 1999). As described metaphorically by Wills and Sanders (1997), ‘if the therapeutic relationship was a car, the cognitive therapist would use it to travel from A to B, whereas the
psychodynamic or Rogerian therapist would be a collector, spending hours polishing and fine-tuning each vehicle' (p.55). Wachtel (1982), for example, argues that traditionally cognitive therapists do not provide or invest in a theoretical structure that combines the factors related to the therapeutic relationship to those associated with technical aspects of the model.

Indeed, in recent years a shift is being observed and greater attention seems to be paid to the therapeutic relationship in CBT. In fact, some authors (e.g., Rudd & Joiner 1997) in CBT are now venturing to address issues traditionally associated with the therapeutic relationship – such as transference and countertransference – from a cognitive behavioural perspective instead of simply borrowing concepts from other models. Indeed it is believed that CBT is increasingly managing to bridge the gap between the technical expertise and the relational issues necessary in therapy (Safran & Segal, 1996). One of the main vehicles they use is collaborative empiricism, a salient aspect of cognitive therapy encouraging the client to take an active role in therapy together with the therapist (Rees, McEvoy, Nathan, 2005). The therapist often acts as a role model for the client and utilizes feedback to assess both the suitability and timeliness of particular interventions. These aspects of cognitive therapy become salient in the use of homework because they often have implications for the clients' understanding of the homework assignment, and the degree of engagement they exhibit with this aspect of therapy. Through the use of homework assignments, such as thought diaries and mood logs, CBT practitioners are able to grasp more easily the subjective experience, emotions and significance of some situations for the clients which is a central characteristic of our work as counselling psychologists.

**Homework - implications for the therapeutic relationship**

Homework assignments are believed to reflect the collaborative nature of the therapeutic relationship and the active role that clients are encouraged to take; both of which are the main tenets of CBT (Beck, 1995). The collaborative nature of CBT is believed to be very important in encouraging the client to value and pursue change and hence, to follow through with homework assignments (Freeman, 2007). It allows them to openly discuss
any difficulties, fears or antagonistic ideas that they may harbour about the tasks with their therapists.

Nevertheless, studies investigating the relationship between homework, the therapeutic relationship and therapeutic outcome have produced inconclusive results. In some studies, (e.g., Seibel & Dowd, 1999; Svensson & Hansson, 1999), a positive correlation was established between the therapeutic alliance and positive outcome. However, these conclusions diverge from the findings of other research projects. Indeed, a study by Carroll et al. (2005) did not find any correlation between homework compliance, positive therapeutic outcome and the therapeutic relationship. Similarly a study by Dunn, Morrison and Bentall (2006) conducted with therapist and patient dyads revealed that although adherence to homework assignments was correlated to the quality of the therapeutic alliance, no evidence implied that this was in any way related to therapeutic outcome. Notwithstanding their results, Dunn et al. (2006) still suggest that therapists ought to attend seriously to process issues (such as aspects of engagement, aspects of the therapeutic alliance and homework compliance) with clients. They prompt therapists to devote a lot of attention to engagement issues as early as possible in therapy.

Due to the important element under investigation in these studies and the contradictory findings, more research needs to be carried out to determine what effects the therapeutic relationship has on homework adherence and treatment outcome. Some of the studies which did not manage to find conclusive evidence of the correlation between the therapeutic relationship and the treatment outcome are very cautious in reporting their results almost suggesting that the findings may not represent reality. For instance, Dunn et al. (2006) suggest that their results may be a reflection of low sample size. These comments and the caution with which researchers have interpreted an apparent lack of relationship between treatment outcome and the therapeutic relationship may suggest that there could be professional discomfort about the issue. Possibly, it could be a reflection of a ‘core belief’ amongst practitioners holding that the therapeutic relationship itself is a necessary ingredient for the patient’s adherence to therapeutic needs and change.
Different authors have pointed out a number of barriers for homework completion. Many observe that a very common barrier to adherence to assignments stems from the client's presenting problem and their faulty beliefs (Coon & Gallagher-Thompson, 2002). An example is pertinent to the discussion at this point. After a few sessions with Miss A, I realised that she recurrently failed to do her mood diaries even though she appeared to engage very well during our sessions. This was more confusing considering that she never complained about the assignments and she would promptly complete any examples during the sessions. I finally explored this issue tentatively with her and she admitted that she was afraid to use mood diaries since she was not 'very articulate in identifying her emotions'. Her negative automatic thoughts appeared to be about 'not filling them in correctly'. This was beneficial to the therapeutic process since it helped to illustrate another significant aspect around perfectionism in her case conceptualization and this allowed her to be open about her fears. In this context, reflecting about the client life outside the therapeutic hour provided important information about other aspects, such as what could act as a deterrent for this client in engaging in therapy and what compensatory strategies (ignoring emotions) could circumvent our progress.

A common barrier to homework completion appears to be the word 'homework' itself which is often associated with particular emotions and ideas about self-efficacy and success in life; a residue of school-days for most of us. In fact, in a discussion about homework assignments used with children and adolescents in therapy, Hudson and Kendall (2002) point out that 'the mere mention of homework can be enough to prompt a child not to comply' (p. 527). A similar observation was also made by Coon & Gallagher-Thompson (2002) in their article about homework adherence among older adults. Consequently, another possible disadvantage is that the words we use to refer to these assignments could change the perception of the therapeutic relationship from a collaborative, therapeutic one to that of teacher-student relationship which may instil negative emotions in our clients. Although we still lack research investigating the impact of the particular vocabulary utilised to explain in-between session assignments, it is suggested that therapists pay particular attention to the vocabulary they use and the beliefs expectations that clients may hold about them.
Clients' task-interfering cognitive systems may pose other obstacles for the use of homework assignments in therapy. In a discussion about improving homework compliance with clients suffering from generalized anxiety disorder, Leahy (2002) mentions that a common reason behind non-adherence to homework assignments involves the benefits that clients associate with worry itself (such as beliefs that worry protects and prevents disasters). For instance, one of my clients, Miss B, was referred for symptoms of anxiety and depression. She struggled to re-evaluate the role of rumination and worry in her life. Unfortunately, this characteristic had been indirectly reinforced through some of her past experiences. In fact, it was only through her persistence that doctors had continued investigating her son’s symptoms which led to a diagnosis of a serious condition requiring surgery. One can easily understand the survival value that this patient attached to worry and one can also understand how low her therapeutic investment would have been if the goal was to give up her compensatory strategies.

The above discussion has produced different elements that practitioners ought to attend to whilst thinking about homework assignments in CBT. However, fitting all the information together is somewhat complex and tricky. Detweiler and Whisman (1999) attempted to produce a model that combines different information about the different elements related to homework completion. The following is a discussion about this model since it is closely related to the subject of this paper.

**A heuristic model...**

In order to propose suggestions that could help towards homework adherence Detweiler and Whisman (1999) designed a heuristic model that takes into consideration the characteristics of the therapist, those of the client and those of the task given as an assignment as the main features relevant to the client's decision to carry out the assignments (refer to Figure 1 below). One of the advantages of this model is that it recognises the importance of the individual influences on homework compliance which is very important in order to capture the information gathered from the different studies mentioned above.
These authors suggest that the task assigned for homework should have been decided in conjunction with the client in a spirit of collaboration and that it should reflect the client's goals. Research has indicated that one of the most common factors associated with clients' non-adherence to homework assignments is their lack of understanding of the task *per se* (Mazzulo, Lasagna & Griner, 1974). Therefore, tasks ought to be discussed with clients and therapists should ensure that clients are knowledgeable about how to carry out the assignments; possibly working together examples of the assignment during therapy itself. Besides, tasks should be reasonable and graded depending on the clients' abilities, environmental factors and level of motivation.

The second aspect to take into consideration is the client. The example mentioned above about Miss A, who was not articulate in her identification of emotions lends some support to this theory. In this example, Miss A needed to work on labelling emotions before she could realize the impact that they had on thoughts and vice-versa. Another aspect worth considering is the clients' intellectual development and their presenting symptoms. For instance, Miss B's (mentioned above) rumination was a confounding factor for our work together especially since she was already prone to think and worry a lot. Taking into consideration these aspects is essential for the usefulness of homework.
The third component of this model and one which has been found to be more strongly associated with homework adherence is the therapist (Detweiler & Whisman, 2005). It appears as though the competence of the therapist has a significant impact on the clients' likelihood of adhering to homework assignments. Edelman and Chambless (1993), for example, found that clients were more likely to adhere to homework if they sensed that the therapist is competent and self-confident. Other important aspects worth consideration are the therapist's awareness of their own personal beliefs about the client's ability or therapeutic goals and the quality of the therapists' responses to the clients' work (Detweiller & Whisman, 1999).

This model is especially interesting because, by taking into consideration these three aspects it also acknowledges the importance of the therapeutic relationship. Echoing other the contribution of other authors (e.g., DiMatteo & DiNicola, 1982), Detweiller and Whisman (1990) stress the importance of fostering a collaborative relationship with clients. They claim that 'if the client does not feel trust in the therapist, or perceives himself to be a passive recipient of the treatment, adherence is less likely to occur' (p. 278). The model manages to capture different aspects that have been associated with homework adherence and combine them in order to enhance our understanding 'of how to successfully assign and review homework in therapy' (Detweiler & Whisman, 2005, p.222) in order to enhance clients' benefits from therapy.

**Conclusion**

This paper attempted to discuss the role of homework in cognitive behavioural therapy. It attempted to locate homework within the CBT model paying particular attention to the therapeutic values and practice of practitioners in general and counselling psychologists in particular. All in all, this paper highlighted the aspects about homework that have implications for a good therapeutic relationship. Hence, it echoes the recommendation of different research studies and other contributors to the field of the cognitive behavioural approach to pay attention to difficulties arising in the relationship and the resulting non-adherence, suggesting that the latter could be an indication of the former. Ignoring any of these aspects is likely to hamper the client's journey of change. Attending to the
therapeutic relationship and focusing our attention on its needs, is likely to improve the client's ability to change and to adhere to homework.

As a concluding remark I would like to refer back to the 'car' metaphor by Wills and Sanders (1997). Therapeutic change could be thought of as the destination that a client may decide to drive towards. Homework, on the other hand could be conceived as the map towards that destination. The route is continuously revised according to the passenger's (the client) needs in collaboration with the driver (the therapist). However, depending on the condition of the vehicle (the therapeutic relationship), the driver will have to continuously appraise the journey depending on such aspects as the suitability of the road and the speed with which to drive.
References


THERAPEUTIC PRACTICE DOSSIER
INTRODUCTION TO THERAPEUTIC PRACTICE DOSSIER

This dossier relates to clinical practice. It contains brief descriptions of my placements with information about the type, origin of referrals, and duration of therapeutic work. All my placements took place within the National Health System (NHS).

Subsequently, I shall present my 'Final Clinical Paper' which provides a description of my current stage in professional development and an overview of salient aspects of my experience so far.
DESCRIPTION OF CLINICAL PLACEMENTS

First Year Clinical Placement – (September 2005 – August 2006)

For my first year placement, I was working in a primary care counselling service at a primary care setting. This service was part of a primary care counselling service catering for different general practitioner practices in an urban area around London. It employed a number of psychologist and psychotherapists. Clients were mainly referred through GPs for a number of reasons including low-self esteem, difficulties in interpersonal relationships, bereavement issues, depression and anxiety. Within this service, psychological therapy was being provided on a short-term (6/8 sessions) basis to adult clients presenting with difficulties of different type and intensity.

During my honorary contract with this trust, some changes took place in the service. The primary care counselling service of different GP clinics was been amalgamated with other psychological services already existing in the community in order to have a more holistic provision of service. A centralised system of assessments was set in place where all clients were being assessed for all services and, only later, assigned to a particular service. Even though laudable on many fronts (e.g., providing a wider scope for assessment), this change created some friction between the departments especially in primary care which had to deal with a greater influx of patients. This placement allowed me to get a glimpse of financial politics in the National Health System (NHS) which had both negative and positive implications on practitioners.

In this placement, multidisciplinary liaison was mostly limited to correspondence with general practitioners (GPs) about each client after an assessment and after the full cycle of ongoing therapy. As a trainee counselling psychologist my main duties included conducting assessments, providing short-term psychological one-to-one therapy and attending weekly one-hour supervision.

The system involved patients being put on a waiting list after being referred for therapy. After an initial assessment, which would take place approximately two months following
referral, and if deemed suitable for short-term work, clients were put back on the waiting list until they could be seen by a psychologist or psychotherapist.

Throughout the year, my theoretical approach was predominantly person-centred and I gained experience of working with this model in a short-term framework. However, I was also able to combine some psychodynamic reflections to my work through the assistance of my first supervisor who was mainly trained in psychodynamic theory. This also allowed me to extend the number of sessions up to 12 sessions for one or two clients.

Due to personal issues, my first supervisor had to leave the service and I was then supervised by an integrative senior psychologist who encouraged me to use different models and theoretical perspectives in my work with clients. Hence I was even able to incorporate my systemic thinking and to start experimenting with some cognitive-behavioural techniques (such as homework assignments and relaxation exercises). On the continuum between eclecticism and integration, my practice throughout this year was more eclectic since I was using specific models depending on the client’s presentation (e.g., using the CBT protocol for anxiety with a client presenting with panic attacks). I appreciated having a glimpse of the different models because it also provided me with insights about the different values laying at the foundation of the different theoretical approaches.
Second Year Clinical Placement – (September 2006 – August 2007)

Individual work

My second year placement was in a primary care Counselling and Psychotherapy service in another area around London. Similar to my first year placement, the service was designed to offer time-limited psychological therapy (usually spreading over a maximum of twelve sessions) to patients presenting with mild to moderate problems.

After being referred, patients were assessed by one of the therapists. Depending on the severity of the presenting problem, patients were subsequently offered weekly sessions with a therapist for a maximum of 12 sessions. Contrary to the previous placement clients were not put back on the waiting-list but offered therapy after the assessment providing that they were suitable for short-term work. This had both positive and negative repercussions. Indeed clients appreciated the fact that the therapy occurred as a continuation after the assessment and that they were not put back on the waiting list. From a practitioner’s perspective, this was also beneficial since it did not require to re-assess clients after an initial assessment and hence, risking to give mixed messages about the role of assessment in therapeutic work (which, was often the case in the previous placement). The negative aspect of this system was related to the time the length of the waiting list because there was no ‘buffering’ assessment which would differentiate the clients for whom the service was suitable and those who needed other types help. Most of my clients had been waiting approximately 4 to 6 months on the waiting list prior to receiving treatment. This coupled with the fact that the surgery was situated in a very deprived area (where people were less likely to be able or interested in attending regularly), could have been the cause for a relatively high number of clients who failed to attend the sessions when they finally were called in.

As a trainee counselling psychologist my main duties were basically the same as before and included conducting assessments, providing psychological one-to-one therapy from a psychodynamic perspective and attending weekly one-hour supervision. Given the presentation of some clients and my supervisor’s interest in long-term work, I was able to see three clients for longer-term work (up to 20 sessions). The joint decisions for
extending the work were based on a rationale hinging on the clients' presenting problem and their assessed needs.

*Family Therapy Service*

My work at the Family Therapy clinic involved participating in a reflective team and occasionally seeing a family as a main therapist. This was a tertiary care specialist service for people with moderate to severe mental difficulties. Patients usually presented with a variety of problems including long term depression and anxiety, personality disorders, and psychosis. Referrals were received from other professionals within the trust (including GPs, consultants and other professionals in CMHTs).

The reflective team offered multicultural and multi-disciplinary perspectives. Our responsibilities included offering assessments, consultations and therapy to people from different ethnic and cultural backgrounds. We aimed to offer a systemic-based formulation of the presenting problem and an identification of damaged interactive patterns in the relationships of the client. Another objective was to reach a relatively common, systemic understanding of the problem from different, yet, mutually comprehensive perspectives. At times, other professionals (e.g., physiotherapists) working at different levels with the patients and their families were involved as well. Appointments were usually held every 2-4 weeks. The number of sessions to be held with families depended on the severity of the problem and the family's willingness to engage in this type of therapy.
Third Year Clinical Placement – (September 2007 – August 2008)

In my third year placement I worked again in primary care. The general practice surgery comprised of approximately 50 workers from different professions. The number of referrals to the psychological services of the surgery was high given that 15 GPs were working at the surgery and referring to our service.

The client group at this surgery was multi-cultural and diverse. Most of the GPs consulted with our service prior to referring clients in order to clarify whether specific clients could benefit from psychological help. Clients could receive therapy for a maximum of 8 to 12 sessions. Owing to a Cognitive Behavioural Therapy (CBT) perspective a number of protocols could be used depending on the main presenting problem of the clients. These were adjusted for short-term work. On the whole, clients were receptive to this kind of treatment which involved different tasks such as homework assignments, and behavioural experiments amongst others.

My main duties were the same as before and included conducting assessments (idiosyncratic conceptualisations in CBT), providing psychological one-to-one therapy from a CBT perspective (utilising different protocols depending on the assessment conducted in the beginning of therapy), and attending weekly one-hour supervision. In this placement I was responsible for my own caseload and I was able to extend the number of sessions with a client if deemed necessary. Obviously, I would still consult with my supervisor on these matters.

In addition, I was also involved in psychological meetings that occurred every four months in order to discuss referrals, the situation of the service and such issues as the screening and assessment of clients to determine their suitability for therapy. These meetings were attended by the psychologists, the GPs, the nursing staff and a representative from management. The multi-disciplinary perspective was very helpful in this context especially since it contributed to a more collaborative handling of the service.
A JEWELLED TAPESTRY: LOOKING THROUGH THE KALEIDOSCOPE OF MY EXPERIENCES AS A COUNSELLING PSYCHOLOGIST IN TRAINING

Brass Kaleidoscope

My daughter raises the smooth brass kaleidoscope and watches as coloured glass slivers conspire together. New worlds create themselves before her eyes. Garnet spires flirt with sapphire and turquoise. Topaz and amethyst meet in harmony, a selenic mystery. A melody of stars singing a tune only she can hear. Eclectic patterns shiver and shimmer then splinter, sparking off at tangents of tourmaline and jasper. An image complete in itself.

I had a kaleidoscope once. Sometimes I still see oblique patterns.

Slowly my daughter turns the wheel, finds a jewelled tapestry to her liking, and hands the kaleidoscope to me. For a time I see the world she sees and it is good.

Dale Harcombe (1990)
As I stand here, immersed in my own thoughts, several ideas float through my mind. Some hang on: twisting and turning, developing and becoming clearer. Others remain pale, shrouded and amorphous but, invariably, leading to other ideas and insights. I wonder how to make sense of it all and, most importantly, how to deliver this to you, the reader. In many ways, my experience as a developing counselling psychologist reminds me of a kaleidoscope I had as a child. To a large extent in this paper I am the person behind this kaleidoscope of experiences. As I turn the wheel to find the jewelled tapestry of my liking I get absorbed in thinking how to explain what I see to you. I cannot but wonder how what I choose to attend to and describe, is tainted by my own perception of your expectations from a doctoral student in counselling psychology. The beauty of a kaleidoscope lies in the fact that it reflects a picture that is potentially ever-changing, allowing for different patterns and scenarios. Similarly, the way I perceive who I am in life, personally and professionally, is constantly changing and transforming itself. However, for the time being, I invite you to stay with me whilst I describe what I see about my own development at this point in my life. I will do this by relating a story of how I came to own this kaleidoscope.

Finding the Kaleidoscope

That day it was grey and rainy outside and my other toys looked lifeless and uninteresting. So I ventured in my grandparents' box room and opened the closet. I knew that my mischievous uncles had not left much to play with but maybe... and there it was: a discoloured brass cylinder lying among dozens of broken toys and clutter.

I have often tried to identify the time when I started thinking about counselling psychology as a career. Similar to the chubby, untrained hands of a child holding a new toy my thoughts jump clumsily on different experiences which, although not pivotal, have contributed to my desire to walk down this path.

I have always harboured a surreptitious fascination with the field of medicine, possibly owing to my mother's passionate descriptions of her work as a nurse. Yet, as I grew up
and became more aware of the different emotional states that could characterise human existence, medicine lacked explanations that could engage or, indeed, quench my curiosity. Owing to my increasing desire to understand more about myself and others, I chose to read psychology at university. By the end of my first degree I had set my eyes on clinical work with clients especially from a counselling perspective. Unsurprisingly though, direct contact and work with real clients often felt too crude and murky after the sophisticated theories and examples found in text-books.

My first paid job after leaving university was in a residential home on a pilot project for therapeutic intervention for adolescent boys with emotional and behavioural problems. The clients I was working with were coming from very difficult family environments and the majority had been in residential care for most of their life. Although not officially stated, the residential home was often a place for ‘rejects’ (boys whom no one wanted around), a political alternative to a prison, and a place for potentially aggressive adolescents. As documented in different literature (e.g., Coyle, 1997) and developmental theories, adolescence is a time of upheaval and uncertainly requiring a re-evaluation of the self (Coyle, 1997). The clients’ problems were augmented by other difficulties, including family feuds, mild substance misuse and parental mental health. Being a young professional myself, and relatively inexperienced in my own life, I started to wonder about other aspects of myself as a professional, such as my gender, culture and personal beliefs and how these affected my work and others’ perception of me. Hence, I started becoming more self-reflective.

My work with this client group was intense and often emotionally painful. I regularly struggled with creating a working alliance robust enough not to be annihilated by our reciprocal misinformed perceptions of each other. For instance, I still remember my initial discomfort at their evident difficulty to integrate my professional role to their perception of me as a woman, which for many of them did not mean much more than being a mother, carer or sexual partner. Going beyond these factors took time and patience but, in turn, they encouraged me to question the source of what I considered to be ‘general knowledge’ and lending myself more openly to a true understanding of the clients’ frame of reference. Furthermore, I had come to appreciate the value of ethical
practice such as the importance of boundaries, the awareness of one's limitations and the significance of congruence in therapeutic work. Nowadays, I realise how much my practice is still constantly pivoting on these pillars. Another key learning point was the ability to sustain human contact with a 'wounded' person. Anderson and Goolishian (1992) suggest that clients appreciate the human touch of the therapist: their warmth, ability to engage and their ability to demonstrate attention and interest. The most significant interventions would often take place around a cold glass of orange juice after painful (but not infrequent) experiences such as a missed family visit which would often leave the clients feel abandoned and unwanted. Working with these young adolescent males and the pain that they were often unable to articulate was pivotal for my next job which came about unpredictably for me.

Due to financial and political constraints this programme was closed after two years. I was very affected by this decision because I felt that, as a system, we had let our clients down especially because most of them had to go in independent living prematurely. Due to a shortage of job opportunities in clinical work for psychology graduates, I found myself relocated to a social work position initially in a Looked-After Children Team and subsequently in Child Protection Services. I admit feeling rather dispirited by this professional change: by the baggage of unfinished business from the residential home and by my lack of familiarity with social work practices. I experienced a shift in my work ethos since I started operating from a crisis or need basis around much more practical issues. Yet, as months rolled bye, I started integrating my knowledge of psychological theories in 'my' social work. Most often my intervention was not only related to the children per se but also to people and professionals in their environment. At the same time, I had also started following a course in systemic family therapy which helped me make sense of system pressure, patterns of relating and different professional perspectives.

Since my new job revolved around abuse and trauma in infancy and childhood, I often felt devastated after witnessing the physical and emotional effects of child abuse. Notwithstanding regular supervision, some aspect of vicarious traumatisation seeped in my life; a very common reaction for professionals working with trauma or abuse victims
(Hernandez, Gangsei & Engstrom, 2007; Weingarten, 2003). I remember a time where I was contemplating not ever having children because the world seemed too dangerous and treacherous. Dealing with these aspects was a slow process of gradual personal development and discovery. I felt that I had regressed back to childhood where I could not draw the line between playtime and study time. Similarly, in my first years of practice, I struggled to keep my personal life separate from the 'clutter' and pain I experienced at work. However, in retrospect, I feel privileged to have had these experiences because, given the number of clients who present with child abuse issues, I feel I can understand better what they may have experienced. Besides, this experience also allows me to understand better the effects of the system on victims and perpetrators alike.

Moving on

After contemplating what to do with the new 'thing' I decided to go and ask grandma about it. When I asked her she smiled, went to the cupboard and took out some cleaning stuff. When she had finished, the 'thing' looked all shiny and precious. She explained that it was a 'kaleidoscope'. Then she instructed me to close one eye and look through the cylinder using the other eye. She explained that I needed to turn the wheel and then asked me to explain what I was seeing.

Drawing a comparison between my discovery of the kaleidoscope and my discovery of counselling psychology comes easy to me. Similar to myself 'contemplating' the new unnamed toy, my work experience had only given me snapshots of the profession of counselling psychology. My grandmother's role in this case was played by the course: its structure, process and content; all of which endowed me with a mixture of excitement, happiness, fear and sadness. The course defined my career and allowed me to discover what could lie ahead.

I admit that the initial reaction on starting the course was not as positive as I had imagined. In a discussion about a work with a client from a different cultural background, Eleftheriadou (1997) describes the loss of cultural attachment. He explains that '[t]he loss experienced is of the familiar family, culture and environment milieu to
something which is not only new, but can often feel very hostile, rejecting and even continually persecuting’ (p.59). This represents very well my initial reaction. Not only had I changed country, but I had changed roles, environment and also culture. Unpredictably, one of the most bizarre feelings was that of becoming a student again without a personal income and hence the relative lack of self-sufficiency. I had assumed that my 16 previous years in full-time education would have made the transition smoother. However, I was in for a big surprise. Another difficult aspect was living in university halls for three years, which although exciting, also meant that I had to give up some of my independence. I felt very confused at this point and I described feeling as if I had been ‘uprooted’. I later came to appreciate more this experience because it allowed me to glimpse at the meaning of unexpected change in people’s lives especially as a result of loss, trauma and psychological conditions such as depression. My enrolment on this course paradoxically provoked similar discrepant feelings because of the losses and changes it entailed. One may perceive this comparison as far-fetched and presumptuous. Yet, I believe that it gives me some understanding of the intricate and powerful feelings one may experience even in situations where the change is predictable and truly desired such as the case of post-natal depression. I will now proceed to explain my relationship within the course practicing as a counselling psychologist in training.

**Mastering the wheel – Combining knowledge, skill and process**

*The wheels at the base of the kaleidoscope were dusty and stiff. The dust went off easily but the wheels needed oiling. Nevertheless, the delicate kaleidoscope refused to be hastened in coming back to life so we oiled it slowly and respectfully. By then, we had become used to the familiar squeak caused by tiny movements, until... all of a sudden there was silence and the jewelled tapestry transformed gracefully and silently.*

I associate the three therapeutic models I learnt about and practised during the last three years to the wheels at the end of the kaleidoscope. Having worked for four years prior to enrolling on this course and having practiced within other frameworks, my knowledge of the person-centred approach, psychodynamic models and cognitive-behavioural therapy
was faint and muddled. Throughout the course, I have tried to ensure treatment integrity (Perepletchikova & Kazdin, 2005) for each therapeutic model in order to gain a clearer understanding of each model’s phenomenological stance, beliefs about change and compare it to my personal style. Depicting this as an easy process would be unfaithful to my actual experience. Indeed, although I was very comfortable working from a person-centred perspective and was looking forward to learning about psychodynamic theory and cognitive behavioural therapy (CBT), I had my doubts about how I could assimilate the latter two because of the popular negative stereotypes attached to them which clashed my personal philosophy.

The hardest times came punctually at the beginning of each academic year where I would feel utterly deskilled and unprepared. Hence apart from dusting away the grime of stereotypes and lack of familiarity, I had to metaphorically ‘oil’ my knowledge of the models by reading and learning about the models as neutrally as possible. Nowadays, I do not necessarily call myself an integrative counselling psychologist but I am aware that I integrate models in my work depending on the client’s needs and stage in therapy (Hollanders, 2000; 2003). I imagine myself integrating models as far as they coexistmeaningfully in parallel even if they never intersect each other; as long as they still make sense for the therapeutic formulation and therapeutic work. I will now illustrate which theoretical aspects have fascinated me in each theoretical model and how they have played a part in my therapeutic work.

**The person-centred approach**

As mentioned earlier, the person-centred model feels comfortable and familiar because it comes closer to my own personal view of the world and of people, in that, it professes that human nature is intrinsically good (Gordon, 2000; Thorne 2003). As a reader you may wonder how this is possible given my work experience with perpetrators and aggressive individuals. My experience has also taught me that people’s good nature (organismic self) is often thwarted by difficult life experiences and circumstances posing what Rogers calls conditions of worth on the individual (Thorne, 2003; Wilkins 1999). Connecting to the clients’ pain is difficult but, in a way, refreshing and less judgemental than compartmentalising them according to what has gone wrong. Whilst not condoning
any behaviour that brings pain to others, I believe that judging people as innately bad would offer too simplistic and unhelpful an explanation. This model also felt more accessible since I had a relatively good understanding of the core conditions of congruence, empathy and unconditional positive regard which are at the heart of this model (Rogers, 1957; Mearns & Thorne, 1999). Various studies have shown that the core-conditions identified by Carl Rogers (1957) are somewhat correlated to a positive outcome (Kirschenbaum & Jourdan, 2005). In this model the therapist is actively attempting to make use of the relationship in order to explore the clients' social and emotional reactions and in supporting their self-actualising tendency. Hence attending to the health of the relationship is paramount. This became very evident in my work with Mr. X (names are fictional to protect clients' anonymity), a 20-year-old client I met in the first year.

Mr. X was very distressed when he came for therapy because his relatives and friends had just discovered that he was gay. He had managed to keep this hidden for many years whilst having 'serious' relationships with girlfriends but also leading quite a parallel promiscuous life as a gay man. One can easily frame this position as that of the divided self in person-centred terminology where his life as a heterosexual man would represent the conditioned self whilst the underlying homosexual feelings resulted from his organismic self. His coming out had been dramatic because, on learning about Mr. X's sexual preferences, his male heterosexual flatmate had 'thrown him out' of their shared flat and informed Mr. X's family and friends. People had started avoiding him and his request for law enforcement support in order to get his belongings back from the flat he had shared, were in vain. Using acceptance and unconditional positive regard in this case came very natural to me. However, sometimes my attempts at empathising with Mr. X seemed to clash with his irony and distrust. At the beginning of therapy Mr. X was very clearly sceptical about the use of therapy and this could have been exacerbated by what Rogers (1957) called incongruence, that is, the perceived discrepancy between what one feels naturally and organismically and what one is constrained to believe due to social pressures. Being let down so badly and by so many people, also weighed on our relationship and on his self-esteem. The person-centred model was very helpful in his therapeutic development because he was allowed space,
time and a right to make decisions about when to take the lead. My congruence and unconditional positive regard allowed him to start shifting gradually his locus of control and become more trusting of his own feelings and ways of defining himself (Mearns, 2003).

Similar to my exploration of the first ‘tapestries’ in the kaleidoscope, I was fascinated by the many ways in which the core conditions combined to produce such a welcoming space for the clients’ self-actualising tendency. Realising, all of a sudden, that the kaleidoscope’s incessant squeak had gone could be paralleled to my acquisition of the skills (of genuineness, congruence, unconditional positive regard and empathy) which needed oiling and practice until gradually they started becoming more natural to me. Just like the movements of my hands on the wheels of the kaleidoscope, the more I practiced these skills, the smoother the patterns changed and colours merged.

**The psychodynamic approach**

For the reasons already mentioned, I was eager to learn about psychodynamic theory. However, as hinted above, my ‘attachment’ to this model was not straightforward. I believe that, in a way, my attachment developed according to a series of phases identified by Bowlby (1969) in relation to the development of attachment styles in children. The process started with me becoming open and theoretically ‘drawing near’ to the model by reading and listening to lectures (Bowlby, 1969). Then, I learnt to associate the model (attachment figure) to some comfort and safety when it allowed me to make sense of feelings and bodily reactions occurring in my work with clients. For instance, after the sessions with Mr. X, I was often left feeling very tired and heavy with a sense of hopelessness. Initially, I attributed this to my fear of him committing suicide (since he had already attempted it once before) and to my empathic attunement to him. It was only after months that I had finished working with him that I realised that the feeling of hopelessness (so typically unnatural to me), was possibly my response to his projective identification which may have felt unbearable to him and which he therefore needed to get rid of by projecting it to me.
As a trainee, I found a lot of reassurance in the many fields in which psychodynamic theory has been extended and explored. The next step according to Bowlby’s theory of attachment would require me to have learnt to utilize psychodynamic theory (the attachment figure) as a secure base to explore new territories of client work. I am not sure whether I have managed this stage completely because, admittedly, I still find the ground somewhat unsettling when it clashes with my own instinct and intuition as a therapist. For example, I am quite hesitant when offering interpretations to clients especially when I feel that they are overly dependent on other people’s way of seeing reality. Furthermore, as thoroughly explored in my second year supervision, my empathic ‘self’ is sometimes uncomfortable with the silences and the fairly detached position required in psychodynamic psychotherapy. Although dealing with such dilemmas is somewhat strenuous at times, it often opens worthwhile possibilities and alternative formulations of the client’s difficulties. An example could illustrate this difficulty further.

I met Miss A in my work at a primary care setting in 2006. She was referred due to low mood and recurrent panic attacks after a protracted severe physical illness. She was experiencing several symptoms including frequent and unpredictable ‘black-outs’, poor memory and low concentration. Several medical tests had been carried out and all of them indicated that there was no organic cause for her symptoms. From a psychodynamic perspective I wondered whether her symptoms could be a reflection of denied underlying emotions and whether they could be a sign of regression to an infantile state of complete ‘somatic expression’ (Garland, 1998; Zalidis, 1994). Miss A’s childhood history suggested that she had developed an ‘ambivalent’ attachment style (Ainsworth et al., 1978). This was playing a part in therapy where she would be extremely suspicious of my motives behind certain questions and yet continuously craving my attention. Similarly, she seemed to have a pattern of being attracted to men who were very controlling of her but, at the same time, not available for appropriate support. Miss A had also started to engage in a pattern of absenteeism from sessions where she would miss a session every fortnight. I interpreted these absences and the frequent silences during the session as possible signs of defences. Blumenson (1993) suggested that silence constitutes a defense against a patient’s perception of a hostile
world. Creating a balance for my intervention with Miss A was often very tricky. I did not wish her to feel persecuted and I was inclined to be empathic with her wanting her to feel listened to. Yet, any such attempt used to be downplayed and sabotaged from her position.

Providing Miss A with a containing environment that could contain her anger but also providing enough support to the part of her desiring change, was a difficult balance to strike. My understanding of systemic family therapy with her was also very revealing in my attempts to understand how her symptoms had managed to preserve the 'homeostasis' of this ambivalent way of attaching to people and how this same dynamic could be re-enacted in therapy as well (Bor & Legg, 2003; Bott, 1990, 2000; Minuchin, 1976). In my work with Miss A, I found the concepts of 'holding' and 'good enough mothering' as described by Winnicott (1953) necessary for my understanding of her change in therapy and for the therapeutic relationship (Holmes, 1999). Hence, my aim in therapy was to 'attune' my self empathically with her needs in order to provide the necessary holding. Several sessions later, Miss A stopped complaining about her symptoms and finally was attending her sessions regularly. By the end of our sessions together she was much more tranquil and content.

Turning back to my metaphor of the kaleidoscope, I associate my experience when I first noticed some dents in the wheels and some scratches on the brass cylinder with my acquisition of psychodynamic skills and theories. Cleaning the kaleidoscope necessitated particular caution in these areas. My hands would invariably rest on those dents created many years before. However, in order to move the wheels smoothly I had to train my hands to add a quick jolt to my turning when the movement of the wheels got stuck. Similarly, with my experience of psychodynamic theory, the more I learnt about the 'dents' in people's lives, the more I learnt about the way I needed to deal with them in order to have a smoother therapeutic 'movement'.

The cognitive behavioural approach

The shift to a cognitive behavioural therapy (CBT) brought perplexing feelings. In many ways it felt dry after psychoanalysis due to the strict adherence to protocols and models
for each presentation. Indeed, one of the initial difficulties I had to face was the apparent obligation to assess clients and ‘diagnose’ symptoms. Yet, for a trainee who approached a new model, the availability of protocols and models of therapeutic work was very reassuring and ‘containing’. The available number of studies advocating the rapid response and success rate of CBT (Wilson, 1999) also suggested that it could be a very useful asset in my development. Thanks to my supervisor, I have been able to work in a very pure CBT way and although challenging, I realized that this model is much more complex than I initially believed. Again, I found myself ‘oiling’ my memory of the basic assumptions in CBT and building on a clearer understanding of the model by reading and observing my supervisor’s work. Although I cannot consider myself an expert in the model, I feel quite proficient with the CBT protocols existing for different client problems. As a practitioner I realize that there is a point of contention between the advantage of being able to use a model for time-limited therapy and the limitations often caused by narrowing clients’ difficulties to one diagnosis. My work with Miss H. can illustrate this further.

This client was referred due to her long-standing hair pulling habit which she had been finding extremely distressing. An investigation of her symptoms suggested that she could be diagnosed as suffering from trichotillomania (TTM), an impulse control disorder according to the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (1994). The cognitive behavioural approach views the person’s experience as a by-product of the interaction between cognition, emotions, behaviour (Beck, Rush, Shaw, & Emery 1979; Rudd & Joiner 1995; Wills & Sanders; 1997). Hence my work with Miss. H involved me conceptualising TTM as a by-product of this interaction. This was very helpful for Miss H. Following a particular treatment protocol of TTM (Mansueto, Golfinger-Golomb, McCombs-Thomas, & Townsley-Stemberger, 1999), we initially identified all the behavioural stimuli related to her habit and then those related to her cognitions. Through cognitive intervention and personal motivation Miss H managed to reduce the extent and frequency of her habit significantly. However, as treatment progressed, I became more aware that her need to control everything and her perfectionist tendencies were still very strong. Work on these aspects from a CBT model appeared to be restrictive and in some way, the model and its attention to
detail appeared to be colluding with her need to control everything. The fact that we were able to speak about this and that we were also able to discuss the transference re-enacted in the room was very important. Rudd & Joiner (1995) suggested that taking concepts of transference and countertransference purely in their psychodynamic sense could be problematic for CBT treatment integrity. Hence, I conceptualised these phenomena from a CBT perspective and explained them in terms of her core-beliefs that could be re-enacted within therapy. This enabled me to provide a more model-consistent representation of what was going on (Rudd & Joiner, 1995).

In conclusion, I believe that every model has provided me with techniques and perspectives about how to formulate the difficulties presented in client work. I find myself seeing these three models, together with the systemic model (which often also informs my thinking), as parallel lenses with different patterns through which to look at my work.

Looking in the kaleidoscope

Weeks after the 'discovery', I was still fascinated by the kaleidoscope. I would sit next to my grandmother peering down the brass cylinder for hours discussing what I saw. Although I had become used to the sequence of patterns and colours, they never became boring. With every conversation, every pattern and every colour came a new tapestry and if I looked close enough...a new perspective.

Throughout my experience on this course, I have often found that my grandmother's part was being played by my supervisors and my personal therapist who have handled much of my 'newly found' knowledge with care and patience. With their input they enriched my work and helped me 'name' some processes I was experiencing.

In my first year on the course, I was working in a primary care setting with Mrs P, a woman in her forties who had been referred due to symptoms of depression. The triggering event appeared to be the discovery of her husband's unfaithfulness with a younger woman 'with thick dark hair'. When I took this client to supervision the supervisor commented that even though this woman's story was objectively painful, she
felt unable to subjectively connect with the pain and almost felt annoyed and frustrated. After overcoming the initial surprise, I realised that my supervisor had just described what I had been feeling all along with this client. I had been unable to connect with the pain and had sensed her hostility ever since we started therapy. As a result, I had often felt incongruent in my work with her. My supervisor had used her countertransference to enable a process of discovery. Marshall (1996) points out that ‘the supervisor’s emotional response can be helpful and facilitating to the course of supervision and therapy, just as we believe that the transference of the therapist can be of use’ (p. 79). Being able to verbalise this, lifted the veil of confusion I was experiencing. My supervisor also commented about the fact that, in many ways, I resembled Mrs. P’s description of the woman with whom her husband had been unfaithful. Indeed we were both younger than the client and we both had ‘thick dark hair’. My supervisor explained that in the transference, I had become a dangerous rival for Mrs. P; hence her difficulty to trust me and be vulnerable in our sessions. Realizing this was very revealing to me. I had been unaware of the effects of transference and seeing it re-enacted in the session and in the supervisory relationship allowed me to approach it with expectation and fascination.

My second year supervisor continued to help me understand aspects of the therapeutic relationship which were shrouded in unconsciousness. He was especially helpful in teaching me how to reflect in therapy and how to find the space I needed in order to think even when clients were overly talkative and dynamic. Indeed, I often tended to be drawn in the client’s rhythm in the session and, as a result, I often felt unable to connect with myself and with what I was feeling. As I was allowed to observe him on some assessments, I noticed how he would often allow silence in the session and regularly look away from the individual. In contrast to my dramatic expectations of what could happen if clients are not responded to promptly, his demeanour appeared to facilitate the therapeutic alliance (Harris, 2004; Lane, Koetting & Bishop, 2002). Initially, I found my imitation of his behaviour quite daunting and difficult. It took me time to be able to relax and be able to be silent and look away from the client in the session. This offered me many possibilities. The supervisor facilitated my learning but, most importantly, he was patient with my difficulties and was receptive to my own therapeutic style.
I gave these two examples as practical illustrations of two important lessons learnt through the process of supervision. Another complimenting aspect for supervision was personal therapy which has shed light on my personal story and professional narrative. Notwithstanding the compulsory nature of personal therapy and the frequent financial and emotional strain it entailed (Macaskill & Macaskill, 1992), it has been one of the most reliable sources of support. During these three years I have had the possibility to undergo long-term therapy and to build on my short term therapy I had in the past. With hindsight I realise that amongst the many benefits of personal therapy, it has been instrumental in four main areas. Firstly, as suggested in literature (e.g., Macran, Stiles & Smith, 1999), it has encouraged me to use my personality in therapy. My therapist modelled a style that allowed me to see her as another person behind the techniques and the various interventions. This encouraged me to be ‘myself’ with clients and accept my feelings whilst bringing them more into consciousness. Secondly, therapy has been helpful in reminding me that boundaries with clients ought to be appropriately permeable: neither too porous, nor too insulated. Thirdly, through observing my therapist’s ability to make me feel supported whilst refusing to rescue me when I needed to connect with difficult feelings, I learnt to do the same with my own clients; hence suggesting to them that I trust in their ability to face difficulties (Macran & Shapiro; 1998). Finally, through my own experience in therapy and my therapist’s ability to detect and reveal unconscious material, I learnt about how transference and countertransference issues are acted out in therapy.

Similar to how my grandmother listened to my narratives, these professionals have all been instrumental in allowing me to experience the anxiety of closing one eye and to look curiously into different models of therapy. They have done so with a lot of respect and care for who I was becoming and for the people I was meeting in therapy.

**Concluding Remarks**

Dear reader, writing this essay has not been as smooth a process as I was expecting it to be. Because the definition of myself as a person and as a professional is constantly changing, writing about who I perceive to be at this point has sometimes felt unduly
restrictive. At the same time, however, I have discovered a valuable experience behind the initial pale, shrouded and amorphous story. Indeed, this essay represents a movement towards a very desired yet feared ending: that of a course which has been responsible for so much development and challenges in my personal and professional life. Here I find it worthy to refer back to a journal entry I wrote at the beginning of this course after having discussed 'endings' in class: 'notwithstanding the desired changes that this course promises to bring, I am also aware of the chapters I am constantly closing and this makes me sad...'. At this point I am aware of experiencing the same emotions but somehow they feel different. Maybe I have realised that at the back of a sheet of paper with an ending there is also an introduction to another chapter. After all, even though the kaleidoscope has been buried away in my own clutter for all these years, I can still think about it and take pleasure in the multitude of patterns, colours and tunes it still displays in my mind. Now, having found a jewelled tapestry of my liking, I hand you the kaleidoscope for you to tell me what you see...
References


INTRODUCTION TO RESEARCH DOSSIER

The research dossier consists of a literature review and two qualitative empirical studies. The literature review explores the impact of body image on adolescents’ quest for self-discovery and identity formation. The second paper develops from the literature review and investigates qualitatively the impact of acne in adolescence. Finally, the third paper investigates the role of risk in supervision from a grounded theory perspective.
LITERATURE REVIEW:

THE IMPACT OF ALTERED BODY IMAGE ON ADOLESCENTS’ QUEST FOR
SELF-DISCOVERY AND IDENTITY DEVELOPMENT

Abstract

Altered body image, coinciding with the period of adolescence, can present particular difficulties for young people in different spheres including the emotional, psychological and social ones. This paper looks into studies carried out with adolescents who perceive an alteration in their body image. An attempt is made at discussing the issues related to identity threat as experienced by the adolescent during this crisis. Although no specific theory of identity development tackles this particular issue, an attempt is made at conceptualizing identity threats related to this situation through existing theories of lifespan development and social psychology. This paper also discusses the ways in which adolescents with altered body image may be affected as a stigmatized group. All this leads to a discussion about the implications for the practice of counselling psychology. Finally, suggestions for future studies are made in view of the limitations and weaknesses within the available literature.

Keywords: Adolescence; Aesthetic Difference; Altered Body Image; Stigma; Identity; Counselling Psychology.

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1 This paper is being formatted to conform to the notes for contributors of the journal Body Image (refer to appendix A).

2 Refer to appendix B for an example of Literature Search.
Introduction

The endless hours spent in front of the mirror trying to tame that unruly wisp of hair, the roller coaster of emotions, the raging spot punctually erupting on one's face on that special occasion... Most of us look back to the days of adolescence, when all changes seemed to happen simultaneously and uncontrollably, with a mixture of sweet and bitter feelings. Adolescence is often a time when the world turns upside down, when the mythical beliefs of childhood seem obsolete and when the reflection of the body in the mirror is persistently disappointing. Yet, for those adolescents experiencing a change in their physical appearance leading them to feel shameful and stigmatized, the picture may be difficult, possibly bleaker.

It is well known that our physical appearance has profound significance for all of us and in many different spheres of our lives. It is therefore scarcely surprising that the adjustment to the discomfort resulting from perceived aesthetic differences is multifaceted and unsettling in adolescence especially because it is likely to coincide with other physical, emotional and cognitive challenges. Some authors argue that age is not influential in an individual's effort to cope with physical differences. For example, Crocker and Major (1989) explain that the stage in one's life in which a stigmatizing condition is acquired does not pose such a vulnerability factor in comparison with other aspects of the condition. However, most authors would agree that age or one's stage in life when the aesthetic difference becomes evident is very important. Waddel (1998) for instance, claims that 'the challenges of adolescence and its resolution are generally viewed as making a central contribution to a person's future life, in terms of his [sic] character and growth in personality' (p. 127). Consequently, one could presume that the impact of the onset of extreme aesthetic difference may be pervasive and long-lasting if coinciding with adolescence. A theoretical lacuna appears to exist in the available literature about what may be the effects and consequences of acute physical alteration on the formation and consolidation of adolescents' identity. Hence, it is necessary to have some insight about the effect of severe physical change on one's identity and further development in order to broaden the psychological understanding of this experience and provide counselling psychology with a theoretical basis for the work and intervention
with these adolescents. The question presented in this paper is: does altered body image, occurring in the period of adolescence, affect the quest for self-discovery and identity development, and how? It is hoped that the ensuing discussion will stimulate reconsideration with regards to the needs of such adolescents and the services provided to them from a counselling psychology perspective. In order to facilitate understanding in the discussion a definition of the main terms used is necessary.

In this paper, the terms 'aesthetic differences' or 'altered body image' are used to refer to any physical characteristics that fall short of what is ordinarily considered physical 'normality'. Such characteristics would include, but would not be limited to, the social understanding of disfigurement. Excessive weight, for instance, is considered to be an aesthetic difference in most societies but not necessarily a disfigurement. Furthermore, in the existing literature landscape, a major distinction is drawn between disfigurements acquired as early as birth and disfigurements that are acquired later in life. For the purpose of this paper, attention will be given to the latter; specifically, those acquired or coinciding with adolescence. This decision is being made because it is believed that the novelty of body change in adolescence may carry other connotations in the understanding of one's self and identity. The origin of acquired disfigurements can vary. Thus one finds that such disfigurements may be caused by genetic predispositions (e.g., vitiligo), deficiency in the normal physical development (e.g., idiopathic scoliosis), trauma (e.g., accidents), disease (e.g., acne) and surgical intervention (e.g., amputation). All of these may provoke noticeable physical differences. In this paper the term 'adolescence' refers to 'the period that lies psychologically and culturally between childhood and adulthood rather than a specific age' (Bee, 1994; p. 253). This definition seems to be appropriate because it allows for an exploration of the individual needs of the young person as dictated by events and personal experience rather than by specific age brackets.

This paper reviews available relevant studies and research about aesthetic differences occurring or coinciding with adolescence. Theories of identity development will be utilized to explore possible threats and crises that can contribute to the adjustment or later difficulties experienced by people who suffer alteration in their body image in
adolescence. Furthermore, literature seems to suggest that stigma and shame are very much interrelated with altered body image (Lee, Scragg & Turner, 2001). As Garland (1998) explains, ‘trauma touches and disrupts the core of the [individual’s] identity’ (p. 5). Therefore, a section of this paper will present a discussion of the effects of stigma and shame in light of physical differences as experienced in adolescence and as catalysts for possible difficulties with one’s self-perception and identity later on in life. A final section is dedicated to the implications that the ensuing discussion will have upon the practice of counselling psychologists in this field.

Findings Related to Aesthetic Differences Set Off During Adolescence

Various sources of research in the field of physical disfigurement claim that psychological distress seems to accompany severe change in the physical appearance of an individual (Papadopolous, Bor & Legg, 1999). These findings are revealed by studies carried out with different age groups including those with adolescents. It is widely acknowledged that adolescence is marked by an interest in personal aesthetics and body image (Murray Thomas, 1990; Sobanski & Schmidt, 2000a; 2000b). A brief review of some of the studies addressing the effects of facial disfigurement, head injury, excessive weight and sclerosis related to such experiences of perceived physical difference will be presented. Subsequently, some studies focusing on trauma in general will also be presented in an attempt to incorporate other dimensions of physical change.

Studies about Physical Differences

Some literature implies that facial disfigurement or facial malformation may be the cause of major distress for people (Newell, 1999; Partridge, 1990). For instance, studies have revealed that the presence of acne, a condition that seems to coincide with adolescence, seems to be related to psychological difficulties such as depression (Aktan, Özmen & Şanlı, 2000; Smithard, Glazebrook & Williams, 2001). Two studies carried out with adolescent students and focusing on the effects of acne have found some contrasting results in this respect. The first study by Aktan et al. (2000) involved 2657 students
diagnosed with acne. The findings suggested that there was no apparent relation between anxiety and depression, and acne. However, gender and anxiety seemed to be correlated. Indeed, girls reported higher levels of anxiety than boys in this study and, therefore, it was suggested that 'girls may be more vulnerable to the negative psychological effects of acne' (Aktan et al., 2000; p. 356). On a similar note, the second study by Smithard et al. (2001) investigated the degree of psychological morbidity in adolescents suffering from acne. Their study was conducted with a representative sample of 317 students aged between 14 and 16 years. In contrast with the findings reported by the previous study, Smithard et al. (2001) found that participants with evident acne problems presented higher difficulties than those without such a condition and were almost twice as likely to score on the abnormal end of the Strengths and Difficulties Questionnaire. They also found that the more objective the evaluation of acne, the worse the emotional health appeared to be for the participants. From this study it is apparent that young people are likely to misjudge the severity of their acne and thus they fail to ask for the necessary help. Clearly, the results of the two studies have contrasting outcomes. Smithard et al. attempt to explain this contrast between their study and others - including the one by Aktan et al. (2000). They suggest that the difference in findings may be attributable to the different methods being used to collect data (such as the use of different self-assessment instruments) and to the variation in the use of grading besides a possible discrepancy in the diagnostic criteria for acne. Indeed these suggestions seem to be plausible. Moreover, although the findings emerging from the above-mentioned studies are very important because they explore the possibility of correlating acne with psychological distress, they may both present other pitfalls. From a quantitative perspective, the difference in the results may be attributable to the fact that since both studies relied on self-assessments to gather the data, there has probably been a substantial difference in inter-rater reliability. For this reason, it would be interesting to explore the actual experiences of participants from a qualitative perspective since it could give indications about the actual experiences of these adolescents. Indeed, it appears that

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3 The Strengths and Difficulties Questionnaire is a brief questionnaire which can be administered both with the children themselves (if aged between 11 and 16) or with significant others in their life. It aims to enquire mostly about the child's emotional and behavioural difficulties (Goodman, Meltzer, & Bailey, 1998)
the conclusions drawn from these studies lack the in-depth exploration about the actual experiences of the participants. Such aspects are very important when considering the actual implications for the young people themselves and for the provision of services for these adolescents.

Studies have shown that health professionals may overlook the importance of a particular aesthetic condition. Indeed, Clarke (2001a; 2001b) explains that GPs are likely to underestimate the psychological impact of minor disfiguring conditions such as acne because they do not present alarming medical symptoms. Yet, research such as that conducted by Smithard et al. (2001) suggests that acne is a condition affecting the individuals at one of the most vulnerable and weak stages of their life and that ‘there is evidence that both the social and the psychological impact of acne linger in adulthood’ (p. 279). Acne and other ‘minor’ conditions may be unexpectedly distressing for the young person because they provoke reactions from the social environment that are unpredictable and therefore the person is less likely to be equipped with effective coping strategies. When professionals undervalue the importance of the psychological difficulties associated with minor disfiguring conditions, they may also fail to provide and propose the necessary assistance or services.

Other studies have focused on facial disfigurements or malformation and the social environment. For example, research in social psychology has shed light on the attractiveness bias which implies that people are likely to assume that what is attractive is good (Stevenage & McKay, 1999). Other research has also suggested that we tend to make judgements about other people’s personalities depending on their appearance. Such beliefs are at the basis of a lot of stereotypes in society. Indeed, a study carried out by Stevenage and McKay (1999) investigated the effects of disfigurement on recruitment. This study was conducted with 57 professional recruitment personnel and 59 undergraduate degree students on a Business and Administration degree course who would be recruiters in the future. Each participant was presented with a fake application including fake photographs of candidates and they were asked to state whether they would choose the applicant or not. These photographs depicted applicants with (a) facial disfigurement, (b) without facial disfigurement, (c) in a wheelchair without facial
disfigurement and (c) in a wheelchair with physical disfigurement. The results show that having a facial disfigurement has more negative consequences than having a physical disability and that people with facial disfigurements are less likely to be recruited when other variables (such as age and gender) are controlled for. This study presents different limitations. For instance, participants were presented with only one applicant, which meant that they did not have the possibility of comparing different hypothetical candidates. In addition, the participants' awareness of the artificiality of the exercise may imply that they did not have to consider possible aftermaths of their decisions. However, the study still indicates that facial disfigurement affects recruitment. Taken broadly, this finding suggests that stigma about facial disfigurement can have extensive consequences especially on a social level where adolescents find themselves unjustly treated and misjudged. Such difficulties are not exclusively related to facial disfigurement. They seem to be related to alterations in the appearance resulting from other conditions as well.

Psychological difficulties were also reported by a study carried out with 12 adolescents following a severe head injury. In this study Bergland and Thomas (1991), report that the change in physical appearance due to the head injury was reflected in a change of self-image and self-esteem. They found that, amongst other dimensions, these adolescents were mostly affected by a change in physical appearance and a reduction in cognitive abilities and in social relationships. These adolescents also found that a change in other people's response to them after the operation was also significant. Anger and frustration were the most prominent emotions reported by adolescents enduring long-term and evident physical differences after the injury especially in response to being treated as disabled. This study suggests that the way that others perceive and behave towards adolescents with altered body image has a major impact on the latter's lives. It also implies that disfigurement may lead young people to distance themselves from others either voluntarily (social avoidance) or involuntarily (when they are hospitalized for a long time in cases of burns, amputations, etc.). The authors also propose that social distancing may lead adolescents to miss particular 'rights of passage' that are part of their development and thus, they will be disadvantaged in relation to other youth. On considering the relevance of this study in relation to this paper, one needs to keep in
mind that the results from this study are not exclusively linked to physical change. They may also reflect the change in cognitive ability. Thus, other factors may be involved in the effects of head injury as described above.

Excessive body weight and idiopathic scoliosis have been the focus of other studies investigating the effects of alterations in body image. A study conducted by Rierdan and Koff (1997) with 176 adolescent girls revealed that discontentment with one’s body image, due to excessive weight, was related to symptoms of depression. The findings of this study suggest that the psychological (as opposed to the biological) aspect of body image seems to be related to the depressive symptoms. Another study by Rosenblum and Lewis (1999) has stressed the importance of the adolescents' appraisal of their body image and weight in relation to social standards. The findings suggest that the beliefs of adolescent boys and girls about their body go through some changes between the ages of 13 and 15. Girls seem to become more dissatisfied with their body image in this period whilst boys appear to become more fulfilled (Rosenblum & Lewis, 1999). The authors propose that girls at about 15 years of age are likely to have a reduced satisfactory view of their body because of the increase in body mass experienced after menarche. At the same time, they are bombarded by the social standard of the ideal female body which is thin and virtually without curves. The discrepancy between the natural physical changes and the social ideal of the female body may thus give rise to dissatisfaction about one’s image. Gender differences also surfaced in the study about idiopathic scoliosis carried out by Sapountzi-Krepia et al. (2001). The participants suffering from scoliosis were wearing a brace. The findings revealed that the perceived impression of these adolescents' body image was poorer than those of the control group which consisted of adolescents without this condition. Furthermore, it was found that girls with scoliosis had higher levels of dissatisfaction and unhappiness in relation to their perceived body image than boys. Possibly the same factor identified in the previous study, that is, the social ideal of the female body, is also related to the dissatisfaction of these adolescent girls. Similar to other studies mentioned previously, the studies mentioned here have been analysed quantitatively. Possibly, more information could be gathered if these studies took a more phenomenological approach.
In summary, the studies outlined above focusing on altered body image resulting from, facial disfigurement (due to acne, burns, etc.), head injury, excessive weight and scoliosis, suggest that there is an observable difference between the psychological state before the onset of the condition leading to the altered body image and after. Emotional difficulties have been observed in various instances. Besides, these studies have also presented implications and difficulties encountered by people with altered body image on psychological and social levels. Indeed, some studies have suggested that misconceptions about a particular condition (by the client and by the medical professionals) can have a detrimental effect on the adolescent if the necessary help is not sought or prescribed. It is believed that altered body image can be a traumatic event for adolescents. The next section will focus on instances of traumatic onset of altered body image.

**The traumatic onset of physical change**

When the onset of physical change is sudden, other factors may come into play because the young person is unprepared for the resulting physical appearance. A study by DeWitt (1993), for instance, investigated adolescents' experience of rehabilitation after trauma. The sample for this study was made up of 12 adolescents who had experienced physical trauma. The findings were multifaceted and involved a lot of themes mentioned by these adolescents in relation to their recovery. Indeed, one of the main fears reported by these adolescents was the fact that they were uncertain about whether they would ever recover or feel healthy again. Furthermore, in a study conducted with victims of road accidents, Harms (2004) reported that many participants expected to recover completely from the accident. The realization that this was unrealistic and unachievable, often leads to further trauma. DeWitt (1993) claims that, for the adolescents taking part in her research, the question of whether they would have a full recovery provoked doubts about the future and about the changes they had to face. Most of the participants also mentioned feeling less worthy and important because of the trauma. Furthermore, other people seemed to treat them differently as if they had a disability or as if they were not normal any more. Besides, their physical appearance had an impact on their social activities: their relationships with friends, their first attempts to enter an intimate
relationship, finding a job, and so on. Studies focusing on the psychosocial effects of facial disfigurement, for instance, have stressed the fact that social situations may be very challenging for the individual. Such situations often lead to discomfort on a personal and social level with the person experiencing feelings of social anxiety, low confidence, and so on (Clarke & Cooper, 2001; Walters, 1997).

Other studies carried out with different age populations have identified similar themes in the experience of participants. In their paper, Rybarczyk, Nicholas and Nyenhuis (1997) mention five themes that need to be addressed by professionals working with people coping with leg amputation. These themes are a result of different findings elucidated by other studies. They point out that although leg amputation has often been correlated with high levels of depression, it is important to notice that adjustment and coping depends on the person's cognitive appraisal of the situation. Thus, if a person had been suffering prior to the amputation and therefore experienced some relief after the operation, the likelihood of depressive symptoms was much less. Conversely if the person feels that the amputation is restricting one's life, it is more likely to provoke psychological disturbance. The authors also suggest that the developmental stage is a very important variable in adjustment. They explain that since adolescence is a time where 'individuals are more vulnerable to the issues of body image and self-worth' (p.244) their rehabilitation may be more problematic in terms of adjustment. They propose that often, after amputation, people are treated differently by others and often discriminated against: 'the cumulative effect of these attitudes can be a sense of isolation and stigma on the part of the person with disability' (p 246). The research conducted by these authors suggests that people experiencing stigma are likely to experience depressive symptoms as well. Rybarczyk et al. (1997) continue to explain that after amputation the individuals' self-perception changes and they are likely to be embarrassed and shameful about their condition. The authors refer to this as self-shame and explain that this may not be a temporary condition but that it is likely to be carried around by the individual for many years. Again, these feelings were often conducive to feelings of depression.
With this sense of stigma, people in these circumstances also face an increased sense of vulnerability which may lead to challenges to their identity status. This may lead them to over-protect themselves and therefore to distance themselves from others. With the picture presented by the different studies, it is now important to look at the difficulties that may appear in relation to one's identity consolidation occurring in adolescence in relation to altered body image.

**Identity Consolidation in Adolescence**

From a lifespan perspective, adolescence is a time of re-evaluation and of major developmental upheaval (Coyle, 1997). Young people at this stage are particularly sensitive to the way their looks are considered by others (Murray Thomas, 1990). Coupled with the shock and novelty of physical disfigurement, the awareness of failure to match social expectations (as dictated by the media and famous people) can be confusing for one's identity. To the extent that identity confusion is seen as due to foreseeable developmental tasks, it may be discounted, but when it is seen as occurring in conjunction with physical trauma, it may be augmented.

Adams and Marshall (1996), claim that the purposes of identity are five:

1. 'providing the structure for understanding who one is;
2. providing meaning and direction through commitments, values and goals;
3. providing a sense of personal control and free will;
4. striving for consistency, coherence and harmony between values, beliefs and commitments;
5. enabling the recognition of potential through a sense of future, possibilities and alternative choices.' (p. 433)

At the point in life when the young person is trying to achieve a coherent sense of identity or when one's identity is threatened, one could suggest that the above are affected and challenged significantly. Hence, at the point when young people experience loss or significant change in their identity, they also might have questions about their
understanding of themselves, the meanings and directions they have in their lives. Moreover, such a situation could easily create doubt about the individual’s free will and personal control in life leading to confusion regarding one’s values, beliefs and commitments.

One of the most prestigious contributors in the field of identity development is Erik Erikson. In his psychosocial development theory, Erikson proposes that the human being develops in stages, each of which is characterised by emotional crises and important choices. The resolution or not of these crises is important for the individual and has repercussions on future development as well (Coyle, 1997; Shaffer, 1995). Erikson believed that the crisis emerging in adolescence is that between identity and role confusion. He was the first one who focused on the importance of social aspects in the development of identity (Kroger, 1996) and he conceived of the adolescent as struggling to determine one’s sense of self and one’s values and one’s concept of the world (Coyle, 1997). Erikson’s perspective seems to be relevant to this paper because one of the possible negative outcomes of an altered body image in adolescence is that of an identity crisis. He conceived adolescents as struggling to determine their sense of self, values and concept of the world. Part of our identity is also related to our physical appearance. In the case of altered body image, one’s identity is also likely to undergo particular changes. Partridge (1990) explains this in relation to drastic facial disfigurement stating that ‘the image that you see in the mirror is your new exterior — it is you in the eyes of the rest of humanity’ (p. 9). Kroger (1996) illustrates this concept stating that in adolescence ‘others […] become important not merely as potential sources of identification but rather as independent agents, helping me to recognise the ‘real me’’ (p. 9). Therefore, the way we construct our identity and the perceptions that others have of us (translated in the way they relate to us) are intertwined. Findings such as those presented above of the bias that people may harbour in relation to people with facial disfigurement are likely to have a huge impact on the identity of the adolescent.

Expanding on Erikson’s theory, James Marcia suggested that adolescents could be categorized in four identity statuses (Shaffer, 1995). The identification with each category depends on the adolescent’s exploration of various alternatives. The statuses as
identified by Marcia are: identity confusion, identity foreclosure, moratorium and identity achievement. After physical disfigurement, the adolescent is most likely to be in what Marcia calls moratorium stage, which is described by the individual being in an unstable situation and experiencing uncertainty. Indeed, one of the reactions to dramatic physical change is related to this uncertainty. The event leading to the physical disfigurement itself accentuates this uncertainty. The results by DeWitt (1993) and Richmond et al. (2000), stating that the survivors of traumatic accidents and victims of physical differences, are likely to be very confused about their future and about their life – seeing it almost as split between life before and after the incident – exemplify this uncertainty. Moreover, such a crisis in one's identity has also repercussions on the way one perceives the world (Athens, 1995). For instance, adolescents are often believed to be strongly influenced by the myth of invulnerability (Nightingale & Fischhoff, 2001). However, after a traumatic event for instance, they are likely to question this assumption. The study by Thompson et al. (2000) has highlighted the fact that after a traumatic event, individuals are likely to become more aware of their vulnerability and mortality. This was also echoed in the study of Rybarczyk et al. (1997) where participants expressed their confusion about being suddenly discriminated against and thus sensing a change in other people's perception of them as people with a disability. Partridge (1990) explains that adolescents may get caught between wanting to identify with disabled individuals and accept their norms and expectations, or else feel part of the 'normal' group to which they belonged prior to the onset of the disfiguring condition or event. All these aspects stand to indicate the intricate process of identity formation especially after physical disfigurement. Thus it becomes clear that resolving this identity crisis is a lengthy and uneven process that could stretch into later life.

The model suggested by Breakwell (1986) takes into consideration the change as dictated by certain events that pose threats to our identity. In her identity process theory, Breakwell acknowledges the importance of the biological organism on one's identity. She explains that 'identity structures [...] consolidate around the basic material of the biological organism. They are the product, initially, of the interaction of the biological organism with its social context' (Breakwell, 1986; p.11). In addition, she explains that the biological organism is at the heart of our identity. Thus one could suggest that any
drastic change in one's physical appearance can pose a threat to the inner core of identity. Breakwell suggests different ways in which we could deal with a threat.

Firstly, Breakwell (1986) mentions that the individual could decide to resort to intrapsychic strategies which include such processes as temporary denial, 'anticipatory restructuring' and transient depersonalization. Partridge (1990) discusses the issue of denial which, he calls 'deception'. He explains that people with physical disfigurement are often caught in the game of convincing themselves that they are only slightly injured and that maybe their face will miraculously heal and bring back their good looks. Secondly, she identifies a few intrapersonal strategies used in such situations when the individual perceives a threat to one's identity. She mentions isolation, negativism, passing (removing oneself from the situation) and compliance. These strategies have limitations as regards to their value in different situations. However, different studies (e.g., Aktan, 2000; Richmond et al., 2000; Rybarczyk et al., 1997) seem to report similar findings in relation to physical disfigurement. Thirdly, Breakwell (1986) also suggests that the individual may resort to interpersonal strategies in order to deal with the threat to one's identity. She explains that this involves joining or identifying oneself with a group that is able to provide the necessary support. These adolescents have the added difficulty that a support group of people with similar difficulties is not readily available. Indeed, studies about acne for example, have found that such adolescents are less likely to ask for help due to the awareness of the stigma associated with being physically different (Smithard et al., 2001). Finally Breakwell also suggests that in difficult situation leading to identity crisis, people may decide to rely on the process of evaluation. This basically entails re-evaluating the contents of one's identity. Adolescents with altered body image may find this difficult to cope with at an early stage and are probably more likely to cope with the identity crisis, in this way, at a later stage when the initial shock and disbelief is over.

Notwithstanding the theories related to the crises or identity change in adolescence, none of the theories mentioned above are specifically related to the threat to one's identity occurring due to altered body image. However, looking at the theories of identity formation one can get a glimpse of the meaning of such aesthetic changes.
The Consequences of Physical Disfigurement on the Adolescent's World

The origins of the word 'stigma' can be traced back to ancient Greek where it was described as a mark left by a pointed instrument. Nowadays it means 'mark or sign of disgrace or discredit' (AskOxford.Com, 2006). However, it is very close to the word 'stigmata', which for Christians symbolizes the marks matching those left on Christ's body by the Crucifixion. In brief, all definitions refer to a distinguishing mark on the body leading to marginalization or to physical and psychological pain. Various studies have shown that stigma is attributed to different social groups in our society. Amongst these groups we find various people who are suffering from physical deformity or disfiguration that make them different. Misunderstandings about one's condition and source of physical difference can cause an individual unnecessary or unwarranted distress. Smithard et al.'s findings suggest that young people's ignorance about their condition (e.g., the severity of acne and its causes) can add to the stigma associated with the condition and also prevent them from taking the necessary steps to look for the necessary help.

In their discussion about stigma, Crocker and Major (1989) explain that 'physically unattractive' people are likely to experience economic and interpersonal problems in society. They refer to studies tackling these difficulties and they mention that people who are perceived as unattractive or different are less likely to be hired for jobs and to receive attention from others. As stated above, the novelty of the altered body image can be perceived as a threat to one's identity. Hence, it is likely to create further stress and confusion. Crocker and Major (1989) point out vulnerability factors associated with difficulties to deal with real or perceived stigma. Amongst other factors, the ones that seem to be most relevant for this discussion seem to be the time since the onset of the stigmatizing condition, the internalization of societal negative views about the stigma, the responsibility for the stigmatizing condition and the importance one attributes to the stigma in relation to the self-concept.

According to Crocker and Major (1989), one of the determinants of how well people with physical 'stigmatizing' conditions cope, is the 'time since the acquisition of the stigma' (p. 618). In this case, the time is determined either by the event that led to physical...
disfigurement or the time since the acknowledgement of the body image alteration (e.g., in cases of excessive weight). Thus, people who have only recently entered the stigmatized group may lack the strategies of self-protection that a longer identification with the category could earn. In their paper about coping with leg amputations, Rybarczyk et al. (1997) disagree with this argument. They argue that in their two studies and in other similar studies, the time since the amputation was only slightly correlated with adjustment and coping. The contention in this paper is that the extent to which timing is related to coping depends on other variables as well. Indeed, timing in physical disfigurement may be a highly significant factor when the disfigurement is abrupt and accidental. On the other hand, in cases of body image alterations that may actually lead to improved quality of life (such as in the case of amputations after years of chronic pain), timing may not be so important because other variables (e.g., comfort) are at stake.

Crocker and Major (1989) also contend the age of the individual when he or she acquires the stigma is not so important. However, from the studies presented earlier, it seems that both age and timing share equal importance when trauma occurs in adolescence. Indeed, one cannot underestimate the significance of age in relation to how easily or not people cope because physical attractiveness is an important part in the adolescent's equation of well-being. One could hypothesise that the importance of body image for adolescents is paradoxically evident if one considers that one of the psychiatric disorders related to distortion of the body image is likely to appear initially in childhood and adolescence (Davison, Neale & Kring, 2003; Sobanski & Schmidt, 2000a). Body Dysmorphic Disorder (BDD) with its particular and extreme concern with a real or imaginary minor physical imperfection in one's appearance, usually induces a lot of shame on the person's part, so much so, that it is often difficult for such a person to ask for help or look for support. Therefore, having a noticeable physical difference at this time may provoke particular psychological and emotional challenges (Rumsey & Harcourt, 2004).

A second factor determining how well a person copes with stigma is the extent to which one accepts the negative attitudes towards the stigmatizing condition. In relation to this aspect, Rybarczyk et al. (1997) explain that it is usually assumed that being conscious of
the negative perceptions that society might have in relation to physical difference and being able not to personalize these perceptions is a way to cope healthily with the stigmatizing disfiguring condition. However, their study suggested that this can be a faulty perception. Indeed they found that the more individuals perceived the stigma around the condition, the less optimistic was their adjustment. Similarly, Crocker and Major (1989) sustain that 'those who have internalized society's negative views [...] should be at particular risk of low self-esteem' (p.619). Therefore, the fact that the individual has had the opportunity to observe others with a stigmatizing condition, from an observer's perspective prior to the onset of his/her own stigmatizing condition, is important (Goffman, 1963). Applied to the aim of this research therefore, one concludes that the adolescent acquiring the disfiguration is more likely to be affected negatively since s/he is more likely to have been 'socialized' into the stigma towards others and therefore is theoretically proficient in the labelling and beliefs associated with the stigma.

The extent to which the adolescent is held responsible (by self and others) for the onset of the stigmatizing condition is also believed to be very important in determining one's adaptation to the condition. Some studies suggest that people are more likely to be treated well when they are not held responsible for their condition (Crocker & Major, 1989). This factor is relevant in relation to the adaptation of those adolescents who may be assuming responsibility for the accidents which have led to the onset of the stigmatizing condition (Bulman & Wortman, 1977). In such circumstances, such people are also likely to experience shame. Mollon (2002) explains that shame occurs even when we anticipate dissatisfaction or disapproval from others. Other authors have found it useful to distinguish between internal and external shame (e.g., Gilbert, 1997; Lee, et al., 2001) where internal shame refers to intrinsic beliefs about our inadequacy and lack of value and external shame refers to the belief that others see us as inadequate or unworthy. Having lived as observers of the non-stigmatized community and having probably idolized physical perfection themselves, adolescents are likely to foresee other people's distancing from them. In these circumstances, adolescents with altered body image are likely to feel alone and rejected by others. Nevertheless, if such adolescents internalise the beliefs of larger society and see themselves as inadequate and unworthy,
there may be worse consequences because internal shame is likely to lead to affect negatively one’s identity.

The final factor discussed in this review associated with the possibility of low self-esteem is the importance and centrality one attributes to the disfiguring condition. Hence, in conjunction with the above factors, an adolescent to whom the condition is still a novelty and therefore still carrying the observed attitudes of society to people with such ‘differences’, the responsibility s/he holds in these circumstances and the centrality of priority one gives to this condition in relation to the self-concept are very important. Research has shown that such individuals are more likely to have low self-esteem.

**Implications for Practice**

As indicated by various studies mentioned above, adjusting and integrating the new physical appearance in one’s identity can be quite threatening. Partridge (1990) suggests that, after disfigurement, it may be easier for patients to start rediscovering themselves with unknown people rather than significant others. The same may apply to other physical changes such as excessive weight. The contention is that with unknown people, the person is less likely to feel constantly compared with the way she or he looked before. The question thus appears to be: who is going to take this role with such adolescents with altered body image? Although in cases of sudden disfigurement, medical staff are likely to be more readily available for these clients, evidence from some studies suggests that they may not be the most willing or competent enough to offer the necessary support. Indeed, Clarke and Cooper (2001) found that nurses felt more competent to address the physical needs of rehabilitation rather than the psychosocial needs. Quinn and Crocker (1998) also explain that in other conditions, such as those related to excessive weight, there is a prevailing social belief that ‘overweight people are personally responsible for their condition’ (p. 125). Moreover, in the case of acne, the medical staff themselves may fail to address the psychological impact of the condition (Clarke, 2001a; 2001b). This may lead medical staff to underestimate the needs of such patients. Certainly such findings
capture the need for such adolescent patients to feel supported and understood. The counselling psychologist can fulfil this role.

The inner core of counselling psychology is planted in the belief that human beings can be assisted in discovering their inner potential for growth and change without necessarily focusing on illness and impairment (Tyler, 1992). What has been mentioned so far shows that there is a strong need for counselling psychologists to deal with issues of altered body image in adolescence. The blend of knowledge about lifespan development, the versatility of techniques used by counselling psychologists, in conjunction with the ability to create a trustworthy therapeutic alliance, could be a precious element in the distribution of services to this population. The implications for practice mentioned below are focused on interventions of counselling psychologists prior to crisis development (prevention) and during the therapeutic endeavour itself.

Perhaps lying at the basis of any therapeutic intervention is the necessary condition for counselling psychologists to be aware of beliefs and ideas they may have in relation to a particular client's presenting problem. In visible aesthetic difference, the presenting problem may be outwardly noticeable, and therefore less easily ignored. Thus, counselling psychologists need to be more aware of emotional attitudes as well as cognitive assumptions around clients presenting such difficulties. A study conducted by Holaday and Wolfson (1997), conducted with 226 university students following a first degree course in counselling investigated their opinions about children and adolescents with severe burns. These authors came to the conclusion that negative expectations and approaches to these clients were mainly originating from:

1. An endorsement of societal values idealizing beauty and shunning disability or aesthetic difference;
2. The emotionality and affect caused by the physical appearance of the client. In this case the authors predict that in some cases, empathy can hamper the counselling process and engender more countertransference;
3. A reminder of their own personal vulnerability especially when the clients are very young; and
4. The fear of social contamination. The authors suggest that people may be afraid of others' misconceptions about them being psychologically maladjusted if they are in company of people with severe scarring.

Holaday and Wolfson (1997) caution that a 'counselling relationship built on these inaccurate, inappropriate and pessimistic ideas and personal fears can lead to errors in clinical judgement, can interfere with the establishment of a positive working alliance, and can result in mistaken diagnosis or improper treatment' (p. 55). Furthermore, counselling psychologists need to be aware that they can pose a threat to the client if indeed they underestimate the importance of their own beliefs or perceptions. Kelly (2000), for instance suggests that therapists are a credible and knowledgeable audience in the clients' perspective. Any misconception that affects the way they treat clients may be generalized by the clients to other professionals and to significant others. Therefore, it is imperative for counselling psychologists to acknowledge and explore difficulties or hidden beliefs that might influence the interventions with these clients. Clients with physical differences have their own needs and difficulties which need to be addressed responsibly and ethically. 'Fears of being unattractive to others, not being selected or chosen, feeling marginalized by others, feeling inadequate, inferior, not being good enough, worthless and lacking in social confidence are common problems presenting to therapists' (Gilbert, 1997; p. 127). These difficulties are likely to be poignant in the life of the adolescent with physical differences and if not thoroughly explored and addressed the counsellors' beliefs may collude with the clients' fears.

Rumsey and Harcourt (2004) suggest that professionals' interventions can be very fruitful as a preventive measure as well. Admittedly, one of the roles of counselling psychologists would include monitoring the psychological adjustment of these adolescents especially if one considers the warnings originating from different studies about the high probability of psychological breakdown in the aftermath of altered body image. Furthermore, in cases where the change in physical appearance is foreseeable (such as, in cases of head and neck cancer), it is important that the counselling psychologists prepare the clients for the imminent change and the emotions, fears and conflicts possibly arising from the event. The role of the counselling psychologist is also
very important after the onset of the aesthetic change. Partridge (1990) stresses the
importance of professionals being aware of the afflicted person's need to take the
necessary time and not rush in acknowledging the change in appearance. In relation to
people afflicted by burns, for instance, he suggests that the victims need to find the
appropriate timing to look at themselves in the mirror for the first time. Seeing the
different image reflected on a mirror is very powerful and may affect radically one's
sense of identity. Therefore a counselling psychologist needs to be sensitive and open to
the difficult stages that such people may go through.

In this regard, several research studies suggest the need for people with perceived and
real change in body image to focus on learning social skills that would enable them to
cope with other people's stigma and ignorance - even as prevention for future bullying or
self-esteem problems (Clarke, 2001a; Clarke & Cooper, 2001; Walters, 1997). The
counselling psychologist needs to take this into consideration and be sensitive to clients'
needs in this domain. Furthermore, through the therapeutic alliance, he or she will be
able to encourage an environment of empathy and sympathy, which are vital in order to
understand the difficulties that the young person may be facing after the onset of
physical change. The counselling psychologist may be aware of the fact that other
professionals who are less concerned about the psychosocial sphere of the client's
difficulties (due to the nature of their work), may be less cognisant of the actual
difficulties the client is facing. Thus, attention should be given to the client's needs and
resources to satisfy those needs. It is important that young people are educated to
understand what the implications of their conditions are. In the case of acne, for instance,
they might need to be more knowledgeable about how to treat it. They need to
'recognize that they have a common, treatable skin condition' (Smithard et al., p.278).
Consequently Clarke (2001a) points out that sometimes, clients are not aware of where
and who to turn to for help. He suggests that clients may not communicate their needs
well enough to professionals, such as GPs, who could influence dramatically their
situation (by for instance, suggesting skin grafting) and thus, they may be less likely to
receive the necessary help. The role of the counselling psychologist would also involve
helping the client face some fears or difficulties related to how and to whom to ask for
help.
In such instances, where a lot of psychological pain is occurring the role of the counselling psychologist may spill into other areas besides the one-to-one therapeutic relationship with the client. There are cases where the families or significant others cannot cope with the pain of seeing their loved one in distress. Thus the counselling psychologist’s role may also involve helping significant others to understand and support the individual and possibly preparing them for possible breakdown of the client’s defences (Bradbury, 1996). Besides, psychologists may provide a bridge with the outside world. This happens when the young person may be too devastated to meet other people, friends or colleagues or when the physical rehabilitation constrains them to spend a long time in hospital away from other people. The psychologist may be the only person who the client feels comfortable enough to talk to without feeling judged or scrutinized all the time. Thus the role and the job of the counselling psychologist is multifaceted and is closely related to the effects experienced by the clients in the physical, psychological and social fields.

**Future directions**

Most of the studies and theories presented in this paper seem to agree with the fact that altered body image occurring in adolescence has various implications for the young person. The fact that altered body image can be related to different body parts, sometimes makes the research of it’s affects on other dimensions, difficult to investigate. However, there is a possibility of conducting both qualitative and quantitative work in order to discover more about the experiences of adolescents presenting with issues of altered body image in general. Their self-concept and identity development seem to be significantly affected by such changes. Another possibility for future studies would involve testing the hypothesis generated from various studies, that is, that identity is likely to change in conjunction with altered body image in adolescence. Undeniably, the implications to counselling psychology are various and intimately associated with the emotional, social and psychological needs of the young person in these circumstances. Certainly more research about this area needs to be encouraged. In fact, it seems that
although various studies imply the possibility of threat to one's identity in relation to altered body image, there seems to be no specific adequate theoretical framework related to this issue. By inferring from other theories, one runs the risk of underestimating or of ignoring particularly important issues for this group.

From a therapeutic perspective, Cognitive Behavioural Therapy is often suggested as the most popular framework for treating difficulties with altered body image. Although this aspect could not be tackled extensively here, it is also suggested that other therapeutic theoretical frameworks could be proposed. For instance, the role of shame and guilt is extensively explored from a psychoanalytic perspective. This perspective could shed some light on the possible unconscious processes occurring when a person experiences physical changes in adolescence. Undeniably, there is still much more to be done and discovered!
Personal Reflection

"Who are you?" said the caterpillar. Alice replied rather shyly: “I...I hardly know, sir, just at present – at least I knew who I was when I got up this morning, but I must have changed several times since then.”

Lewis Carroll, *Alice in Wonderland*

This quote is taken from a very popular children’s story and it captures an issue which has stirred my interest in this topic: what happens when we lose sight of who we are? Interestingly, Alice is the girl that meets a lot of different creatures in another world. She is fascinated by their differences and they are puzzled by her. A girl that would be considered ‘normal’ in everyday life is suddenly propelled into an environment when she is different and here she loses sight of her identity. She knows she has changed but this is not helpful in answering the question. This is probably similar to the experience of adolescents with altered body image. These young people, who are just coming out of the world of childhood, a world where heroes and heroines are depicted as beautiful people with flawless skins and amazing bodies, are suddenly faced with the fact that their own bodies have changed in ways which make them different and which attract uneasiness and embarrassment.

Two reasons have probably led me to choose this topic. The first reason is related to my work experience. I have often worked in close contact with adolescents voluntarily and in paid employment. I admit finding this age group inspiring and challenging due to the complex dynamics that they have to face, the changes that they experience and the strength and the energy with which they approach life. Mostly, my experience involved working with young people who have been stigmatized due to their behaviour or family ties. Indeed, working in a correctional facility and, later on, working with young people suffering from behavioural and emotional problems, has been very helpful in understanding the extent to which stigma affects the lives of young people. Furthermore, in my opinion, the first great obstacles in relation to adult life appear during adolescence. Thus studying the subjective reality of adolescents on the pathway to self-discovery and
self-understanding opens the frontiers to other difficulties that a person may encounter later on.

The second reason is more related to my personality. I am a person who strives to keep everything in order. One could say that I fall into the cliché of the perfectionist. However, in my experience, both personally and professionally, I have encountered situations in which the presenting reality is far from perfect. Sometimes, in these situations I admit appreciating the complexity of things that are 'different' and not perfect. Paradoxically I find myself attracted to people whose life is not perfect, and whose daily struggle often simply to keep 'afloat'. My drive for perfectionism has possibly encouraged me to become a 'rescuer'. However, through experience, training and supervision I am less likely to take that role. I am more likely to be a supportive bystander, to appreciate difference and react to it with humble respect. After all, the difference in others makes them just that: different from me, not better or worse than me. And I have also learnt that with difference comes a wealth of knowledge that makes each person unique. I have come to the conclusion that being able to connect through that difference is what matters personally and professionally.

What has attracted my interest to altered body image has been the fact that, going beyond the physical difference may sometimes be more complicated than the difficulties presented by other aspects. Especially with physical difference originating from trauma, there is always the underlying feeling that one cannot understand its complexity without experiencing it. Although possibly this can be true, I am aware that we connect most fully and most intensely on psychological levels especially in our professional lives. Learning more about the difference, the changes experienced, the profound threat to identity, have all been very important to gather a glimpse and possibly to be able to connect more readily and easily on a psychological level with clients presenting with such symptoms.

The two major ideas that I have found particularly interesting on a personal and professional level in this piece of work have been: (1) the fact that when a condition is not deemed medically serious enough, such as in the case of acne, we tend to underestimate the impact that it can have on one's life, and (2) the fact that after serious alteration of the
body image, the person is often faced with the struggle of reinventing one's life. These two aspects seem to have serious connotations in relation to counselling psychology including the extraordinary importance we need to give to our listening skills and to the therapeutic alliance. Although, often assumed to be basic to our practice, paradoxically they can also be the most easily underestimated by the richness of experience. My experience so far has led me to appreciate immensely the importance of personal contact which has often prevailed over the therapeutic intervention. The more stigmatized a person is, the more difficult it can be for one to connect with him or her because, whatever the struggles which we face, we are still potentially part of the environment from where the stigma is originating.

I end this section with a glimpse back to my initial quote about the girl called Alice finding herself unprepared to face the mysteries of Wonderland. I had associated Wonderland with the adolescents' world after the change in body image. Interestingly, the first half of the word is 'wonder'. We wonder and are curious about things that are interesting to us. In the case of counselling psychology facing the challenges of altered body image may our wonder originate from sincere interest and may it not be shamed by curiosity if this is not seated in unconditional respect.
References


APPENDIX A – NOTES FOR CONTRIBUTORS
Body Image is an international, peer-reviewed journal that publishes high-quality, scientific articles on body image and human physical appearance. Body Image is a multi-faceted concept that refers to persons' perceptions and attitudes about their own body, particularly but not exclusively its appearance. The journal invites contributions from a broad range of disciplines psychological science, other social and behavioral sciences, and medical and health sciences. The journal publishes original research articles, brief research reports, theoretical and review papers, and science-based practitioner reports of interest. Dissertation abstracts are also published online, and the journal gives an annual award for the best doctoral dissertation in this field.

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Online submission is strongly preferred but authors can also submit via mail. Four (4) copies of the manuscript, plus the file on computer disk, including one set of high-quality original illustrations, suitable for direct reproduction, should be submitted to the Editor-in-Chief, Thomas F. Cash, Ph.D. Department of Psychology, Old Dominion University, Norfolk, VA 23529, USA Tel: +1 757 683 4439, Fax: +1 757 683 5087, Email: tcash@odu.edu. (Copies of the illustrations are acceptable for the other sets of manuscripts, as long as the quality permits refereeing.)

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4. The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available.
5. The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to
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APPENDIX B – EXAMPLES OF LITERATURE SEARCH
Literature Search details

The search conducted for this topic was not specifically derived from a database search because a lot of searches were bringing inconclusive results which were not deemed pertinent to this literature review. However, articles and books were sought through the reference sections of the main pieces of literature around the topic. This provided a more focused search of the subject since, as mentioned in the main body, the area of altered body image is too vast whilst studies on adolescents are limited.
Research Report 1:

The Impact of Acne on Adolescents' Quest for

Self-Discovery and Identity Development

Abstract

Altered body image coinciding with the period of adolescence can present particular difficulties for young people in different spheres including the emotional, psychological and social ones. An IPA study is being presented in this paper dedicated to explore whether acne affects adolescents' view of the self and their underlying sense of identity and consequently, whether this impacts on the way these individuals perceive their place in the world their future. The analytical process has demonstrated that there are some areas which seem to be absent in the available literature. 14 themes emerged from the data. These were then grouped into four categories which suggested that their experience was significantly coloured by: the impact on the sense of self, the types of useful coping strategies, the impact of acne on the interpersonal sphere (and view of the world) and the centrality of treatment in their lives.

Keywords: Adolescence; Acne; Altered Body Image; Identity; Counselling Psychology.

4 This paper is being formatted to conform to the notes for contributors of the journal Body Image (refer to appendix A).
Introduction

Then he felt quite ashamed, and hid his head under his wing; for he did not know what to do, he was so happy, and yet not at all proud. [...] He would never become vain or conceited, and would always remember how it felt to be despised and teased, and he was very sorry for all the creatures who are so treated merely because they are different from those around them. Then he rustled his feathers, curved his slender neck, and cried joyfully, from the depths of his heart, "I never dreamed of such happiness as this, while I was an ugly duckling.

_Hans Christian Andersen, The Ugly Duckling, 1844_

The above quote is taken from a popular tale about an ugly duckling transformed into a beautiful swan after enduring many hardships due to his obvious physical difference from other ducks. Being a children's story, it indicates how early in life we start being fed this belief about the importance of aesthetics in society. It seems to suggest that for a happy ending the ugly duckling has to become a beautiful swan. Probably many of us have dared fantasise at different points in our lives that we could be graced with the same destiny: that one day our imperfections and blemishes will miraculously lift to reveal perfect beauty.

In reality, our sense of self is stretched to embrace many aspects of us but it appears to be strongly related to our appearance. As stated by Breakwell 'each characteristic of the physical being carries messages about [one’s] identity' (1986, p.12). Thus, one can imagine the extent of the impact that unwanted aesthetic differences, such as those brought about by genetic predispositions, irregular physical development, trauma, disease and surgical intervention can have on people. Indeed, available studies suggest that there is an evident difference between the psychological state of individuals before the onset of a condition leading to altered body image, and after. Such consequences appear to be observable with individuals of different ages. However, because adolescence is especially marked by an interest in body image, some authors (e.g.,
Rybarczyk et al., 1997) speculate that if the onset of aesthetic change occurs at this stage, the adjustment of the individual may be more problematic (Sobanski & Schmidt, 2000a; 2000b).

This paper is precisely intended to delve into the experiences of people who have experienced facial aesthetic changes due to acne. The underlying rationale for this study is the belief that there are particular issues at play when aesthetic change is experienced in adolescence since this is a time of rediscovery and redefinition of oneself.

Especially in adolescence, our identity is largely affected by the way we present ourselves to others and the ‘feedback’ we receive from them. In fact Moss and Rosser (2008) explain that adolescence ‘appears to be a period of increased appearance salience and concern – possibly due to the increased importance of relationships during this time, in combination to dramatic physical change’ (p. 493). Adolescence, as intended in this research, is a period that ‘lies psychologically and culturally between childhood and adulthood’ (Bee, 1994; p.253). From a lifespan perspective, it is a time of re-evaluation and of major developmental upheaval (Coyle, 1997). It is a time where we usually establish our identity and sense of self (Erikson, 1968). Kroger (1996) states that in adolescence ‘others [...] become important not merely as potential sources of identification but rather as independent agents, helping me to recognise the ‘real me’’ (p. 9). Thus, even our self-worth becomes considerably affected (Tiggemann, 2005). An overview of the available studies shows that there is an increasing interest in the effects and meaning of changes in body image. These studies span different topics of altered body image and focus on different outcomes and effects of aesthetic changes.

The psychological and social effects of changes in one’s appearance are evidenced by many studies. For instance, a study carried out by Rierdan and Koff (1997) investigated the implications of excessive weight for 176 adolescent girls. This study revealed that excessive weight was often the cause of dissatisfaction with body image. In turn this was associated with symptoms of depression. A similar finding was brought to light in a

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5 Acne is a chronic inflammatory disease, the onset of which usually occurs in adolescence and accompanies the individual until approximately the mid-twenties (Aktan et al., 2000).
study of the effects of physical trauma such as leg amputation. Rybarczyk et al., (1997) found that often leg amputation was correlated with depression. Although this study was conducted with different age populations, the authors suggest that age can be an important factor in adjustment issues. Hence there may be specific implications for the adjustment in adolescence. In another study concerning physical trauma, DeWitt (1993) found that after traumatic injury, adolescents would feel vulnerable and doubt their future and the possibility of regaining their health. Whilst these studies provide a landscape for us to understand the various implications of changes in one's image, this paper is trying to focus on one specific domain concerning changes in facial appearance. The special focus on the face is important for two main reasons. Firstly, because as identified by various authors (e.g., Cole 1998; 2001), the face is a crucial medium of communication. Secondly, because, focusing on one aspect of aesthetic alteration provides some specificity for the analysis of the data in order to be able to observe overarching themes and insights.

Gradually, more studies are recognizing the struggles that people with facial scarring or disfigurement are dealing with. It is apparent that difficulties arising from changes experienced on one's face can have profound and long-lasting implications. A study conducted with adolescents who had been victims of severe head injury demonstrated that, after the injury, these adolescents experienced changes in their self-esteem and self-image (Bergland & Thomas, 1991). Acne, another cause of aesthetic change and one of the most common and insidious causes of facial scarring in adolescence, has been associated with psychological difficulties such as depression and anxiety. For instance, in their study with 317 adolescent (14-16 year old) students diagnosed with acne, Smithard, et al. (1997) found that when compared with other students, those with acne were more likely to score on the abnormal end of the Strengths and Difficulties Questionnaire6. Some studies (e.g., Stevenage & McKay; 1999) also demonstrated that stigma about facial disfigurement can have extensive consequences especially on a social level where

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6 The Strengths and Difficulties Questionnaire is a brief questionnaire which can be administered both with the children themselves (if aged between 11 and 16) or with significant others in their life. It aims to enquire mostly about the child's emotional and behavioural difficulties (Goodman, Meltzer, & Bailey, 1998)
adolescents find themselves unjustly treated and misjudged. According to Gilbert, Pehl and Allan (1994), shame has an impact on various dimensions including the individuals' self-concept and their actions. This will, in turn, affect the relationships they have through their interactions with others and ultimately, their quality of life.

Acne is one of the most common causes of change in the facial image during adolescence. However it seems that, studies investigating the implications of acne for adolescents mental health, have been inconclusive (Smithard et al., 2001). Although quantitative research (e.g., Pearl et al., 1998; Aktan et al., 2000) has shed some light on the diversity of people's experiences in relation to acne, there appears to be a need for more research concerning the intricacies related to the experience of facial changes due to acne. Hence, this research has attempted to investigate this topic qualitatively since it was intended to explore the unique situations and experiences for the participants in this study (Yardley, 2000). The findings increase our knowledge of the individual processes that people may go through when suffering from acne. The questions that this research has tried to answer have been:

1. Does acne affect the young persons' view of the self and their underlying sense of identity and, if so, in what way(s) does this influence their way of integrating their new appearance in their identity?

2. How does acne, as experienced in adolescence, impact on the way these individuals view their place in the world and on how they relate to the future?

Relevance to Counselling Psychology

This study is relevant to counselling psychology because it is intended to provoke more thinking and understanding about clients bringing such issues to therapy. As stated by Gilbert (1997), clients with physical differences have their own needs and difficulties which need to be addressed responsibly and ethically: 'Fears of being unattractive to others, not being selected or chosen, feeling marginalized by others, feeling inadequate, inferior, not being good enough, worthless and lacking in social confidence are common
problems presenting to therapists' (p. 127). These difficulties are likely to influence negatively the adolescent with physical differences. The focus on acne is interesting because this condition is so traditionally associated with development that it may be overlooked and its actual consequences, underestimated. Some studies (e.g., Smithard et al., 2001) have also indicated that both the social as well as the psychological repercussions of acne could be long-lasting. Hence, the more we know about individual experiences, the higher the likelihood of providing a sustaining well-tailored service to these clients and the more equipped professionals will be in order to address possible long-term effects.

Method

Design

This study employs a qualitative approach since it was aimed at understanding participants' experiences and allowing them to be contextualized and understood within a personal narrative (Elliott et al., 1999; Yardley, 2000). For this reason, semi-structured interviews were used with people who have experienced acne in their adolescence as it is believed that they are the best source of knowledge regarding their experiences. The resulting data was subjected to Interpretative Phenomenological Analysis (IPA) as this method focuses on the individual meaning making of experiences.

Participants

Six participants, who have experienced undesirable change in their adolescence due to acne, accepted to participate in this study. It was decided that the six participants with acne could still generate very important information about the personal understanding and narratives of these participants. The sample size was considered suitable for IPA which favours smaller sample sizes that would enable the researcher to hold both the

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7 In accordance with the definition presented earlier on, adolescence was taken to include those ages between childhood and adulthood, that is, the ages between 12 and 18 years of age.
individual participant’s narrative and the themes within it (Smith et al., 1999). Purposive sampling was used for this intent since these participants were more likely to provide personal, contextual and phenomenological insights of the experience (Smith & Osborn, 2003). All participants were recruited through a ‘snowballing’ technique. Initial contacts were made through personal acquaintances. Subsequent contacts were made by word-of-mouth. The participants are all Maltese due to the nationality of the researcher and, hence, her contacts. The group of participants (see Table 1 below) is made up of 5 Females and 1 Male. They are all aged between 18 and 25. They all identified their ethnic background as White Maltese. In terms of their qualifications, three of them reported their highest educational qualification to be A-levels or equivalent and the other three have a university degree or equivalent.

Table 1: Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Age of acne onset</th>
<th>Marital Status</th>
<th>Level of education</th>
<th>Treatment Modality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephanie</td>
<td>20</td>
<td>White Maltese</td>
<td>12</td>
<td>Single</td>
<td>Secondary</td>
<td>Medication</td>
</tr>
<tr>
<td>Julie</td>
<td>25</td>
<td>White Maltese</td>
<td>15</td>
<td>Married</td>
<td>Tertiary</td>
<td>Medication</td>
</tr>
<tr>
<td>Francesca</td>
<td>18</td>
<td>White Maltese</td>
<td>15</td>
<td>Single</td>
<td>Secondary</td>
<td>Medication</td>
</tr>
<tr>
<td>Ruth</td>
<td>24</td>
<td>White Maltese</td>
<td>13</td>
<td>Single</td>
<td>Tertiary</td>
<td>Medication &amp; chemical peeling</td>
</tr>
<tr>
<td>Fiona</td>
<td>25</td>
<td>White Maltese</td>
<td>14</td>
<td>Married</td>
<td>Tertiary</td>
<td>Medication</td>
</tr>
<tr>
<td>Sean</td>
<td>18</td>
<td>White Maltese</td>
<td>14</td>
<td>Single</td>
<td>Secondary</td>
<td>Medication</td>
</tr>
</tbody>
</table>

The inclusion criteria were that participants should be aged between 18 and 25, having experienced facial acne between the ages of 12 and 18, being psychologically robust for the interview and voluntarily interested in the study. The age bracket of 18 and 25 was favoured for two main reasons. Firstly, this period proceeds from adolescence and therefore the time when they started suffering from acne. Thus they were likely to have clearer recollections of their experiences. Secondly, because of their age, people in this
age bracket were also more likely to reflect and discuss the meanings that such experiences had on them. The condition for participants having the acne experience during adolescence (12 to 18 years of age) was set because it is believed that having acne at this stage in life carries particular implications for the quest for identity development and self-perception which may be different from those of adolescents who have experienced physical alterations from birth or from a very young age.

**Research instruments**

For this study, data were collected through in-depth semi-structured interviews. These provide the researcher with the necessary amount of flexibility for an IPA study since the aim is to ‘analyse in detail how participants are perceiving and making sense of things which are happening to them’ (Smith & Osborn, 2003, p.55). Furthermore, semi-structured interviews allow for more coverage of the questions addressed through the co-constructed interview process where the researcher and participant take the direction that best suits the participant’s experience (Langridge, 2004). The interview schedule used for data collection was formulated to include questions about the respondents’ beliefs about the importance of aesthetics in general, their impression of adolescence as a particular period in development, the meaning that the physical evidence of acne had on their face, any available resources (personal or interpersonal) that helped them cope with acne and their views about themselves nowadays and their view about the world. Open ended questions were used in order to allow participants autonomy in expressing themselves during the interview. These had previously been developed out of a review of literature available about the subject. Prompts were also made available for the researcher to encourage participants to focus in their narrative.

The interviews were piloted with two volunteers who were slightly above the age bracket (26 and 27 years old). They have helped the researcher develop an insight on the impact of specific questions. The piloting of the interviews was beneficial and has ascertained that the questions were clear enough and sufficiently related to the topic and aims of the study. It has also helped the interviewing process by adding another question to the original interview, namely question number 8 (see interview schedule in Appendix B) in relation to personal perception due to treatment. In fact the piloting of the interview
allowed the researcher a better understanding of the centrality of treatment options to acne.

**Procedure**

After ensuring that ethical approval was granted (Appendix C), participants were contacted by phone in order to ascertain their suitability for this study. A screening interview\(^8\) was used for this purpose (Appendix D). Participants were all given information about the research and provided with a copy of the Information Sheet (Appendix E) and the Participant Consent Form (Appendix F) prior to the interview. They were then invited for interviews which were held in an office at a local parish building which provided the necessary security for both researcher and participant. A risk assessment has been carried out prior to all interviews and necessary precautions taken. Each interview lasted approximately 45 minutes. Variations to the time depended on the participants' willingness to share information and on their personal style.

Due to the sensitive nature of the research topic ethical practice necessitated special attention in order to minimize feelings of anxiety and distress in participants (Lee & Renzetti, 1993). Therefore interviews were conducted using the counselling interview. Apart from facilitating the research process by promoting a good relationship between interviewer and the interviewee, this style was also found to be valuable in helping the latter develop a 'narrative' of their experience (Coyle & Wright, 1996). The use of counselling skills during the interview was not intended to encourage a therapeutic relationship between the researcher and participants. It was rather considered necessary in assigning value to the interview by providing clarification, forming a narrative of the experience and be possibly cathartic for the respondents (Coyle & Wright, 1996). A

\(^8\) In order to encourage the participants to feel more comfortable, a Maltese version of the screening interview was also developed and used.
Maltese version of the main interview was developed in order to make the environment and the procedure more comfortable for individual participants.

At the end of the interview, participants were debriefed and asked about their experience of taking part in this study in order to supervise the research process and any inadvertent effects it may have had on them (Barrett, 2000). Participants were provided with a list of possible services offering psychological assistance in Malta (Appendix G). Furthermore, they were also provided with university contact details of the researcher in order to ensure continued contact in case they decided to withdraw from the research at a later stage.

**Analytic approach**

This paper employed Interpretative Phenomenological Analysis (IPA) in order to investigate thoroughly and subsequently describe the participant’s understanding and meaning making of physical change experienced in adolescence (Smith et al., 1999; Smith & Osborn, 2003; Langdriddle, 2004). The aim of IPA is to gain a phenomenological understanding of the individual’s experiences and perception of events. In comparison with other approaches, IPA manages to incorporate the importance of the individual participant’s narrative and the cognitions behind the narratives (Brocki & Wearden, 2006; Flowers et al., 1998). This was believed to be valuable for the aims of this study especially in order to explore issues of identity and emotions.

IPA also acknowledges the active role of the researcher in the research process (Smith, 2004). Therefore, it allows the researcher space to comprehend these adolescents’ unique experiences whilst bearing in mind the landscape of findings about identity and aesthetic change provided by other studies. Besides, IPA reinforces the role of the researchers' reflexivity and essentially requires the researcher to interact closely and meaningfully with the data generated during the interviews (Brocki & Wearden, 2006). In this study, attention was given to the conjoint relationship between data generation and the

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9 The interview schedule was shown to fellow colleagues in Malta (who are considered to have a good command of both English and Maltese) to ensure that the meaning of the questions in Maltese reflected the intended meaning in English.
researcher's self-awareness. The interviews held with participants were recorded and, at a later stage, transcribed and translated in English (see Appendix H for an example of a transcript). Each transcript was read thoroughly for the researcher to engage more intensely with the meanings and contextual experiences of each participant (Dallos & Vetere, 2005). Themes were then identified for each participant independently after which, a second process of analysis involving the collection of inferences and reactions of the researcher to the text occurred (Smith & Osborn, 2003). Subsequently, over-arching themes were developed as resulting from the pool of interviews. These themes were later discussed in the light of the findings of other literature and research studies and interpretation was sought in relation to the contexts and phenomenological understanding of the participants. In the analysis section below, interpretations are supported by extracts from the data gathered during the interview. It is believed that this will encourage readers to explore the meaningfulness of the analysis themselves (Knudson & Coyle, 2002).

** Evaluative approach **

The evaluation of this study is intrinsically dependent on its qualitative nature. Thus, it should be seen within the context of actual participants' experiences and with the literature available (Elliott et al., 1999) around the topic of disfigurement and aesthetic change. This leads into the choice of methodology as related to the research topic. IPA appears to be the most adequate choice of analytic approach but one should ensure that each of the themes outlined is represented in the data collected during the interviews themselves (Brocki & Wearden; 2006). The researcher's own position in relation to the aims outlined above has been clearly influenced by the available literature previously reviewed. Other literature seems to lead into the belief that unwanted change in body image has different effects and possibly substantially negative and long-lasting consequences on the individual sense of self and identity. This may have had an impact on the information pursued during interviews and later interpretation of data. Besides, the researcher's own experience with acne during adolescence, the age (which is very

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10 Permission for audio recording was required in the consent form
close to the participants’), the nationality and similar cultural background have also been instrumental in the interpretation of the findings.

**Analysis**

During the analysis of the interview transcripts, fourteen major themes emerged. The themes resonated amongst all participants. On further investigation these themes seemed to fall into four main domains which included: (1) impact on the sense of self; (2) coping strategies found to be useful; (3) impact of acne on the interpersonal sphere and the view of the world; and, (4) the centrality of treatment for people with severe acne problems. (see Table 2 below). The categorization of the themes into these domains is not meant to be absolute. Indeed the categorization of some of the themes has presented a few difficulties since they seemed to overlap between different domains. The final table of domains and themes was developed out of the researcher’s interpretation and meaning-making of the data. The themes seem to share at least one feature. They all seem to have relevance for the individual participant on a psychological, social and physical level. This is quite encouraging from the point of view of the researcher because it also represents the actual narrative of the participants. In fact, issues pertaining to the physical, psychological and social aspects of their experience with acne were constantly cropping up in their narrative.

The first and the third domains were particularly revealing for the topic under investigation and the researcher has found them particularly informative. Hence the following discussion will be developing them further in order to portray the significance that the participants attached to them. Due to space limitations, the other themes will not be tackled here since they are believed to be less directly beneficial in answering the research questions presented above.

In the following extracts, ellipses (...) will represent any omitted material. The researcher has also deleted minor hesitations (such as ‘mhm’, ‘ehm’, or repeated words). Necessary clarifications will be presented in square brackets. Some details about the
people interviewed in this study have been altered or omitted in order to prevent identification.

Table 2: Table of Domains and Themes

<table>
<thead>
<tr>
<th>Domains and Themes</th>
<th>No. of participants with theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on the sense of self*</td>
<td></td>
</tr>
<tr>
<td>1. Concern about the course of the condition*</td>
<td>5</td>
</tr>
<tr>
<td>2. A possible threat to identity*</td>
<td>3</td>
</tr>
<tr>
<td>3. Physical pain is often underestimated*</td>
<td>5</td>
</tr>
<tr>
<td>Coping Strategies found to be useful</td>
<td></td>
</tr>
<tr>
<td>1. One's character is important when dealing with acne</td>
<td>3</td>
</tr>
<tr>
<td>4. Fantasizing that someday it'll be over is important</td>
<td>4</td>
</tr>
<tr>
<td>5. Expectations from others to be understanding</td>
<td>5</td>
</tr>
<tr>
<td>6. Importance of supportive relationships</td>
<td>5</td>
</tr>
<tr>
<td>Impact of acne on the interpersonal sphere &amp; the view of the world*</td>
<td></td>
</tr>
<tr>
<td>2. Interpersonal problems affecting the view of the world*</td>
<td>5</td>
</tr>
<tr>
<td>3. An appraisal of the experience of acne in one's life*</td>
<td>2</td>
</tr>
<tr>
<td>The Centrality of medical treatment for people with severe acne problems</td>
<td></td>
</tr>
<tr>
<td>1. The importance of treatment</td>
<td>6</td>
</tr>
<tr>
<td>2. Physical implications and side-effects of treatment</td>
<td>5</td>
</tr>
<tr>
<td>3. Change in lifestyle due to treatment</td>
<td>3</td>
</tr>
<tr>
<td>4. Improvement after treatment</td>
<td>5</td>
</tr>
</tbody>
</table>

* Areas discussed within analysis
The impact on the sense of self

This domain reflects the participants' recollections and understanding about the impact that acne has had on the way they perceived themselves. The themes resulting from the data included the different feelings that were triggered in view of the course of acne and the possible threat to their identity.

Concern about the course of the condition

One of the greatest fears that participants admitted facing when they had acne appeared to include the fear that the condition would last forever. The unpredictability of the course of acne seemed to be salient to different participants. This suggests that, unlike people with congenital disfigurements, young people with acne may lack the self-protection strategies necessary to cope with and the possible permanence of the problem. Francesca explains:

When I was maybe younger I used to think “but when are these spots going to stop? They do not want to stop’... You find people telling you “when you turn 18 then they will diminish”. Then you’re 18 and actually these are not diminishing but increasing. Will this last forever?

This fear was also linked to the perception of lack of control for participants, since as they explained, there was no way they could control or understand its course. This echoes the findings of DeWitt’s study conducted in 1993 where he found that for adolescents experiencing a physical trauma, the question of whether they would have a full recovery provoked doubts about the future. Fiona, for example describes herself as a very determined and pro-active person: ’I am a person with an internal locus of control’ and she has found the lack of control very challenging. She stated:

My dermatologist (...) made me aware that some people had acne in their thirties and forties (...) I had always thought that acne was something that appeared in adolescence and then disappeared. So, sort of, approaching my twenties: twenty one and still having this problem...I started to realise that it was not going away, sort of, as I expected. I think it was a bit of a shock. Fiona
On the same lines, Stephanie said:

I used to tell my mother that I had three wishes: I wanted to change my haircut, to lose weight and to overcome my acne problem. So I used to think that for the change in haircut, I could go to a hairdresser and simply change my style, for my weight, I simply needed to control my eating habits but with the acne...I knew that that needed time and I did not know how long it would have taken for the spots to disappear. Stephanie

In the above comments the fear of lack of control is palpable and evident. People with physical disfigurement and scarring have been found to try to convince themselves that they will miraculously get better and that they would overcome their condition (Partridge, 1990). The lack of control and the erratic course of acne probably encourage people to fantasize that the condition will miraculously disappear. From the literature consulted for this study, there does not appear to be an explicit identification of the importance of this aspect in relationship to acne. However literature in health psychology has identified the mechanism of denial in response to stress (Lazarus & Folkman, 1984). In this case, one hypothesizes that the presence is perceived as too threatening for the established sense of self. This may lead to more serious difficulties related to the mental health of the person. Indeed, a body of research (e.g., Aktan et al., 2000; Smithard et al., 2001) suggests that depression and mental health issues may be associated with acne.

Although mental health difficulties may arise even in relation to other types of unwanted changes in body image, the case presented by acne is different because, as a condition, it is continually changing and the consequences on the face in the beginning may well differ from those at the end of its course. The importance of this aspect is very relevant to counselling psychology since it brings to life the continuous traumatic experience that people with acne can have as contrary to those whose disfiguring condition has a particular and time-limited onset.
A possible threat to identity

During the interviews, participants spoke at length about the effects that acne had on their behaviour and emotions. Three of them explained how their character changed when they became more aware of acne and how this affected the way they behaved around others. Sean, for instance explained:

You withdraw and you become more introvert and detached...I felt that I could not contribute to conversations because at that time, at that age, I was quite shy (...) With the problem I had I was even shyer. Everything made it worse. I was so self-conscious.'

Ruth's comments were quite similar to Sean's and she said that:

Before it started, I was the jolly type, the class clown, the person that made everyone laugh and was always laughing. When acne started, I became introvert. Nobody could talk to me. (...) I used to cry all the time, always bringing up excuses not to go out.

She continues to say: 'I was devastated. I am not saying that I wanted to be in the spotlight but deep down I wondered "what am I". I am neither a boy nor a girl'.

This feeling seemed to last for some time for Ruth and she explained that, even nowadays she does not have a good sense of herself. Both extracts from Ruth and Sean's narratives echo Newell's (1999) and Partridge's (1990) claims that facial disfigurement or scaring can cause major distress to people. They also bear resemblance to the findings of a study conducted by Bergland and Thomas with patients of head injuries who experienced a change in self-perception and self-esteem. Therefore, as a condition leading to a change in a person's body image, acne could pose a threat to the inner core of identity. Breakwell (1986) suggests that one of the ways one could chose to react when faced with an identity threat is by using interpersonal strategies. For instance, both Sean and Ruth appear to have used isolation and passing (removing oneself from the situation) as interpersonal strategies. However, other people could apply intrapsychic strategies in order to face a threat. Francesca, for instance, explained that:
Well, actually, it was not that different, I was not shy, actually I did not realise I had so much spots on my face. It was more the other people that made me conscious of this fact by saying "Oh my God look at your face"

According to Breakwell’s theory of Identity Process, Francesca could be resorting to temporary denial as a deflection strategy in order not to face the implications of the threat (Breakwell, 1986). Therefore, she denies the actual extent of her problem. Stephanie, offers yet another alternative when she states 'I used to say, now I have this condition, but I won't let it stop me from doing what I enjoy doing (...) So I tried to adapt myself to the situation.' According to Identity Process Theory, Stephanie is probably using an acceptance strategy called anticipatory restructuring where, because she is aware of the possible threat before, she anticipates the restructuring of her identity. Indeed, Stephanie's elder brother had had a very severe case of acne. She recounts:

Yes, I (...) have observed its development. The fact that I knew how long it had taken for my brother to get over it was quite scary. I started thinking about the length of time it would take for me as well to overcome it. This has had a huge impact on me. Then I also started thinking about the medication and how I would have had to get used to taking so many pills.

This could have acted as a prologue to her experience and, therefore offered the necessary space for her to make such allowances in her identity.

IPA's commitment to individual phenomenology is believed to be essential at this point in order to embrace different and seemingly contradictory perceptions and narratives presented by participants; especially in the cases of Sean, Ruth and Francesca. The first two had explained that prior to the onset of acne they had paid little attention to aesthetics and body image. On the other hand, Francesca had explained that 'Although not overly obsessed with the way I looked, I was always quite attentive to body image. I used to be very careful with body facial products for instance.' IPA provides the necessary flexibility to understand the different perspectives provided by different participants. From their comments, it seems that their experience with acne has been significant enough as to change the relationship they had with their body image. Perhaps
this could be a significant finding in relation to the main aims of this research since it captures the transience of adolescence. Being such an instrumental period in the establishment of identity, this finding may reveal the impact that acne has on the adolescent in his or her quest for self-identity.

Thus, for Sean and Ruth, who had not paid particular attention to their body image, aesthetics became quite important, whereas for Francesca it was the opposite. Smithard et al. (2001) offer yet another suggestion. These authors found that the more objective the evaluation of acne, the worse the emotional health appeared to be for the participants. This reflects the weight that one's cognitive appraisal could have on the way one experiences the condition. Sean, Ruth and Francesca seem to appraise the situation differently.

Physical pain is often underestimated

Whilst discussing the different effects that acne has had on their lives, the participants explained that one of the clearest memories that they have about the outburst of acne was the pain that they used to experience due to the spots. In relation to this, Stephanie explains:

> Then one has to remember that spots are also physically painful. I remember that sometimes I would go to the hairdresser's and I would flinch as soon as she would touch my forehead with the scissors. These memories are still very vivid.

This comment demonstrates the physical pain that Stephanie has experienced due to acne. However there seems to be more to it. Indeed, Stephanie indicates that sometimes the pain associated with acne is not taken seriously into consideration. Other participants have commented on this as well. One could interpret this as a disappointment towards society that does not consider or validate their actual physical experience. Indeed, literature has suggested that sometimes acne is not considered a serious and worrying condition. For instance, Clarke (2001a; 2001b) explains that even GPs are likely to underestimate the impact of minor disfiguring conditions such as acne because they do not present alarming medical conditions. It appears as though the validation that these
participants were looking for was sometimes declined even from close people in their environment. Ruth reflects on this and says:

My mother used to tell me that I was exaggerating... I never felt understood. Nobody can understand. You feel you’re surrounded by people but you’re alone at the same time. Then when they tell you that you are exaggerating... That is actually the most painful.

This factor has not been mentioned by other research studies as a quite significant aspect in terms of dealing with acne. Most probably this is related to the fact that most of the studies are quantitative in nature and, therefore, less focused on the individual experiences. However, it is believed that this theme is essential in portraying an understanding of the actual experience. This has serious implications to the profession of counselling psychology which is committed to offer a validating and supportive environment to clients. If professionals in the field undervalue both the physical and psychological difficulties associated with minor disfiguring conditions, they may also fail to provide and propose the necessary assistance or services.

The next domain to be tackled overlaps with the one above in some respect. It looks into the impact that acne may have on the interpersonal sphere in a person’s life. As stated above, the face has been recognized as a necessary instrument in order to communicate with others. It has implications for our perception and behaviour towards each other (Cole, 1998; Maruyama & Miller, 1981). Anything that is relevant for the self usually has important implications to how we position ourselves in the world and to our future

The impact of acne on the interpersonal sphere and the view of the world

This domain addresses the second question of this study, that is, the bearing that acne, as experienced in adolescence, has on the way individuals view their place in the world and on how they relate to the future.
Interpersonal problems affecting the view of the world

The participants' accounts suggest that due to acne, their experience in their interpersonal sphere has an impact on the way they view their place in the world and their future. Indeed, Julie describes how, when she was younger, her peer group affected her behaviour:

There was a particular boy I fancied who told me bluntly that he thought my face was full of spots. I was dating him and as a result I was spending a lot of time with his peer group (...) I used to put foundation on all the time because of him and the rest of them. When finally when we broke up, I left the group as well and I stopped putting foundation. In the new group I found, I was actually encouraged to stop using foundation.

In this extract Julie explains how much her behaviour and attitude changed when she changed her peer group. Literature in social psychology and youth studies has long established that peer group membership is very important for the young person's development: The importance of a peer group for adolescents lies in the fact that it provides a mini system from which they can evaluate the perspectives of other people besides developing their own value system (Shucksmith, et al., 1993). Hence one can hypothesize that Julie's new peer group represented a new way of seeing life and that it indirectly proposed a new value system which she could more easily assimilate in her identity since it lifted the stigma that the first group was ascribing to her because of acne.

Sean describes a different situation of a time when his friends would not acknowledge him at school:

I was confused and I did not know what to think. Was it that they [his male friends] did not see me? I mean, come on...They knew I was there...Especially when they were around girls they used to ignore me even more. I could not believe what was happening. I had known these mates since primary school.

Sean seems to struggle with anger and frustration for being ignored and almost ostracized by people he trusted and considered his friends. Because this reaction from
his 'social cluster' was unpredictable, it has also probably been more distressing because he was unequipped with effective coping skills (Clarke 2001a). It is interesting to note that instead of continuing to focus on this disappointment, Sean decided to focus on another aspect of his life: ‘I decided that they were not worth it and so I dedicated my time to studying. It’s a pity because you never know whom to trust’. This seems to suggest that Sean gave up on these friends and seemed to generalize his mistrust to others. Indeed, according to Breakwell (1992) the experience of being outcast has a debilitating effect on one’s confidence and sense of self-efficacy. On a similar note, Francesca comments about how ‘certain friends’ stopped any physical contact with her whilst her acne was still very evident.

I did not feel isolated but ... they [friends] only seemed to keep [contact] to a minimum such as limiting themselves to saying ‘hello’. Nowadays they are different. They come and start a conversation with me. You know, as girls we always kiss each other on the cheek before we leave. In those days, they would avoid even that. Yet I understood their position due to my problem. They would probably think “what if a spot bursts, yukk’ and I understand.

Here, Francesca, actually takes on the role of trying to understand her friends’ position. Besides, she also seems to internalize the disgust about her condition. Although she seems frustrated on one level, she still makes allowances for their behaviour. According to Crocker and Major (1989), the internalisation of societal negative views about stigma poses a vulnerability factor for people to deal with stigma. Francesca’s co-existing feelings of acceptance and disappointment towards her friends’ behaviour may represent her own ambivalence of having to live for so many years with a condition that she actually hates. In this light, one can also make a link with one of her quotes presented before where she admitted not having noticed the state of her acne.

Francesca’s experience also brings to light the fact that acne has often been associated with lack of personal hygiene. Three of the participants mentioned that they were often urged by other people to take much more care of acne almost suggesting that they did not or that, in a way, they had some control over it. This is interesting if one considers the literature about perceptions of responsibility for facial disfigurement. Weiner, Perry
and Magnusson (1988) state if disfigurement is considered a result of someone's behaviour, it is believed to be less acceptable. Crocker and Major (1989) indicate that this could be another vulnerability factor for dealing with trauma. One of the dangers in this case is if participants perceive themselves as contributors to their condition, as if they were being duly punished for their lack of hygiene and thus denied the compassion and understanding that they would need. Thus they feel even more isolated.

When one considers the implications of all this in relation to counselling psychology, one can understand how important it is for us to offer a safe and neutral environment where such individuals do not feel judged and where they can feel that they are safe enough to explore the feeling of anger and confusion that all this may trigger.

An appraisal of the experience of acne in one's life

From the participants' accounts, it transpires that the way they experienced acne and the way they have cognitively processed their experiences leaves an important mark of their way of looking at the world and their future. Three of the participants have mentioned that, on looking back, they are filled with a sense of achievement for having managed to overcome acne without serious problems. However, they seem uncertain on whether they should foster such feelings. In Stephanie's account:

Sometimes I think back to the whole experience. Even looking at the mirror before leaving home reminds me of it; almost like a flashback. (...) I realise that I could have been much worse affected by it, especially when I think about other people I know who have had a very different experience of acne. I was thinking that, to a certain extent, I did not go through such a bad patch.

Similarly, whilst approaching the end of the interview, Fiona explained that she had found the interview helpful for one main reason:

I am glad, I revisited this experience. I am glad because I haven't thought about it for a very long time. Now I appreciate that it wasn't easy for me. It reminds me that I need to give myself more credit. I went through this [acne] and now I am fine. Well done, sort of.
These excerpts from the interviews are considered powerful because notwithstanding the hardships, the length of time and the social difficulties, these participants manage to frame this experience positively.

However not all participants appraised the situation in this way. Some of them still feel stuck in the situation and this has serious implication for the way they see their future and their expectations in life. Ruth, for instance, explains:

It affects everything all the time. A hug from your family, at work...Because I believe that when you do not feel comfortable about yourself, you cannot give your utmost (...) Acne has had a huge impact for sure, and will always have... Nowadays it decreased but I am not perfect and unfortunately we are living in a society where you need to be perfect to feel accepted. I feel I still have a lot to deal with.

This quote portrays the difficulties that Ruth still faces when she thinks about acne. And this seems to have an impact even on the way she perceives her life, her expectations and her possibilities. At a later stage she states that she has lost hope of finding a man who would be willing to share his life with her because of her looks. She comments:

I'd like to meet someone who is able to focus on my character but we are living in a materialistic world. Oh how much I'd like to live in older times where fat women were considered beautiful, where people used to focus on a women's character: whether she had guts or whether she was able to do stuff. But today's men do not want anything other than a toothpick/ very thin model: a very thin model and a perfect one. Perfect hair. Perfect face.

One could interpret Ruth's position as one in which she has internalized the stigma around acne and facial scarring. According to Crocker and Major (1989) 'those who have internalized society's negative views [...] should be at particular risk of low self-esteem' (p.619). It seems that Ruth is still tormented by her experience and her thinking process reflects her distress.
Overview

This research was intended to explore two questions of (1) whether acne affects the young person’s view of the self and his or her underlying sense of identity and, if so, in what ways does this influence their way of integrating their new appearance in their identity? and, (2) how does acne, as experienced in adolescence, impact on the way these individuals view their place in the world and on how they relate to the future? Some of the findings of other studies conducted in this domain have been reflected in this study suggesting that acne has strong psychosocial implications (Aktan et al., 2000; Smithard et al., 2001) and that these affect the way young people perceive themselves and their identity. The identity process theory (Breakwell, 1986) has been found very helpful in order to interpret and contextualize the themes presented in the domain named ‘Impact on the sense of self’. This does not mean that the participants’ experiences could only be discussed within this theoretical perspective. On the contrary, other findings resulting from other quantitative studies have also been helpful in order to capture the co-constructed meaning that the researcher has developed in the analysis. However, what has transpired was the fact that acne is quite unique in its effects on the individual. For a start acne does not happen suddenly. People don’t simply realize one day that they have acne unless there are other issues (such as cognitive impairment) that hinder such realization. Therefore, it may be necessary to start distinguishing acne from other disfigurements and scarring (e.g., burns) that are more sudden and unchanging in nature.

Other results of this paper in the context of these particular participants’ experiences could be considered original in that they gave a perspective that is somehow downplayed in other studies about acne such as the lasting effect of physical pain on people suffering from this condition. Another important aspect elucidated by this study is the centrality of the treatment in the lives of these young people. Having to undergo treatment and assume strong medication because of acne contradicts the feelings of omnipotence and the urge for freedom that are usually so distinctive during adolescence (Becker et al., 2003).

On the whole, this study presented with a number of limitations and the researcher has been constantly aware of them. Firstly, as a qualitative study this research cannot be...
used to generalize findings. This means that some stakeholders in society who could consider changes in provision of treatment may not be convinced by the size of the sample. However, this does not mean that the meanings drawn from this analysis cannot resonate with the experiences of other individuals who have had the same experience. Secondly, the sample itself presented a difficulty for this study since adolescents are sometimes quite a difficult group to reach. Their lifestyle, their position between childhood and adulthood, and their natural tendency to search for an identity by not necessarily conforming makes them less likely to participate in such research. Furthermore, the issues presented earlier on in relation to the role of the counselling psychologist, that is, these young people’s perceived vulnerability may make them less approachable. Thirdly, the study has been conducted with a Maltese ethnically homogenous sample. The Maltese context could give a different twist to these adolescents' experiences which may not reflect the interpretation of other adolescents' experiences.

A final word about future research

Given the interesting discussions had with the age group selected for this study (18-25 years of age), the researcher wonders about the possibility of carrying out qualitative studies about acne across different age groups that would be more usually associated with other life events (e.g., bearing children etc.) It would be interesting to discover the meaning they themselves attach to the experience with acne. Future studies could also take into consideration an aspect already mentioned: the uniqueness of acne as a disfiguring condition that would alert professionals to the subtle but powerful differences that may exist between specific disfiguring conditions.
Personal Reflection

I admit that whilst thinking about embarking again on this topic for an empirical study after carrying out a literature review last year, I found myself wondering again about what had led me to choose it in the first place. Throughout this year this study faced many obstacles on a practical level. Concurrently, my engagement with the topic has had its ups and downs as well. Personal therapy has been very useful in order to discover more about what lies behind my interest in this topic. My own experience with acne could have contributed to the difficulties I was facing when I was trying to think about setting up the interview schedule and the other stages of this study. Although, during the analysis I could connect very well with the experiences that participants were presenting, there were a few times where I was surprised because their experiences brought up memories which had long been forgotten such as the painful aspect of acne. Analyzing something that has such personal significance was intriguing but not always easy in order to represent the participants' narrative in the foreground. However, the fact that IPA allows for the researcher's perspective has been beneficial.

Moreover, as mentioned in association with last year's topic of research, I believe that most of my interest stemmed from my work with an adolescent girl who had suffered severe scaring (unrelated to acne) on different parts of her body. In retrospect, I remember that she was one of the most challenging clients I have worked with: presenting me with doubts about my professional status and my competence. Engaging with her was particularly challenging even though, at the time, I was sure that her appearance had nothing to do with it. I was convinced that I did not have any prejudices in relation to this. However, as transpires through this research as well, people with such conditions have their own thoughts, experiences and expectations about how others behave towards them. I may have underestimated the meaning of this in our relationship.

I found my role as a researcher interesting and engaging. Although, as mentioned before, there were several obstacles along the way, I believe that I have learnt a lot precisely because of this process. One of the greatest obstacles encountered was when the project was not granted ethical approval. Apart from the nerve-wrecking length of
the whole process, what was most difficult, was that this suggested that I had not been as ethically aware as necessary in the process. This was a sour pill to swallow. However, I must admit that although not intentionally careless, I had failed to take into consideration all the stages of the research with enough attention. I had taken things for granted. This could have created problems for my study but especially for the participants themselves. When, finally, I was granted approval I was more aware of the constraints of the research and the limitations that could have impacted on the research project.

Apart from the difficulties encountered for ethical approval, some problems also cropped up whilst attempting to find participants. For a long time, there were no participants interested enough to take part in this study. This was very disheartening. At the same time, having read about constrains, fears, doubts and discomfort that change in physical appearance could lead to, I could understand and empathise with the difficulties that prospective participants could face. Thus, my feelings seemed contradictory and ambivalent. Yet, when time came for me to interview participants with acne, I learnt that, in order to do a good job I needed to integrate both aspects in my role.

Another important aspect about my role as a researcher was encountered during the interviews for data collection. Since I was using counselling techniques to make the interview experience more comfortable for clients, I found myself using such skills in a different frame from the therapeutic one which I am more familiar with. In general, I have found the combination very powerful and beneficial in order to sustain participants and encourage them to talk at the same time. I observed myself in this process and there, I have encountered a researcher who is capable of keeping good contact with the participant during but not exclusively during difficult parts of the interview.
References


APPENDIX A: NOTES FOR CONTRIBUTORS
An International Journal of Research

Guide for Authors

Body Image is an international, peer-reviewed journal that publishes high-quality, scientific articles on body image and human physical appearance. Body Image is a multi-faceted concept that refers to persons' perceptions and attitudes about their own body, particularly but not exclusively its appearance. The journal invites contributions from a broad range of disciplines psychological science, other social and behavioral sciences, and medical and health sciences. The journal publishes original research articles, brief research reports, theoretical and review papers, and science-based practitioner reports of interest. Dissertation abstracts are also published online, and the journal gives an annual award for the best doctoral dissertation in this field.

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

Submission
Authors can upload their article as a LaTeX, Microsoft® (MS) Word®, WordPerfect®, PostScript or Adobe® Acrobat® PDF document via the "Author Gateway" page of this journal (go to http://ees.elsevier.com/bodyimage/) through the "submit online to this journal" link, where you will also find a detailed description on its use. The system generates an Adobe Acrobat PDF version of the article which is used for the reviewing process. It is crucial that all graphical and tabular elements be placed within the text, so that the file is suitable for reviewing. Authors, Reviewers and Editors send and receive all correspondence by e-mail and no paper correspondence is necessary.

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Electronic format requirements for accepted articles

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1. Make sure that the disk and the hard copy match exactly (otherwise the diskette version will prevail). 2. Specify what software was used, including which release, e.g., WordPerfect 6.0a. 3. Specify what computer was used (IBM compatible PC, Apple Macintosh, etc.). 4. The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available. 5. The file should
follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to Contributors. 6. The file should be single-spaced and should use the wrap-around end-of-line feature, i.e., \textit{returns at the end of paragraphs only}. Place two returns after every element such as title, headings, paragraphs, figure and table call-outs. 7. Keep a backup disk for reference and safety.

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Reference to an authored book:

Reference to an edited book:

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APPENDIX B – INTERVIEW SCHEDULE
Interview Schedule

The participants were asked to fill in a personal data form and later they will be interviewed according to the Interview Guide below.

Personal Data

1. Are you? Male _________
   Female _________

2. How old are you? _______ years

3. How would you best describe your ethnic origins?
   Choose one section from [a] to [e] and then indicate the appropriate category.
   [a] White
       ___ Maltese
       ___ Any other white background please specify ___________________
   [b] Mixed
       ___ White and Black Caribbean
       ___ White and Black African
       ___ White and Asian
       ___ Any other mixed background please specify ___________________
   [c] Asian
       ___ Indian
       ___ Pakistani
       ___ Bangladeshi
       ___ Any other Asian background please specify ___________________
   [d] Black
       ___ Caribbean
       ___ African
       ___ Any other black background please specify ___________________
   [e] Chinese or Other ethnic group
       ___ Chinese
       ___ Any other please specify ______________________

4. Which of these best describes your current status?
   Please tick
       ___ Single
       ___ In a steady relationship but neither married nor cohabiting
       ___ Married
       ___ Divorced/Separated
       ___ Widowed
       ___ Co-habit
5. What is your highest qualification?

*Please tick*

- [ ] None
- [ ] GCSE(s) / O-level(s) / CSE (s)
- [ ] A-level(s) / AS-level(s)
- [ ] Diploma
- [ ] Undergraduate
- [ ] Post-graduate

*Thank you for taking the time to answer this questionnaire.*
Main Interview

( Words or phrases in italics were intended as cues or points for reflection for the researcher)

Introducing myself and reminding participant about research aims
My name is Miriam Geraldi and I am studying at the University of Surrey. As you may remember from our recent telephone conversation this study is intended to explore the experience of acne during adolescence.

Before, we start I would like to remind you that taking part in this research is completely voluntary and that you can withdraw your participation at any point should you find it uncomfortable or decide it is not what you would like. You can do this without feeling constrained to give me an explanation.

Provide Consent form.
Can you please read through this and sign if you agree with the contents.

Provide Contact details
I am also providing you with my contact details for you to contact me if you would like to withdraw at any point.

Provide list of Counselling and Psychotherapy organizations
I would like to make it clear that if at any point during the interview, you feel uncomfortable with anything we are talking about, we can stop. In any case I would like to offer you a list of organizations that could be of help to offer support and counselling.

Providing this prior to starting the interview should help the participant more readily identify between my role of researcher and counsellor since I am already directing them towards other help venues. Moreover, providing the list at this point and not at the end can reduce the possibility of the participant thinking that I am suggesting they need specialised help.

Provide personal data questions
Before starting the interview, I have a quick questionnaire about demographic data like your age, sex and ethnic origin. This information is important for me to have a better understanding of your stage in life and it will not be used to identify you in any way. Do you mind filling it in for me?
Interview Guide

I am very interested in your experience with regards to acne. Therefore, in this meeting I would like to ask a few questions about this and I invite you to feel free to express anything that crops up in relation to this. I remind you that this interview is confidential and that the presence of the recording equipment is only for practical purposes, in that, it will allow me to better remember your answers at a later stage. As I explained before, the recordings will be erased after the research has taken place.

1. Thinking about the time before the onset of acne, can you tell me something about how life was for you?
   Ask about how they paid attention to their appearance at the time. Prompt about friends and social activities.

2. How would you describe your adolescence?
   Elicit information about situation prior and post the onset of the condition. How did they live their adolescence: peer groups, natural physical changes, relationship with the other sex? Be aware of myths of invulnerability as well.

3. I would like to ask you about the first time you sensed that your appearance was different.
   • Can you tell me more about when acne became a problem?
     Try to elicit information about the age when this happened and how it happened, where it happened and how did the respondent notice the difference
   • How did you feel about it? (prompt – Can you think of anything else that was brought out in you when this happened?)
   • Do you know anyone who has had a similar experience to yours? How did this influence you?
   • Do you think that your experience with acne is similar to other people’s experience with different changes in their body image? Can you tell me more?

4. Did anything change for you? (prompt – In what way?)
   • What, if anything, helped you deal with the situation?
     Try to elicit information about view of self especially in relation to others. View of the future.

5. What kind of support did you have at the time? How did you cope?
   Try to learn more about this and ask about any therapeutic experiences.
   • How helpful was this for you?
• Was there anything, from the support you received, that you felt that was unhelpful?

• Would you have expected anything else from the people around you?

6. In the adolescent years we usually start to notice changes in ourselves and we start becoming more aware of becoming adults rather than children. Therefore our identity usually changes as well.

• Do you think that what happened with acne had any effects on how you perceived yourself in this process? Can you explain more?

  If yes, was this something that they noticed only in themselves or was it something they gained from others as well?

7. How do you see yourself nowadays?

  Try to elicit information about the value that they give to appearance nowadays, and about anyone who is close to them (e.g., partner).

8. Do you think that you would be different if you had not undergone treatment? (prompt – Can you tell me more?)

9. Some experiences in life leave an impact on us and on our way of looking at the future... Do you think that this is true?

• How much, if at all, has your acne impacted on your sense of self and identity?

• Do you think that this has been mediated by how people reacted to you?

Interview Closure

10. We are coming to the end of our time together so now that we have been talking for a while about this topic, I wonder how you feel about participating in this research.

11. During the interview, were there any instances where you felt uncomfortable or that I did not completely understand what you were saying?

  If yes, when was this? What could I do to make things more helpful?

12. Was there anything that you would have wanted me to ask?

13. How are you feeling now?

We have come to the end. Thank you very much for meeting me and participating in this study. Your contribution is really important.
APPENDIX C – ETHICAL APPROVAL
Miriam Geraldi  
Department of Psychology – PsychD  
University of Surrey  

11 May 2007  

Dear Miriam  

Reference: 114-PSY-07  
Altered body image in adolescence: Understanding the impact it can have on the young person’s quest for self discovery and identity development  

Thank you for your submission of the above proposal.  

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.  

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.  

Yours sincerely  

Dr Kate Davidson
APPENDIX D - SCREENING INTERVIEW
Screening Interview through a telephone conversation

The following is intended to provide a general outline of the screening interview. For the sake of clarity and economy of expression, the interview presented below may sound dry. However, the researcher made sure that the conversation with participants was as empathic and compassionate as necessary.

• Introduction to myself and my research

My name is Miriam Geraldi and I am a Counselling Psychology trainee at the University of Surrey. At the moment I am conducting a research study on the experience of physical change during adolescence. I am interested to hear about your experience with acne but before, I would like to ask you a few questions in order to establish whether I have explained myself clearly in the letter and whether participating in this study is the right thing for you. Is that OK?

• Participation in the study

Taking part in this research involves an interview that will take about an hour but it largely depends on the flow of the interview and how long you need it to be. We can think together about when it is convenient for us both to meet.

• Exclusion criteria

Unfortunately I will not be able to interview anyone who is currently receiving regular psychotherapy or medical treatment, who is experiencing a crisis or anyone who is older than 25 and younger than 18 years old. Besides, I cannot interview anyone who has suffered from acne before the age of 12 or after 19 years of age. By any chance, does anything of what I have mentioned apply to you?

Tell me more about it if you are comfortable with it...

• If they fulfil at least one of the criteria

I am really sorry about this because it seems that this research may not be appropriate to you. I still appreciate that you dedicated some time to speak to me and I wonder whether you feel disappointed that we will not be able to meet.
Would you like me to give you some information of services that you could contact?

*If yes, provide list of counselling and psychotherapy services.*

- **If they don’t fulfil any of the exclusion criteria**

In this case I would like to ask you some more questions to see whether participating in this study may be the right thing for you. Can you spare a few minutes so we can go through some questions together?

**Questions for screening**

1. Would you like to tell me how come you decided to take part in this research?
2. When deciding to participate in this research, was there anything you wished to get out of it? *(Be aware of covert desires to receive therapy)*

   It’s important that you know that this is a research and that means that I will not be able to offer therapeutic work. Nevertheless, I do still ensure that participants for this research are not hurt inadvertently.

3. Is there anyone in your life whom you feel is very supportive of you and who you can talk to openly?
   
   3.1 **If yes**
   
   That is very important. Will you be able to contact this person and talk to him/her after the interview, should you feel the need to talk to someone?
   
   3.2 **If no**
   
   Would you like me to give you some information about services that offer help and support for people who need some support and listening?

   If yes, provide list of counselling and psychotherapy services.

4. Have you ever been in therapy or received psychiatric care?
   
   4.1 **If yes**
   
   Would you like to tell me why? Are you still in therapy/seeing a psychiatrist? Are you on any medication related to this (psychiatric condition)?

   *This is important in order to ascertain whether the psychological vulnerability of the prospective participant. If deemed too psychologically vulnerable consider unsuitability.*
5. How do you feel about this research and taking part in it? Is there something you are concerned about?

6. I think that it is my responsibility to conduct the interview as sensitively as possible and, in general, you will decide how much you would like to share with me. Yet, sometimes, during these interviews some powerful feelings are triggered which people may be unable to predict beforehand. How do you feel about that?
   *Try to observe whether prospective participant is open to this and whether she can think about it.*

6.1 If this happens to you, how would you like me to respond?

- **Suitable participants**

  I will soon be starting the interviews. However, I would like to give you some time to think further about it especially in view of what we have spoken about today. Can we make an appointment now? I think we should set it in about 2 weeks' time so that you will have the opportunity to inform me if you decide not to take part anymore. If I don't hear from you though, I will assume it is still on. Is that comfortable for you?

- **Unsuitable participants**

  I am really sorry about this because it seems that this research may not be appropriate to you. I still appreciate that you dedicated some time to speak to me and I wonder whether you feel disappointed that we will not be able to meet.
APPENDIX E – INFORMATION SHEET
Information Sheet

Information sheet sent to participants prior to the interview

Hello,

My name is Miriam Geraldi and I am a student at the University of Surrey. I am very interested in people’s views about their appearance especially when changes occur in adolescence due to unpredicted or unwanted experiences such as facial acne.

I am therefore, conducting a research about this as part of my Doctoral course training and I am wondering whether you would be interested in taking part in it. Confidentiality is of utmost importance and, I will be taking precautions to ensure confidentiality all the time.

I understand that this may be a very delicate subject for some people but if you decide to take part, you could help us improve our understanding of the actual meaning of such experiences for the individual person. The more we understand, the more we are likely to reach out appropriately to people who have had your experience.

Taking part in this research involves a telephone conversation with me to discuss whether participating is a good thing for you. In this case, a face-to-face interview will follow, which will take up to an hour. This interview will be audio-taped for research purposes. I will only use it to help me remember what you say more clearly. I will transcribe the interview after our meeting paying attention to leave out any identifying material and I will thereafter erase the contents of the audio tape. This will be done in order to ensure confidentiality.

Because of the requirements of my research I can only interview people who are between the ages of 18 and 25 and who have experienced acne between the ages of 12 and 18. Besides, due to the sensitive nature of this research I will not be able to interview people who are currently experiencing a crisis or who are still receiving regular medical or psychotherapeutic treatment for their condition.

If you are in this age group and you feel that you would like to contribute to this research or you would like to learn more about it, please contact me on the following address:

School of Human Sciences
Department of Psychology
University of Surrey
Guildford
Surrey GU2 7XH
Email: m.geraldi@surrey.co.uk

Or call and leave a message on 01483 689176
Dear Participant

Thanks a lot for volunteering to participate in this study. Below, I am listing the points we have agreed upon. I would appreciate if you could read them again and sign if you still approve of them:

- You have agreed to participate in this study about your experience of acne.
- The interview that you are going to give will be recorded. This will help me to have clearer recollections of your experience and to represent it as accurately as possible. The recording is only intended to help in the analysis of this research and your identity will be protected at all times. This means that in making the transcriptions I will omit any identifying information you may mention during the interview. Therefore, names and places mentioned will be withheld. The audio tape of this interview will be erased following transcription.
- If, during the interview, you do not feel comfortable answering any question, you have the right to refuse at any point.
- I am interested in your own personal experience. Therefore, I do not believe that there are any correct answers to these questions.
- It is important to bear in mind that you are free to withdraw from this research at any time.

Please read the following and if you agree, sign or write your initials below

I understand the purposes of this research and I am satisfied with the explanation given to me. I give my permission to give this interview about my personal experience and for this interview to be recorded and later transcribed for the sole purposes of this study.

Signature / Initials ___________________________ Date ____________

Researcher’s Name __________________________ Date: ____________
APPENDIX G – LIST OF SUPPORT ORGANIZATIONS
Support Organizations in Malta

If this interview has created any anxieties or distress on your part and you feel that you need help, please contact any of the following:

- Your GP and ask to be referred to a local counsellor.
- Agenzija Appogg – Supportline 179
  Call on No: 179
- Maltese Psychological Association
  Website: http://www.mpaonline.net/index.htm
APPENDIX H – TRANSCRIPT
Transcript: Stephanie

R: I'd like to start by introducing myself so that I can actually put this into a context. I am based in the UK studying at the University of Surrey. The idea behind this research is to explore the physical change that may occur through acne or through other conditions besides acne and see what psychological effect it can have on the person or whether there are any psychological implications for the person.

S: Mhmm...

R: So just for me to get things clear from the beginning. Participating in this research is completely voluntary. If you decide to stop at any point, you can do so without giving me a reason for that and even if you decide to stop later on. For example, you don't want me to use whatever you are going to say here, I will just not use the interview so you can do so without giving me an explanation and all that.

S: Mhmm...

R: You have signed the consent form already and I will be giving you my contact details afterwards so that you can have them and you will be able to reach me.

S: OK

R: I will start by asking you some demographics. Can I ask you your age?

S: 20

R: And, you have also finished secondary education?

S: Mhmm...

R: How would you describe your ethnic background?

S: Yes I am Maltese.

R: So, thinking about the onset of acne... Can you tell me something about what was happening beforehand? I mean, can you remember anything about your life: how it was before acne started?

S: I was round about twelve years old. They started very quickly. At that point I had just stated secondary school and the fact that my brother had gone through the same experience...Well, even from my parents' point of view, they were always more aware. So they took me for treatment almost from the start in order to spare me the problems that my brother had to face....On the whole, I was a normal student, nothing special. At the point I wasn't even going out on weekends because I was too young.

R: OK. How would you describe yourself at that point...How important were aesthetics for you.

S: I don't remember any of my friends suffering from the same problem. None of them was suffering from the same because, usually, acne is not common amongst
twelve-year olds. But, I seem to remember that my brother's problem with acne was there for ever because he had had it for a very long time, since childhood. However, it seems to me that once you grow with the knowledge of its effect it's.....

Nevertheless, I used to be afraid that it could occur to me as well and there were a lot of things that I detested. Firstly, that it's in the face. It's frustrating that it's so evident on your face. Secondly, I did not like the medication because I had to take loads of pills. The medical regime is long and one has to take pills every day. That was something exasperating.

R: So, when you say that the medical regime was long, I suppose you hint at the fact that you could not actually envisage the end of it.

S: No...I spent five years taking medication. It is a long cure.

R: And would you say that the medication left any effect on your body?

S: Well, before prescribing any medication, the doctor used to ask us a lot of questions. For example, he would ask us girls about our period in order for him to ascertain that the medication does not have an impact on the body. Besides, for some of the tablets, he had to carry blood tests as well. This means that they need to be very careful not to have any serious negative effects on the body.

R: Did you need to take a lot of tablets?

S: I used to take two tablets daily. He had first prescribed lighter ones. But then, gradually he used to change them into stronger ones. I was prescribed about four or five different types of tablets. There is one type of tablets that are very strong. You need to have blood tests for it and girls also need to have a pregnancy test in order for the doctor to be able to prescribe them these tablets.

R: Mhmm....

S: Yes because they can have huge negative effects on them. In fact, before being prescribed this set of medication, I had to sign a contract stating that during the time that I would be taking this medication and for the following six months, I would have had to avoid becoming pregnant because the baby could be deformed with this type of medication. The doctor had also mentioned cases of people who have had to have an abortion if they became pregnant during the time of medication.

R: So, how would you say that this has affected you?

S: I used to be quite worried. In fact, I used to ask my doctor every time whether the effects of the medication would wear of by time and whether the likelihood of me having a deformed baby would be like anyone else's or whether I would still have a higher risk. I was very conscious of this issue. In fact, even the doctor had postponed prescribing these tablets for a very long time. He had tried for a long time to find other tablets that would be effective as well in order to avoid prescribing those tablets. However, my condition was serious quite serious and I only that medication helped at the end. My acne would not have healed if I hadn't taken that course of tablets.
R: Did you take them for long?
S: The course of medication was six months long. First I took them for the three months. Then the doctor assessed the situation. Because it had not healed yet, he gave me the rest of the course. But after six months, it had healed. Besides, the other side-effects there was also the issue that I could not take this medication during summer months, because the sun can have a very negative effect on the skin. Another problem was that I had to change some of my usual habits, such as waxing; because the skin used to be so fragile that stuff like that could be dangerous.

R: It seems that even the treatment had an impact on your life during that period especially when you were taking the medication that you have just mentioned.
S: Yes...And, I had some problems with my medical appointments such that I started the medication in January. This meant that I would have finished the tablets in the summer months. Usually they try to avoid this. Because, I stopped in June, I had to restrain myself and stay away from the beach because, in that situation, I was not supposed to stay in direct sunlight. After that experience, I am also very cautious when I buy my sun block. I say to myself, 'after all that I have been through, I should not mess about with my skin which could be risky for my skin.

R: So, from what I understand, you have continued to be vigilant...even nowadays.
S: Yes, and anyway, at the end of the day, I think that since I know very well that sun rays can be quite dangerous, it's obvious that I pay more attention. But, apart from this, if before I had the acne problem I used to apply a sun protection of forty, after this period, I continue to use a sun protection of sixty in order to avoid any risks as much as possible.

R: It seems that this experience has made you more aware and careful about your skin and about general ways in which you take care of yourself.
S: Yes I definitely became more aware of these things because I knew, that there was also the risk of my face becoming scarred if I went into the sun whilst I was taking that medication.

R: So, you have told me that you started having spots when you were twelve years old and that, at twelve, you had quite a few, how would you describe your adolescence?
S: Well, I used to try hard not to let this whole issue have a huge impact on my life because...I believe that it has a lot to do with your character. Maybe I took it one way, whilst others may have had a worse experience. I think that because I was always very sociable, I tried hard for it not to have a detrimental effect on my life. However, I remember that if, for example, I used to go out I used to wear foundation. (voice lowers) Nowadays, that I have matured and dealt with it, I often go out without wearing any make-up. But in those days...For instance I used to go to drama lessons and I couldn't leave home without make-up in order to cover my spots. You would feel that you needed to conceal something. To be
honest, even when I used to look into the mirror I used to hate my face in that condition. I was very conscious of them... a lot in reality.

Besides, other people used to comment about it. Even my school mates used to ask me. Some would ask simply out of concern, in order to see how I was doing... Others would just say something like ‘Oh my God, your face!’ And it depends a lot on how they say these things to you such as the tone of their voice. I remember that even our family doctor was very aware of them and he used to ask me about them a lot. But, that was because he was concerned as a professional.

R: So, from what you have just mentioned, do you think that people would have ulterior motives for asking you about your face?

S: Yes, yes there were people who did that... But, it also depends on how you perceive that. For example, I remember very well that my brother’s schoolmates used to comment a lot about it. I would say that it was some kind of bullying... So you could be bullied because of acne.

R: So how do you think that you were effected by the fact that there were people would react this way?

S: Yes I used to be quite distraught with that because, you would already be very troubled by the spots especially when you look into the mirror and you see your face in that condition. Then when other people comment on those lines you get more annoyed. It makes a huge difference. I remember that one of my schoolmates suffered from the same condition and we used to find solace in one another. So when other girls used to pass some comments we could understand each other and what we were feeling. I used to tell her ‘Look at them. They pass these comments when they know very well what you have’.

R: How do you think that this affected your behaviour around your friends?

S: Personally, I used to try hard not to let this affect me. So I would not shy away from taking part in public activities because of my problem. But I believe that in most cases, it works differently. For example, people stay more indoors. Nevertheless, I believe that it depends on one’s character. I wouldn’t want to say that because I did not let this experience effect me so much, others don’t have a difficult time. Yet, I do believe that one’s background has a huge impact on the way you perceive things.

I believe that my character had a lot to do with how I coped with the situation. Firstly if I consider the way I was brought up by my parents... Then there is also the way I am myself. I used to get involved in a lot of things. Therefore, I did not become a recluse. For instance, in drama I never gave up any roles during plays even though I had to perform on a stage. I never let acne stand between me and what I enjoyed doing.

R: So you tried to fight it back...

S: I used to say ‘Now I have this condition, but I won’t let it stop me from doing what I enjoy doing.’ Because, at the end of the day, it wasn’t something disabling
in such a way that I couldn't have a normal life. So I tried to adapt myself to the situation.

R: How would you compare this condition with other physical changes? What I mean is that, in adolescence, we go through a lot of changes. Would you compare the changes in appearance due to acne to the once we experience as part of puberty?

S: I believe that in these cases one becomes more preoccupied with acne. In my case, it was with acne. Physical changes are normal and an experience that is shared by everyone. Therefore, when you go through them, you would not feel any different from others. But I was quite focused on the changes on my face because it was a different experience than for other people.

The human being is always trying to look better in order to feel better. One of the things that I remember quite vividly is when I used to tell my mother that I had three wishes: I wanted to change my haircut, to lose weight and to overcome my acne problem. So I used to think that for the change in haircut, I could go to a hairdresser and simply change my style, for my weight, I simply needed to control my eating habits but with the acne...I knew that that needed time and I did not know how long it would have taken for the spots to disappear.

R: From what I understand then you would say that they are different in that one could be controlled and expected whereas the other was less so...

S: Exactly...

R: Do you remember about a particular time when you became more aware of acne and of the changes on your face?

S: I started having spots since when I was twelve. But I guess it became a problem when I started going out; approximately, when I was thirteen. It was the time when I started meeting my friends once in a while for the occasional outing. I believe that that was when I started feeling that this was different. My obsession with foundation is still very vivid in my mind: I always wanted to put foundation in order to cover my spots. And, yet, I could still feel that they were visible. What I found most annoying was the fact that some other girls whose face used to be clear without any spots. I would, for example, be in a public toilet and they would go in front of the mirror and start complaining: 'How much I hate my face...I have so many spots'. I would shut my mouth and think, 'these girls don't have anything and yet they are complaining and, poor me, with the state of my face...How can say something like that in front of me?' This used to happen mostly on Saturdays. They were all obsessed with their non-existent spots. I remember this very clearly.

R: So you are suggesting that there were few people who were experiencing the same problem. And that few were insensitive to your difficulties.

S: Yes, I don't remember anyone in my circle that had acne. There was someone at school but no one from my social circle.

R: Earlier on you mentioned that the closest person you knew who had the same problem was your brother. You had been brought up with him, observed what he
had to go through. You also said that how you deal with acne also depends a lot on your character. Would you say that his experience has had an effect on you?

S: Yes, I definitely think it did because I have observed its development. The fact that I knew how long it had taken for my brother to get over it was quite scary. I started thinking about the length of time it would take for me as well to overcome it. This has had a huge impact on me. Then I also started thinking about the medication and how I would have had to get used to taking so many pills. Besides, even the fact that he was bullied was quite daunting because I used to think that it could happen to me as well.

R: And, how would you react to all this?

S: I used to be very afraid.

R: Afraid...of bullying or of....

S: Bullying, definitely bullying. I had never encountered any problem with my friends. I was not discriminated against. This was quite fortunate because I was quite lucky to find people who continued to treat me in the same way. But I used to be afraid of unfamiliar people who would not know anything about me and who would, for example, just see me walking around at school and pass comments. These things were very scary.

R: So are you saying that people stop at appearances and think whatever they like about you?

S: Yes...these people would just look at your appearance rather than who you are as a person. It's more a question of them becoming disinterested in who I am. They would just look at me, see my spots and say: 'let's tell her something about that.' They would not be interested in getting to know me, what I feel or what kind of person I am. This kind of people usually enjoys gossiping about others.

But still, if as a person, you would be less concerned about what other think about you, you would have fewer chances of people bullying you because they are likely to pick on the weaker ones. I have seen others being bullied. If you are weak, you give them power. But if you show them that you are not affected by what they have said, even though you would be hurt, they will give up.

R: When you consider other conditions that have an impact on facial appearance; conditions such as burns or scarring resulting from accidents. Do you believe that you can compare these experiences to acne?

S: Perhaps. However, with acne you have the expectation that you will overcome it one day. Who knows what these people, with more permanent facial scarring, feel! I must say though, that whilst one is going through the experience, some people do think about it in a similar way. And the way others look at you: 'she really has a lot of spots.'

From personal experience, the fact that I have been through it myself, I react differently. Even when I am watching television and I see someone with a lot of pimples, I do say 'Wow,' but I don't say so simply to pass a comment. On the contrary, I would think about how difficult it must be for him. The fact that I
have been through it yourself, makes me more sensitive to others with these problems and I always wonder: 'who knows how he's feeling?' I have heard about other adolescents with a similar problem. Someone I know stopped going out because of acne. People experience it differently.

R: Do you think that anything changed in your life when acne became more visible?

S: Definitely the medication is a big issue. One needs to integrate it in one’s routine, in one’s life. One has to take the pills every morning and every evening. Then one has to remember that spots are also physically painful. I remember that sometimes I would go to the hairdresser’s and I would flinch as soon as she would touch my forehead with the scissors. These memories are still very vivid. On a particular occasion, my hairdresser was trimming my fringe and I cringed because I was really afraid that she would touch my spots. I remember that this surprised her. These things may seem trivial but, at the same time, if one does not have spots, one would never behave in this way. Therefore, in reality, acne would be affecting your life.

R: You have mentioned that acne affected different parts of your life such as the social relationships. Did acne have any repercussions on your life at home?

S: Kind of...For example my aunties would check often about us and ask whether we are taking good care of the acne. Sometimes they would talk to my mother and tell her ‘It seems that the spots have increased’. They would emphasize that we should take care of our acne. But, we have always been very cautious in relation to acne, so it easily became part of the routine. Other people may have different experiences within their family. Even if you consider the financial aspect; there was no way that my brother and I would have been able to cover the medical costs. Since we were going to specialists for our medical visits, we had to pay a reasonable amount every time. Besides, the medication was expensive as well. My parents could have easily not helped with such a high amount. They may have decided that they could not afford it. But they did their best and they still managed to take good care of us. But, who knows how many out there are not supported by their families and are left to fact this problem on their own?

R: Was there anything that you have found helpful in this period?

S: Family support makes a lot of difference in the way one deals with it. Moreover, I believe that the fact that I did not have other female siblings was helpful. Let me explain. I imagine that if I’d have had a sister who did not have acne whilst I had it, it would be a bigger issue for me....In my situation, I could really share this experience with my brother. I believe that this has helped me feel less vulnerable because we used to have similar experiences.

R: If you think back, was there any instance in which you felt that although people were trying to help, they were not being successful?

S: Sometimes, I’d be somewhere and people start commenting trying to find a solution for me. They would start telling me: ‘do this, do that’... I used to be annoyed with them trying to appear as if they know better. I knew that only medication was the solution so I did not appreciate at all their involvement. However, I was aware that, in reality, they were just trying to help out.
R: What would you have wished for then?

S: I just wanted them to stop commenting about my face; that they would just ignore the issue. I knew that I had the problem but I did not want others trying to find a solution for me.

R: Now, with the changes that occur in adolescence we start to see ourselves from a different perspective. We also start to perceive ourselves as adults in the future. Would you say that your experience with acne has had an impact on the way you saw your future and the way you imagine yourself as an adult?

S: I don't know...Because, especially because I started having these problems when I was only twelve years old, I was still quite young and did not think much about these things. When I started experiencing other changes in my body, such as when I was thirteen, I had had acne for two years already so I was used to it. Probably it would have been different if I had started to have these problems when I was 13.

R: So you do not think that it has had an impact on your future.

S: Well, maybe the fact that I always had in mind that I wanted to change, to be better. This is the most I remember about it. I remember that until I overcome acne completely, I was obsessed with wanting to change my face. I wanted my face to look different especially between the ages of 18 and nowadays. In this sense, yes I am aware of the impact that acne has had on me.

R: So how do you perceive yourself nowadays that you have overcome acne?

S: Well, I must admit that nowadays I am very happy. When I look back I remember a time when I was constantly absorbed with my acne. I would continuously check my face and be fixated with spots. Nowadays I look in the mirror I am always amazed at the way my face has become. I remember the summer when I stopped taking the pills. I used to be so happy every time I used to look in the mirror! And, I still experience that nowadays even though it's two years later. You know what? I believe that because of this experience, I have come to appreciate more myself. Before, I used to detest looking at the mirror because of all the scars that I had. Nowadays I am amazed at the improvement and I appreciate it a lot. Besides, even the fact that nowadays I don't wear make-up, which I usually tend to avoid nowadays, is great. I say to myself that I would like to enjoy my actual face. Now my face is in a good condition. In this way, I believe I am different nowadays. Even the way I style my hair. Notwithstanding the fact that my hair has always been short I was always conscious that they may be more evident. But, nowadays, I am happier to be able to tie my hair up. All is clear now. But, to say the truth, I am still quite amazed at the difference on my face. Even my father has noticed this. We are a very closely-knit family and we pay a lot of attention to one another. I remember that when the acne started subsiding, my father used to be very happy, He would tell me 'Bless you, look at how difficult you look' How smooth it looks.

R: Do you think there would be any difference to the way you are today if you had not taken the treatment?
S: Yes definitely. Now that I am older it is more important. When I was younger I did not pay much attention to the other sex. But, I know that in a girl's life these things are important as well. I often think how I would feel if I were twenty and I would still have such a big problem with acne. When I was younger I was concerned about some other stuff. But nowadays, with work...Because, if you consider, at school one would sit for an exam without having anyone observing him. Therefore, if one passes, he or she would have passed the exam. That's it. Nowadays, sometimes I am invited as a representative for the company I work for. I often talk to my mother about this and I am always thinking what would have happened if I would be 20 and having all those problems. I would not have felt confident enough to do this. I believe it also makes a difference on the way you go for something like this. I would probably be more reluctant to take up these opportunities.

R: My final question...It seems to be that we have already spoken about this. However, just in case....How do you think you have been influenced by the different ways in which other people behaved towards you when you had acne?

S: Well it has helped me realize even more that in life there are good people who have your best interests at heart whereas others who are simply malicious. This is something that you learn in general, apart from acne. I believe that it is a learning experience as well to a certain extent. But then, you either give up and let it devastate you or you pluck up courage. I know that compared to other conditions, acne is not so awful but...you either struggle with it in order to overcome it and live your life to the full or you surrender to it, staying indoors and losing anything else that is beautiful in life. At the end of the day, with my condition, I could still enjoy everything else in life but probably other people with other conditions would be more restricted in life.

R: Would you say that having had such a close experience of someone else - in this case your brother- suffering from acne has had an impact on you?

S: Yes...I used to be afraid. Well seeing the condition of his face...My brother's acne was quite severe. Then, later on, my own condition became as bad. But yes, I used to be scared and I knew how painful it could be. Definitely it was scary.

R: So what you were mostly afraid of was actually the change in appearance and the physical pain that he felt rather than the way he was treated by others.

S: Well, the way other people treat you is very important as well; especially the attitude that other people your age have towards you. Yes that is scary. The way you become afraid of the other people at school or when you go out...You start becoming preoccupied with the way people look at you. But, I still believe that it depends on how you behave yourself.

R: From what I understand, in your opinion, one's character is very important in order to deal with acne. What else would you say is significant?

S: Yes I think so. Besides, I think that one's family is also very important and one's closest friends are important as well.
R: Now that we are coming to the end of the interview, I would like to ask you something about this interview itself. How do you feel not that you have spoken about acne with me throughout our time together?

S: I believe that through the interview I have been able to think back and wonder about the different stages and issues arising due to the condition. Sometimes I do think back about the whole experience. Even looking at the mirror before leaving home reminds me of it; almost like a flashback. However, in this situation, I was able to think about different aspects of it and how it has affected me on different levels. Whilst talking to you, I actually realized that I could have been much worse affected by it. Especially if I think about other people I know who have had a very different experience of it all. I was thinking that, to a certain extent, I did not go through such a bad patch.

R: Was there any time during the interview where you felt uncomfortable or when you felt that I was not getting your point.

S: No not really. I don’t think that this interview elicited a lot of personal information.

R: Was there anything during the interview that you think I could have asked about or now that we are ending, is there anything you would like to say that has not been mentioned earlier?

S: No I believe that the questions you asked were quite broad and so you have been able to tap on different aspects of acne as a problem.

R: And now that we are ending, how do you feel?

S: No I am feeling good. Actually, as I said before, the fact that I have overcome it is very encouraging. I try to focus on my current situation and think how good it is that I have healed. I am OK.

R: OK that’s all. But thanks a lot for accepting to take part in this study and for being available to talk to me.

S: It’s nothing much really...

R: It has meant a lot to me especially because it helps me understand better your experience of acne itself. Thanks
RESEARCH REPORT 2:

SUPERVISION AND RISK: A GROUNDED THEORY INVESTIGATION

Abstract

In light of the ever-increasing number of people accessing psychological help with 'moderate to severe' mental health difficulties, there appears to be a need for further investigation into issues of risk presented to professionals. Although being of central importance to psychologists and psychotherapists, the role of supervision has seldom been explored in relation to risk management. The present research is aimed at investigating the process whereby the supervisor is called to take decisions without the luxury of assessing the client in person and at providing a preliminary understanding and explanation to this phenomenon. This objective suggests that a grounded theory methodology would be an adequate and valuable means of exploring this process. Semi-structured interviews were conducted with experienced supervisors and these were then analysed through the grounded theory method. The data provide a diagrammatical representation of the context surrounding supervisors and a preliminary conceptualization of the process of meaning-making for them. The findings are likely to shed some light on a process that is largely absent in theoretical literature and to encourage supervisors to increase their awareness of the process.

Keywords: counselling psychology, supervision, risk, risk assessment, psychotherapy.

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1 This paper is being formatted to conform to the notes for contributors of Professional Psychology: Research and Practice, a journal of the American Psychological Association (APA): (refer to appendix A).
Introduction

The increase in the number of people with 'severe and enduring' mental health problems accessing psychological and psychotherapeutic services in the community has raised concerns about the provision of care and procedures of risk assessment (Reeves, Wheeler & Bowl, 2004). Risk, commonly associated to the client's suicidal ideation, self-harm, substance abuse or violence towards others, is a very sensitive area for practitioners. Client suicide, to stick to the most obvious case, is a common concern and mortality statistics do not offer any reassurance. Reported suicides in the United Kingdom in 2004 alone were as much as 4183 (World Health Organization, 2007). Suicide has been described as a 'personal and occupational hazard' (Bongar, Lomax & Marmatz, 1992; p. 255) by mental health professionals leading to significant repercussions on their mental health (Kleespies, 1998; Schwartz, & Rogers, 2004). Although legal and ethical frameworks require practitioners to intervene in cases of risk arising in psychotherapy, making decisions in this regard is often tricky and complicated. At this point, the role of the clinical supervisor is crucial in assisting the practitioner to deal with the presenting risk both because the therapist needs help and because it is a professional requirement (e.g., the British Psychological Society, 2005).

The aim of this research is to investigate the process of supervisors' clinical judgement about risk in relation to their supervisee's clients. This area was chosen out of personal interest since the researcher has worked with a number of suicidal patients. However, the available literature addressing this area with regards to supervision is scarce. In fact, there appears to be an absence of a concrete theory or models explaining and describing risk assessment in supervision. Therefore, the objective of this study was to begin filling this gap by investigating the process whereby the practitioner (the supervisor) is called to take decisions without the luxury of assessing the client in person. This objective suggests that a grounded theory methodology would be an adequate and valuable means of exploring this process (Strauss & Corbin, 1994).

Several authors in grounded theory (e.g., Strauss & Corbin 1994; Lincoln & Guba 1985) suggest that a detailed literature review is not consistent with the grounded theory
method since this taints the resulting theory with pre-conceptions and hence, minimizes
the extent to which the theory emerges from the data. Yet it appears to be logical for the
researcher that in this case, since there is a lack of theory combining supervision and risk
assessment, a general review would clarify further the nature of the concepts of
supervision and risk without necessarily contaminating the information resulting from
the data (Cutcliffe, 2000). Furthermore, the researcher cannot deny some acquaintance
with the literature and the field under investigation. The following is a general overview
of the information gathered about the concepts addressed in the research question. It is
aimed at clarifying the nature of the information available to the researcher prior to data
collection.

Even though supervision is a ‘distinct intervention’, it often intersects other interventions
on different levels. Bernard and Goodyear (2004) discuss supervision in comparison to
teaching, counselling and consultation. They explain that, although supervision overlaps
with teaching, since supervisors often take the role of teachers (along with that of
evaluators) and the supervisees that of learners, the supervisory process is a distinct,
individually tailored process and does not require the supervisor to follow a pre-
established general ‘curriculum’. In cases of risk, for instance, supervisors may need to
teach the professional and legal obligations of the psychologist’s role to supervisees, but,
they will discuss these issues in relation to the characteristics of each individual case (e.g.,
the client’s support system, therapeutic goals, etc.). Similarly, while counselling and
supervision share the characteristics of helping the service user explore their behaviours,
emotions and thoughts, the supervisory process is primarily aimed at enhancing the
supervisee’s professional efficiency and, hence, the client’s well being. Therefore, even
though attending to the supervisees’ well-being is an important component in
supervising issues of risk, it is often superseded by the need to monitor the professional
work of supervisees and ensuring that all the precautions to protect clients or others from
harm are adequately attended to. Besides, one cannot ignore the fact that supervision
requires a compulsory attendance whereas, in counselling, attendance is necessarily
voluntary. In summary, Bernard and Goodyear (2004) contend that ‘specific aspects of
such related interventions as teaching, therapy and consultation, are also present as
components of supervision. But, […] the manner in which they are arrayed is unique in
each' (p. 10). Moreover, the varied facets that supervisors exhibit in their relationship with their supervisees may not represent completely or uniformly the three elements.

Various definitions of supervision appear in the current literature landscape (Clarkson, 1998). The nuances of the different definitions appear to hinge on the personality and contextual origins of the different authors. Out of the many definitions, the one by Bernard & Goodyear (2004) appears to be broad enough to represent different aspects of supervision. They suggest that:

Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing professional functioning of the more junior person(s), monitoring the quality of the professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession. (p.8)

Although the above definition captures the evaluative and formative functions of supervision, it does not appear to address sufficiently the element of supervision involved in the creation of 'a space for thinking' (Mollon, 1997) where the supervisor acts as a catalyst and an advocate for the function of joint reflection. This thinking space is particularly necessary for issues of risk in client work. In its absence supervisees are more at risk of disregarding the emotional and professional impact of such issues on their work. This broader definition represents more closely the researcher's own definition of supervision. It also indicates that supervisors may be performing different roles, all of which, may be affecting supervisees on different relational levels.

'Supervisors by definition hold an advantage of power over supervisees. They occupy a position of trust and are expected to act in the interest of the supervisee's welfare' (Harrar, VandeCreek, & Knapp, 1990; p. 38). They are ethically bound to support and give direction to the supervisee since they are considered more competent to take the necessary decisions (Falender & Shafranske, 2007; Fujimura, Weis & Cochran, 1985). This is why, in situations related to risk, supervisees are encouraged (and in the case of trainees, required) to consult their supervisors. These definitions of the role of the
supervisor focus on the political position occupied by supervisors in a professional and social context. However, supervisors also occupy a role on a personal level with supervisees. In fact, although nowadays the demarcation between supervisory and therapeutic practice is clearer, the actual historical roots of supervision can be traced back to the practice of psychotherapy (Bernard, 1992). The present supportive and nurturing characteristics are a reflection of that inheritance. For instance, in discussing the role of supervision in cases of self-injury, Babiker and Arnold (1997) argue that supervisors are an important source of validation for supervisees in cases when their therapeutic plan and insight are questioned. Consequently, supervisors are instrumental in helping supervisees deal with tricky aspects of this work, such as avoiding over-involvement with the client as well as enabling supervisees to keep clear-headed in face of their risk for their clients.

The literature landscape does not provide sufficient information about risk in psychotherapy. However, some studies about suicide provide some information about the possible effects on psychologists and psychotherapists in the aftermath of suicide. Since this is believed to be one of the most common risks in psychotherapy (Brown, 1987), it is a valid source of information. A study by Grad and Zavasnik (1998) investigated the implications of suicide for different professionals. They found that psychotherapists, being ‘the last in the chain of professional caregivers’ (p. 289) feel more responsibility than other professionals for the clients’ actions since many people expect them to ‘fix’ the latter. In these cases, they are more likely to feel guilty and to turn to their supervisors for help. At the same time, this study also suggested that psychotherapists admitted finding it difficult to express their feelings to their colleagues about the matter. The authors suggest that this could be a reflection of the guilt and responsibility they feel. Webb and Wheeler (1998), on the other hand suggest that this could be a reflection of supervisee’s fear of being found inadequate as a psychotherapist. All of this has implications on the supervisory relationship and, to some degree, it may impact the intervention of supervisors.

Another study conducted by Reeves et al. (2004) in the UK is also worth mentioning. These authors sent questionnaires to lead trainers of 49 courses accredited by the BACP.
Their aim was to investigate how issues of risk assessment are addressed in training programmes. In their discussion of the findings from the 24 courses that replied, the authors noted that although the majority of them acknowledged that risk assessment should be an integral part of training, almost half of them believed that it was more closely associated with 'the independent supervision' that trainees receive rather than the main responsibility of the course. This suggests that supervisors are assigned the role of teachers as well as that of consultants in these situations. One wonders whether these courses mirror the fear and discomfort (often related to experiences of risk) that psychotherapists experience in these situations and whether such courses collude with the lack of social discourse about supervision. In view of the above literature, it is apparent that the information about supervision and risk assessment is lacking. Information is most often inferred from studies with different focuses. The present research is aimed at providing a preliminary understanding and explanation to this phenomenon.

**Methodology**

**Participants**

One of the aims of the researcher was to strike a balance between homogeneity and heterogeneity of the sample. A degree of homogeneity of the sample was sought in order to enhance the possibility of developing a 'local theory' from participants who have some experience with the topic of this study (Cutcliffe, 2000). Firstly, all participants had completed professional training in psychology or psychotherapy and were accredited by a professional body which requires supervised practice for accreditation. Secondly, at the time of the interview, all participants were involved in community work (not inpatient work). Heterogeneity of the sample was sought in order to ascertain a degree of diversity in their characteristics such as different theoretical orientation, experience with

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This was decided since it is believed that the possibility of client's observation by other staff may influence the risk assessment strategies of both supervisor and supervisee.
different client groups and different number of years in the profession. These characteristics were likely to offer a wider scope to the theory.

The participants in this study were supervisors in the field of psychology and psychotherapy working in various mental healthcare settings and offering clinical supervision. Using a grounded theory approach involved the use of theoretical sampling\(^3\) as a source of data collection (Charmaz, 2003; Pidgeon & Henwood, 1996). Participants were initially recruited through professional contacts of the researcher and then through 'snowballing' via the first participants. All prospective participants were provided with an information sheet (appendix B) introducing the research project and contacted to ascertain that they fulfilled the inclusion criteria. An appointment was then set for a 50-60 minute interview with each individual participant. On meeting the participants, the researcher reiterated the aims of the research and reminded participants that the interview would be audio-taped for the sole purpose of the research analysis. This was further formalised through the signing of a consent form (appendix C).

Twelve participants were eventually interviewed. Given that the framework of grounded theory requires saturation of data, the recruitment of participants continued until it was felt that no new insights were being gained from additional participants (Kennedy & Lingard, 2006). The sample consisted of 6 male and 6 female supervisors (refer to Table 1) with a minimum of 5 years individual supervision experience. All were involved in supervision in their private practice. Three of them were also working in specialised settings in the private sector\(^4\). They identified their ethnicity as White British or White European.

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\(^3\) Kennedy and Lingard (2006) explain that theoretical sampling is a procedure whereby 'the participants [...] are selected purposefully as the analysis progresses for their ability to provide data that would confirm, challenge or expand an emerging theory' (p. 104).

\(^4\) Participants who had been employed by NHS in the past, were asked to answer the interview questions in light of their experience in the private sector, including their own private practice.
Table 1  *Participants' demographic information*

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Preferred Therapeutic Model</th>
<th>Years as therapist</th>
<th>Years as supervisor</th>
</tr>
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<tr>
<td>James</td>
<td>55</td>
<td>M</td>
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<td>10</td>
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<tr>
<td>Alan</td>
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<td>M</td>
<td>Existential</td>
<td>14</td>
<td>12</td>
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<tr>
<td>Rose</td>
<td>59</td>
<td>F</td>
<td>Psychoanalytic</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
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<td>54</td>
<td>M</td>
<td>Integrative</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
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</tr>
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<td>5</td>
</tr>
<tr>
<td>Anne</td>
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<td>F</td>
<td>Dialectical Beh Therapy</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
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<td>16</td>
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<tr>
<td>Daniel</td>
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<tr>
<td>Christine</td>
<td>59</td>
<td>F</td>
<td>Gestalt</td>
<td>26</td>
<td>22</td>
</tr>
</tbody>
</table>

*Note: Names have been changed for confidentiality purposes.*

**Interview procedure**

Semi-structured interviews\(^5\) were conducted with participants based on an interview schedule developed for this research (appendix D). At the beginning of each interview, participants were asked to complete a number of demographic questions in order for the researcher to be able to contextualise their experiences. The interview questions were geared at being open-ended and non-judgemental in order to enhance participants' freedom and space for expression. Whilst formulating the interview schedule, the researcher was also aware of her role as a trainee and of the implications that this might have had on the participants. Hence, the researcher paid particular attention to stress that participants were invited to be as open as they wished in their answers and that she was

\(^5\) This type of interview allows the necessary amount of flexibility for a grounded theory study in order for the researcher to be able to explore issues as they come up in relation to the emerging theory (Langdridge, 2004).
curious to hear whether they may have different perspectives than the ones available in the current literature.

The interview schedule was initially piloted in order to verify the clarity of expression and its flow. It continued to develop in tandem with the information gathered from each participant. McLeod (2001) explains that in grounded theory the emerging theory should continuously inform and ‘sensitise the researcher to the types of issues or areas to be covered in the next interview’ (p.72). Two questions (questions 5 and 10) were added as a result of the initial interviews and they were retained on the final version of the schedule because they seemed to be significant for the unfolding of the theory.

Analytic strategy and procedure

Grounded theory is a hermeneutic approach providing a systematic technique to explore a phenomenon (McLeod, 2003). It is a general inductive method where the data analysis is a continuously developing process described as iterative in light of the cycles of concurrent data collection and analysis (Glaser, 2005; Kennedy & Lingard, 2006; Pidgeon, 1996).

Each interview was transcribed and each transcript was reread for the researcher to engage more intensely with the meanings for each participant. One of these transcripts is being presented to the reader⁶ (appendix E). An initial attempt was made to elicit categories and alternative meanings from the interviews through the process of ‘open coding’ (McLeod, 2003). After this process, the relationship between categories was investigated whilst continuously comparing the meanings provided by participants of all categories. The researcher used memos and diagrams with the intention of arriving to a main understanding of the phenomenon (Pidgeon & Henwood, 1996). This was beneficial in order to keep the relationship of the categories and the participants’

⁶ The choice of the transcript rested on the fact that this appeared to be one of the most comprehensive and representative of both the breath and the depth of the participant’s answers.
meaning-making in mind thus ensuring that the analysis remained grounded in the data collected.

_Evaluative Approach_

An important aspect of the evaluation of this research rests on its commitment to sound ethical practice. The research proposal was subject to ethical scrutiny through the ethical committee at the University of Surrey (appendix F). Furthermore, in planning the research, particular attention was paid to ensure that it was congruent with the necessary ethical standards. Thus, the researcher tried to monitor closely the participants’ emotional experience in order to alert the researcher in case the individual participants had suffered any undesired effects from the research process.

For the scope of this study the researcher followed the guidelines for good qualitative research as suggested by Yardley (2000). These take into account the sensitivity to context; commitment and rigour; transparency and coherence; and, impact and importance of the research. The sensitivity to context refers to an awareness of the existing literature and the ‘understandings created by previous investigators’ (p. 219). The initial exploration of the concepts under investigation and the continuous attention to literature as the data analysis unfolded represented an aspect of this category. Furthermore the researcher’s self-reflexivity and the contextualizing of the participants’ contribution to data collection encouraged an understanding of different contextual dimensions existing between researcher and participants (Elliott, Fischer & Rennie, 1999). The immersion and continuous revisiting of the categories elicited from the transcripts suggest a strong commitment to the research question. In the present study, rigour as defined by Yardley (2000), is believed to be attained through the saturation of data as elicited from the interviews. The transparency and coherence of the data have also been a priority for the researcher aiming at providing a theory that fits and emerges from the data gathered from the interviews. Finally the impact and importance of this research is woven in the research question itself since it attempts to discover how risk, which is often identified as a potential stressor for therapy, is handled and dealt with in the supervisory relationship.
Data Analysis

The analysis of the data generated a table of codes (table 2 in appendix G) and consequently, a graphical representation (figure 1 in appendix H) of all the inter-linking factors identified through the participants' observations. The analysis suggested that five main factors were significant in describing and explaining the process of supervising risk: the supervisors themselves, their supervisees, the supervisees' clients, other broad contextual factors and the feelings and emotions of supervisors. The latter was not represented by a cluster but more by a fluid 'ring' that orbits around the clusters within the contextual factors. The overlapping areas between the general clusters represent an interpersonal dynamic between them; both on a content and on a process level. The resulting diagram revealed seven clusters: the personhood of the supervisor, the supervisor-supervisee interpersonal relationship, the personhood of the supervisee, the supervisee-client interpersonal relationship, the personhood of the client, feelings and emotions, and, contextual factors.

Whilst trying to develop a preliminary descriptive and explanatory model of the phenomenon of supervising risk, the researcher realised that figure 1 was helpful in providing a snapshot of the experience of participants but somewhat insufficient to describe the fluid process that they appeared to be hinting at. Therefore, the researcher relied on the use of a flowchart to represent a tentative model (figure 2) for the sequential relationship between the main categories elicited from the data. This required further immersion in the data in order to understand which categories were directly involved with the supervisors' meaning-making and decisional process. Some of the categories mentioned in the initial illustration were not used in this diagram because they were not specifically linked to this process. Due to the direct relevance to the research question
and the space limitations of this report, only the categories involved in the flowchart will be discussed\footnote{A small number of changes were made to the participants' accounts, including deleting certain extracts and altering some potentially identifying material in order to protect confidentiality. However, attention has been given to let their personal narrative transpire as clearly as possible in the extracts provided below.}.

\begin{center}
\begin{figure}
\begin{center}
\includegraphics[width=\textwidth]{flowchart.png}
\end{center}
\caption{A local model of supervising risk.}
\end{figure}
\end{center}

**Locating a personal definition of risk in one’s role as a supervisor**

**Supervisor’s own definition of supervision**

Supervisors have different ways of defining supervision and their role of supervisors. The idea of supervision as an ‘overview’ was very common. Lucy echoed other participants’ comments in relation to this when she said, ‘my role would be to be outside of the process and observe and to respond in terms of what comes out of their work with clients’. Other participants commented on who they perceived to be the ultimate
beneficiary of the service. Apparently, this is sometimes problematic. In fact, Karl explains that he often wonders about 'the dilemma as to whom supervision is aimed for: whose interests are to be kept in mind?'

Other participants reflected on the same issue. However, many appeared to think about the aims of supervision as multi-layered and multi-functional. They did not experience Karl's dilemma but suggested that they keep all the functions in mind and that they attempt to fulfil all of them concurrently. Moreover, others commented on different functions of supervision indicating that they adjust their role accordingly. Echoing Bernard and Goodyear's (2004) comparison of supervision to teaching, counselling and consultation, the participants also described shifting in these roles and hence in their role as supervisors. Especially in relation to risk, supervisors are likely to find themselves wearing the shoes of a teacher (explaining to new professionals the multitude of risk they could encounter in conjunction to reminding supervisees about ethical and legal responsibilities), of a counsellor (in helping them deal with their needs and emotions), and of a consultant (in laying a direction for future interventions).

**Overlap between supervisory and therapeutic roles**

The data gathered suggests that a shared understanding on the extent of overlap between therapy and supervision is missing. This mirrors the ongoing debate in literature as well. Hence, for instance, Julie explained that 'many of the skills of a good therapist are used in supervision too. [...] So I am not sure you need training to become a supervisor.' Later on, Julie explained that even aspects of risk are treated similarly in the two contexts. She explained that, as in therapy, where therapists are obliged to inform authorities and intervene when clients disclose that they are hitting their children, in supervision, supervisors are required to report a supervisee who is behaving unethically and to the detriment of clients. This position has been discussed often in literature. Baudry (1995) suggests that the 'pathology' of the supervisee is a legitimate and important aspect of the supervisory process. However, Webb and Wheeler, remind professionals to be cautious since the focus of supervision should only be the interaction with the client.
Indeed, the majority of participants were more drawn to the opposite perspective; a position that seems to be more widely supported in literature as well. Different writers (e.g., Holloway, 1995; Carroll, 1997) suggest that supervision expertise is something that 'counsellors and therapists need to develop through specific training rather than as an extension to their familiar therapeutic role' (Webb & Wheeler, 1998; p.513). They indicated that, as supervisors they may face issues that may be different from those of therapists. Anne represents this latter view when she expressed that:

I think that it doesn't go hand in hand, that if you are a psychologist or therapist you are by default a good supervisor as well. There are aspects of supervision that need to be thought about, in terms of what your role is, what conflicts might come up for you, what ethical dilemmas you may be facing?

**Supervisor's own definition of risk in the therapeutic context**

Many participants explained that they define risk as 'harm to self and harm to others'. When the interview with Lucy led to questions about the possibility of risk for the supervisee, she commented,

When I thought about risk assessment, I thought about it in terms of the client. [...] Monitoring a supervisee's well being is definitely something that I would do but I never put it under the category of risk assessment so that's an interesting way of thinking about it.

This suggests that some participants would still monitor risk for the supervisees but they would not necessarily conceptualise it as part of their risk assessment. However, other participants appear to have actually extended the meaning of risk to include risk for a supervisee and also risk of the therapeutic context. Emma described that 'there's risk to the client and risk to the supervisee. One level of assessment is about the supervisee: how secure they are in their own decision making and their capacity to assess their client'.

The context of work appears to have implications both for the supervisee and for the supervisors. Karl and Anne explained that their way of thinking about risk and the
degree to which they integrated risk assessment in their work was a result of their own working experience. In this regard, Anne, claimed that,

It has been much more relevant since, I've worked in my current job... These people are engaged in a lot of self destructive behaviour and therefore I need to be mindful of the level of risk all the time.

Anne continued to stress the importance of risk assessment skills in her workplace; so much so that she admitted that she places it as a top criterion for the choice and/or acceptance of supervisees.

Theorising and conceptualising risk

The triadic relationship between supervisor, supervisee and the client

Participants acknowledged the fact that the supervisory dynamic is different than their usual therapeutic work because the supervisee's client is virtually present in the room. This makes the relationship distinctive since they need to engage both with the supervisee's psyche as well as with the client's. John suggested that this can make the situation complex: 'it tends to have a different feel also because it has the client in the room. It is not supervisor-supervisee only, but there is the client too'.

Paying attention to the triadic nature of risk also has implications on how the supervisors feel when they are gauging between the concern for the client and that for the supervisee. An excerpt from Emma's transcript is illustrative:

Inevitably there is a knock-on effect. I am there as a supervisor and I have a role to play with the supervisee and the client. I mean, we are all in a relationship. Sometimes I could feel concern for the client, concern for the therapist.

Hence, it seems that the nature of the relationship with invisible, yet present clients provides a different scenario for supervisors who are used to a one-to-one relationship with their own clients.
Supervisor's theoretical perspective and methods for assessing risk

Whilst discussing their ideas about risk and how they usually deal with it in supervision, participants suggested that their theoretical orientation often guides them and provides them with tools to sense, think about and deal with risk. In this regard, participants’ experiences seem to echo the findings of other research studies (e.g., Goodyear, Abadie & Efros, 1984; Miars et al. 1983) suggesting that the roles, attitudes and behaviours of supervisors in their practice appear to be related to the theoretical orientation they identify with. Therefore, different theoretical perspectives appear to suggest different ways to recognise and deal with risk-relevant situations and this has an impact on the supervisor's practice. Alan, for example, coming from an existential perspective, was prone to see risk as a 'cultural preoccupation' and, although he admitted that he would not share this perception with his supervisees, he still felt that society almost encourages an 'unnecessary and impossible phobia about life. We actually become phobic about risk and yet life has got risk in it'. Contrarily, Christine echoed the perspectives of other participants when she agreed that risk is something she is preoccupied with and careful to explore with supervisees. She identified herself as a Gestalt psychotherapist and also indicated that her theoretical orientation has sharpened her sensory/emotional experience as well. She explains: 'because I am a Gestalt therapist, another way that I would recognise risk is by my own body reaction and that is true both as a supervisor and as a therapist. It's almost like I can smell it.'

Similarly, Anne explained that her theoretical perspective provides her with clear instructions and guidance about how to deal with risk: 'because within the dialectic behavioural model, which most of my work is embedded in, there is a crisis protocol, so we have certain functions that we are still guided by the model'. This indicates that, some supervisors are likely to prescribe their interventions depending on their theoretical orientation.

Methods of assessing risk

The policy and procedures at the workplace, the personal theoretical orientation and personal perspective on risk, contribute to the way supervisors conceptualise risk and the
methods they choose to adopt in order to assess it. Three participants explained that as a result of these aspects, they have very formal and rigorous ways of assessing risk especially when the client is initially assessed. This tends to be related to what they expect from their supervisees as well.

Many others rely on less formal means of assessing risks. Rose, for instance, identifying herself as a psychoanalytic supervisor, explained that ‘one’s real advantage as a psychoanalytic supervisor is that I would pay attention to my countertransference: what is stirred up in me. I would then make a comment based on that and see what that says to the supervisee’. Countertransference is, in fact, one of the hallmark concepts of psychoanalysis and one of the definitions proposes that it consists of the therapist’s total emotional reaction to the client (Bateman & Holmes, 1995). However, utilising countertransference as a method to understand what is going on for the client and the supervisee does not appear to belong exclusively to supervisors from a psychoanalytic orientation. Indeed, similar to what is suggested in literature (e.g., Rudd & Joiner, 1997), even participants who do not identify themselves as psychoanalytic supervisors acknowledged the importance of the processes of countertransference in their supervisory practice.

Supervisors’ need for meaning-making

Most supervisors spoke about the necessity of having ‘a space to think’ about their own issues or simply to be able to process their sensations or dilemmas. Hence, it seems that the aspect of supervision, identified by Mollon (1997) as ‘a space for thinking’, discussed earlier on, is important for supervisees and supervisors alike. Participants suggested different ways of doing this. Many of them admitted being very self-reflective in their work. Emma used the metaphor of antennas to sense underlying difficulties. She described this by saying:

My way of taking decisions in view of challenges and dilemmas? Well, I can only explain it in terms of these, sort of, antennae which I reasonably honed for a long time in my own therapy. I stop for reflection: I stop and think because I think that that is an
important process. You can say 'hang on, something is not quite right' and think about it.

These reflections appear to share the same quality as the notion of the 'internal supervisor'. As described by Casement (1985), the internal supervisor is a somewhat detached viewpoint which allows the practitioner to explore the interaction with the other. In fact, they seem to be referring to the acquired 'sense of spontaneous reflection' that supervisors, generate for themselves in order to reflect.

Other ways of reflecting and making sense of the participants' experiences in supervision are provided through peer supervision and, what some authors define as, supervision of supervision. Emma explained that she prefers the latter in comparison to peer supervision: 'I still regard it as important for me to see someone rather than just to have a colleague arrangement because it makes more demands on me.' However Lucy described a different experience and explained that she finds peers supervision enlightening: 'it is fascinating because sometimes a friend can say things to you that other people can't so that's very interesting'.

Sources of gathering information about risk

Amongst the sources for gathering information about risk, the participants mentioned, research and publications, own experiences as a therapist dealing with risk, and peer discussions. Christine explained, that apart from keeping abreast with new literature, 'another thing that informs my thinking is, of course, the professional requirements that there are. When I agree to take on a supervisee, I am agreeing to set risk on professional standards so if I think that there are issues around risk, then I need to be aware of what the professional body is expecting of that, either therapist or counsellor.
**Distinguishing available assets & handicaps**

**Supervisor’s personal characteristics**

The supervisors’ personality seemed to play a significant role in their understanding of the supervisory relationship and their meaning-making around risk. This was evident from their responses where it became obvious that, for instance, their temperament and their style of decision-making was a strong contributing factor. Some personal characteristics appeared to offer reassurance to the supervisor. For instance, Anne explained something about her usual tendency to control her anxiety:

> I find helpful just the general ability to contain my own anxiety because I do think I can contain my anxiety about it when someone is at risk and I think that’s helpful because one can also end up engaging in a lot of misguided behaviour and tension because they are really worried.

Another participant, Julie, explained that her own personal values are very strong and that she finds it difficult to work with supervisees whose values are radically different than hers. She discussed this in relation to suicide and explained how she would probably be unable to let someone decide to kill themselves on the premise that ‘it is their choice’. She illustrated this by commenting that ‘if I was working with a supervisee who said ‘well the client has a right’, I would intellectually agree with her or him but I think I would try to get other people involved to save their life’. This suggests that risk can pose intrapersonal dilemmas for the supervisor. One may understand and tolerate something intellectually but not on a moral level.

**Assessing the quality of the relationship with supervisees**

All the participants in this study agreed that a good supervisory relationship should lie at the basis of any supervisory work. In their accounts, a number of participants seemed to be referring to the core conditions of congruence and unconditional positive regard identified by Carl Rogers (1957) as lying at the base of a good therapeutic relationship. Rose explained that a good relationship is more likely to encourage supervisees to be honest with her and share their difficulties. Daniel however clarified that:
I don’t think it needs to be a very cosy relationship or a very comfortable relationship. I think it needs to be a respectful relationship, a respectful space wherein various questions can be asked, angles can be looked at, stories, situations, challenges can be unravelled, in an open way.

Participants continued to explain what they believed could contribute to the formation of difficulties in the therapeutic relationship.

Unhelpful supervisee characteristics

Various unhelpful supervisee characteristics have been identified as possible catalysts for ‘handicaps’ in the therapeutic relationship such as a general lack of self-reflexivity and humility, a fear of judgement and a difficulty to trust. Participants discussed these in the light of potential risk in the supervisory relationship. Some participants also acknowledged a personal discomfort with supervisees who feel powerless and who turn towards supervisors with unrealistic expectations. Lucy explained that ‘sometimes supervisees have difficulty in hearing what’s being said because they can be very confident. I also think I don’t want supervisees to think that they are going to a supervisor who knows it all’.

Another supervisee characteristic that could be potentially damaging is the supervisee’s lack of honesty in supervision. Daniel elaborated:

You need to be sharp because in my experience not every supervisee is hundred per cent honest … especially when you have the added dimension of you not only being a supervisor but also being a marker of someone’s performance.

Research suggests that especially if the supervisee is still in training, they are less likely to disclose ‘uncomfortable’ issues about their clients especially if they consider perfectionism as a condition of worth. Webb & Wheeler (1998) suggest that this could be related to the trainee’s risk to self (in terms of career progression) and to the fear of clashing with the supervisor. They also conclude that in order to circumvent this obstacle supervisors may need to consider different ways of conducting supervision.
**Possible hazardous impact of supervision**

Apart from describing the possible unhelpful characteristics of supervisees, participants also spoke of possible negative effects of supervision. They have especially focused on the possibility of eliciting shame and fear in supervisees. This seems to be especially relevant for issues of risk since, as indicated above, they are likely to encourage supervisees to be less open and honest about their work with clients (Webb & Wheeler, 1998). James suggested that:

> I think that one of the key things in supervision is to be aware of shame in terms of shaming the supervisee. It can quite easily kick in and the potential for the supervisor to misuse power and get into a sort of recycling and shaming experience can be quite daunting.

Daniel also described the negative impact that could result if the supervisor is not open to the supervisee’s style but expects the latter to conform to theirs. This participant stresses that this could pose a risk for the supervisee developmentally and personally apart from stifling the role of the supervisee as a therapist.

**Contextualising issues**

**The ethical framework**

Supervisors indicated that being familiar with the ethical and legal dimensions of supervision is very important and it appears that this transcends their theoretical orientations and teaching objectives. Participants admitted that they take ethical issues very seriously. Such aspects impinge on their responsibilities and on their attitudes towards supervisees. Christine discussed this and said that ‘part of the ethical responsibility of the supervisor is to gauge whether a supervisee is working ethically. This includes paying attention to their limits of competence and taking action if the supervisor believes that the client is seriously at risk’. Later she explained that she had ‘terminated supervisory relationships because I would not supervise a supervisee who
would accept some clients who were outside her limits of competence. I am not taking that responsibility.

These aspects represent a dilemma for supervisors and also involve practical difficulties in having to terminate a relationship. Whilst supporting this position, Davenport (1992) reminds professionals that the needs of supervisees should not supersede those of clients. Similarly VandeCreek and Harrar (1998) remind supervisors that ‘even when a client gives informed consent to receive treatment from a trainee, the client does not thereby consent to receive substandard care’ (p.14).

The legal framework

Apart from the ethical domain, supervisors also seem to be very aware of the legal framework surrounding their profession. Sometimes, this makes them overly cautious about their work. At least two participants admitted that they feel uneasy to think about their legal liabilities. As Julie disclosed, ‘I have been on intensive workshops about all the legalities and I came away feeling that I just don’t particularly want to be either a supervisor or a therapist because if there are so many restraints, you cannot be natural’. This comment indicates that for some supervisors, awareness of legal implications often acts as a deterrent because they are afraid of sanctions they may face in case something goes wrong. This has serious implications for their job since it highlights the possibility of supervisors being held accountable if their supervisees’ clients die or if they constitute risk for others. Hence, many supervisors feel that, in such cases, they feel driven by the legal framework rather than the therapeutic one. As Alan suggested, ‘risk assessment is turning in a form of regulation’.

The micro context

The social context with its legal and ethical implications also appears to have an impact on the micro context in which supervisors operate. For instance, Daniel whose supervisees are usually other junior staff working in the same organization where he works, admits that, although he may be influenced by theory or by literature about conceptualizing risk in a therapeutic relationship, the way he manages is often dictated
by the organizational policies. Although this participant did not express any discomfort in taking this position, other participants did feel that this was a high price to pay. Anne said:

What I don’t find helpful is that sometimes, in the team where I work, we might be obliged by the wider system to take certain action in order to ensure that we have addressed the issues of risk. It might not necessarily be the most clinically appropriate decision. But it is what we have to do so that, later on, no one can sue us or say that we have taken a risk.

Similarly, even professionals supervising in private practice admit being more cautious about possibilities of risk in their work. Many of them described how important it is to have an idea especially about the supervisee’s likelihood to be at risk themselves or to endanger others especially because of the limitations (of resources and support) existing in private practice. Lucy explained that:

I believe that risk assessment is very important especially if you are working in private practice: that the therapist is able to assess the client for any of the risks that might occur in the work. It’s about assessing to what degree they are manageable and to what resources are available to the client.

Supervisors’ need for self-preservation

Within this scenario, a number of participants commented on how, apart from the responsibility they have towards their supervisees and the latter’s clients, they have a responsibility to protect themselves. Karl spoke about his anxiety in this context when he explained that, ‘I don’t want to get involved or somewhat end up being responsibilised for a client’s harm to self or others and realise that I hadn’t considered that whilst providing supervision. I don’t want to be implicated in such cases’.

Likewise, Christine commented on how her ideas shifted around risk because of stronger social and professional shift in focus on risk and the associated possible legal and professional consequences related to it. She claimed:
Well, twenty years ago, when I did my training, I would not have been so alert to risk assessment. I would be more aware of where the client is. My risk assessment would be there but it would have less priority. Now I think it's important to have a good risk assessment because of all the legal, ethical, professional implications. I am aware of the risk for the supervisor too both psychologically and professionally.

Realising the impact of risk on the therapeutic relationship

General impact of risk on the supervisory relationship

In their accounts, participants appeared to hint at a circular process of supervision where the resulting attitude of the nature of the supervisory dyad influences and is, in turn, influenced by the way that risk is dealt with. At the same time they admitted that issues of risk could either hinder the relationship or make it stronger. Daniel explained that:

I think that it will have positive impact because it would reflect awareness, thinking, and they would reflect an appreciation of how unsmooth this work is. [...] If aspects of risk are not being mentioned or there isn’t the appreciation of risk, it would have a negative impact because it would start eating away the necessary trust I need to have in the supervisee.

Participants also hinted at the notion of parallel process (as discussed within psychodynamic literature) as a possible effect on the therapeutic relationship. This term is used to describe the unconscious re-enactment of the therapeutic dynamic in the supervisory relationship (Morrissey & Tribe, 2001). It suggests that specific behaviours and difficulties of supervisees may actually be a reflection of the client’s process (Webb & Wheeler, 1998).

Other participants explained that the way that risk is handled on the supervisee’s part is often very informative about the supervisee and therefore, it gives them insight on the latter’s aptitude to the job as well. Matthew claimed that:

It also depends on how it is brought up. Obviously, if the supervisee expects the supervisor to take over or to tell them what to do, that would give me an insight about
where they are at professionally. [...] It will obviously be a great window of insight into how the supervisee operates in the world and where we are at in our relationship.

**Calibrating one's own intervention**

Making decisions

Decisions in supervision can vary in scope and depth. Some decisions are about the supervisee's therapeutic process with the client. James, for instance, explained that he had to suggest to a supervisee to stop seeing particular clients because she was not sufficiently robust to work with them. In James's case, this resulted in a severe rupture in the supervisory relationship which led to the supervisee terminating the working alliance. This elicits a lot of feelings for the supervisor. James indicated that he felt somewhat insecure after this episode and hence, he sought help from his own supervisor and from other peers. This suggests that for supervisors, taking decisions about their supervisees' clients may actually involve risk: that of losing a supervisee.

Other decisions require a sound trusting relationship. Participants emphasized how important it is for them to feel that supervisees trust them and that they keep them 'in the loop'. They also explained that they feel that they ought to be accountable and reachable. In fact, they stressed the importance of being available for supervisees, even outside the sessions if issues of risk arise. Christine, for instance, said that she regularly makes it a point to ask supervisees about clients who may have initially presented with risk in order to monitor the level of risk. One wonders whether this is again a reflection of the social atmosphere around risk. Some participants also suggested that it requires a feeling of accountability on the supervisor's part.

Finally, the supervisor's role also involves helping the supervisee deal with the difficult emotions. As suggested by Thorne (2002) today's society places a lot of pressure on 'doing' rather than on 'being' with its expectations of gaining quick results. And yet, there are times where doing is not enough and the clients can still be in danger. In these
cases supervisors may need to intervene and model a sense of acceptance for supervisees. Christine explained:

    Nobody wants a suicidal client and yet, of course, it happens [...] Sometimes these things do happen [...] Sometimes it’s about sitting with somebody and accepting that it is tough and that it is really scary.

Learning from the supervisory setting

The sequence unravelled above often leads to what one of the participants called 'calibrating' of one's intervention. Participants explained that their decisions are not based on the same conclusions all the time and that every situation is unique in its own way. Besides, they also suggested that the supervisory process is not only a source of insight for their supervisees but also for themselves. Again, it is worthwhile mentioning Casement's (1985) concept of the 'internal supervisor' since he suggests that supervising others provides practitioners with the possibility of re-evaluating their own work. Participants explained that they believe that their insight develops considerably through the supervisees' issues. This gives support to the circular nature of the model presented in figure 2. As the supervisors' insight develops, it is likely that they re-appraise their own personal definition of risk.

Daniel reflected on the supervisory context from a systemic perspective and said that 'you cannot view the supervisor only as a giver, because he is also part of the system. So whatever good stuff there is, he or she is feeding on that as well'. This perspective was shared by other participants who agreed that providing supervision may also be personally informative for the supervisor. Rose illustrated this when she said:

    I think one learns from one's supervisees. It makes me aware of the things that I do not think about enough. It also makes me clear about things of bad practice that I may be straying into. It draws me up short and I then think 'actually I can see that I am intending to get into that with such and such patient and I shouldn't'.
Overview

The aim of this research was to develop a localised theory of the process of supervisors' clinical judgement about risk in relation to their supervisee's clients by interviewing experienced supervisors in the fields of psychology and mental health. The data elicited from the interviews suggested that supervisors take into account at least seven interlinking dimensions in order to form a clinical judgement. A graphical representation of these findings was produced (refer to figure 1). Further analysis suggested that this diagram remained inherently descriptive and static. A flowchart was therefore produced (refer to figure 2) depicting the sequential interlink between different stages as proposed by participants. This represents the interpretative stage of this study produced from the contributions of participants themselves. The researcher finds this useful in order to think about this process as a fluid and progressive one. The new diagram focuses primarily on the main categories involved in the process of deciding about an intervention, referred to as 'calibrating one's intervention'. It suggests that initially this process relies very strongly on the supervisor's composite of definitions related to the role in supervision and risk. The next stage involves the supervisor's ways of conceptualising risk and understanding it in the context of available theory and existing professional aids. This step leads to an evaluation that involves the supervisor's distinction between available assets and handicaps present in the situation - an appraisal that leads a supervisor to develop contextual awareness well before 'calibrating' one's intervention. A possible interpretation of the model suggested that, as the decision about risk becomes more critical and the intervention of the supervisor more imminent, the latter becomes more influenced by ethical and legal frameworks than by theory or other aspects related to practice. However, it became clearer that this process does not provide a linear causality explanation but more of a circular co-influence of the stages.

Although the qualitative nature of this research implies that reproducibility is not one of its aims, the resulting themes provide a launching point for a theoretical understanding of the phenomenon under investigation. Utilising a grounded theory approach has been beneficial in developing a preliminary theoretical perspective about the experience of supervisors even with a relatively small sample. The results of this research add to the
existing knowledge and research in supervision whilst providing a focus on risk - a seemingly unexplored area. The vast research and literature available in the field, especially in relation to suicide, appear to be mostly retrospective in that it often focuses on the impact of suicidal patients on professionals after they attempt suicide. As reported above, there are significant implications for the role of supervisors if research suggests that in these situations, therapists tend to be fearful of sharing their emotions or be completely honest with their supervisors. This becomes even more central if one considers how much supervisors depend on the honesty of their supervisees (Devenport, 1992) and how central the rapport between the two is in order to enhance disclosure.

Another important contribution to this study is the realisation that the participants' perception of risk includes the risk to the supervisee, the profession and society at large. However, whilst analysing the data, the researcher noticed that in support of other research (Reeves, et al., 2004) participants were more likely to discuss clients' suicide as the most evident risk. Furthermore, although participants mention 'risk to others' as a category of risk, they were more likely to associate it to issues of child protection or to domestic violence. This contrasts somewhat with the more macro view they take in relation to supervisee-related risk.

This study has a number of limitations. Firstly, as anticipated by the researcher prior to the interviews, it was evident that the supervisors participating in this study were prone to perceive the researcher primarily in her training capacity. Questions were often answered in relation to their experience with supervisees. Hence, it was often necessary to ask questions again about professionals in other stages of professional development. Secondly, saturation of the data in this context can only be declared in the light of the fact that this is an exploratory study providing a preliminary theory. Hence the resulting theory is considered to be progressing and developing and not completed. Thirdly, consistent with the aim of the research, interviews were only held with supervisors. Therefore, the researcher was not able to gather first-hand information about the supervisees themselves. In the researcher's opinion, a more developed theory of risk supervision ought to include the supervisees' perspectives as well.
Future studies could take this into account. Indeed, from the comments of participants and from the researcher's own reflections it is apparent that this grounded theory could be further developed if it includes a larger sample of people and therefore exploring in more depth such aspects as the supervisors' main theoretical perspectives in relation to assessing risk and conceptualising it. Besides, it would be interesting to investigate these findings in relation to the increasing number of training courses in supervision and wonder whether and in what context they discuss risk.
Personal Reflection

As I sit here contemplating the subject, I wonder how to explain to the reader what has led me to research this topic. I admit finding it quite tricky changing the topic of my research at the beginning of the year for two main reasons. Firstly, because the subject of altered body image in adolescence, pursued in the previous two years, managed to combine my interest in counselling, health and adolescence (as an age group) so I was pretty attached to it. Secondly, because the subject investigated in the present research was theoretically new to me. This, inevitably, provoked a degree of anxiety considering that it was my final year and that I knew that it would have been a tough year. In this context, continuing with the previous topic would have been more sensible. However, I also knew that the topic of disfigurement in adolescence was also a tough one since it made it difficult for me to approach a consenting sample. I still remember the difficulties experienced in the previous year when I could not get hold of the sample I was interested in. Apart from being demoralizing, it was also quite stressful considering the time limitations of the course. Hence, I decided to try to find a topic which was interesting both professionally and personally. Pondering on my experience on this course and my previous work experience, I realised that the issues of risk as assessed in therapy had always been considerably important to me. I believe that narrowing the topic down to the supervisory aspect depended on two important experiences.

In my first two years in fulltime employment in Malta I was working in a residential setting with a very volatile population of young adult adolescent male clients with behavioural and emotional difficulties. A number of these residents became suicidal in the process of their rehabilitation. On one occasion, my supervisor was unreachable and, in her absence, we were given instructions to consult another professional. When a particular resident, with whom I had a very good working relationship, became clearly suicidal, I consulted this person but I became quite anxious in the process. I remember wondering how this person could help me if he was unaware of my style of working, my personal definition of risk, and especially anxious since he was not able to gauge the level of this client's distress since he was hearing about him for the first time. Rationally, I knew that this person would still guide me through the statutory obligations of the
setting and my responsibilities. Yet, I felt that his limited relationship with me and the narrow knowledge of the client, constituted a serious disadvantage for us. It somehow did not allow me the space to reflect on the emotional experience of the situation. At the end, the client changed his mind. But, I was left with a feeling of discomfort and anxiety due to this process for quite some time after the episode.

A somewhat similar experience happened on the first session with the very first client I met as a trainee counselling psychologist in the UK. Intuitively I knew that this person was very depressed and she admitted suicidal ideation and suicidal intent. Again, I became very anxious: firstly, because I was working in a different setting in a country with a different legal system and with somewhat different legal obligations and, secondly, because I did not know my supervisor well enough at that stage. Again the situation resolved itself at the end but I was left with many questions about the supervisory relationship, the responsibility of the supervisor, and so on. I became quite intrigued by this area but I did not find literature addressing this issue in particular. In light of this lack of available theoretical insight, I opted to investigate the topic from a grounded theory perspective since my aim was to build a conceptual understanding of the phenomenon from the insight of experienced supervisors.

On the whole, I admit finding the grounded theory method quite intense but satisfying at the same time. Being an established approach, many authors have contributed to its development and there are different perspectives of the method. This provided me with some room of experimentation as well. I also appreciated the total respect to participants' contributions (by the stress that the model places on remaining faithful to the data) and the systematic suggestions about how to work and analyse data. Besides being quite reassuring, this was also functional since it resonated with my own perfectionist tendencies and structured approach to work. Finally I found that the encouragement to use diagrammatical representations of my understanding very refreshing and interesting because I feel that diagrams often add to our knowledge and interpretation of the phenomenon under investigation. However, this method also had some pitfalls. Indeed, its laborious style of analysing data often clashed with the time constraints on this course. Besides, having analysed the data in so much detail and
having to reduce it to an 8,000 word paper constituted a real challenge. I continuously wondered whether the final version would do justice to all the work that it had entailed or whether, on the contrary, it would reflect a mild, opaque version of the real picture.

As I look back at the whole process I do realise the limitations of this study. However, I feel satisfied by the contribution that this has made to literature. It has helped me understand better the process of supervision in association to risk and consequently, I feel that I have gained some kind of closure to the anxiety-provoking experiences mentioned earlier. I feel enormously grateful to the participants who were so eager and willing to participate and to contribute their insight and knowledge to this study. After all, literature has recurrently highlighted the emotional baggage associated to risk in therapy. Adding the responsibility of being a supervisor to that must intensify those emotions. Contributing, at least, to an understanding of what goes on is helpful in itself.
References


APPENDIX A - NOTES FOR CONTRIBUTORS
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Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts appear in the Manual.

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References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:

Authoring Book:

Chapter in an Edited Book:
Figures

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of to the side.

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Other Information

- Appeals Process for Manuscript Submissions
- APA Guide to Preparing Manuscripts for Journal Publication
- Preparing Auxiliary Files for Production
- Document Deposit Procedures for APA Journals
APPENDIX B - INFORMATION SHEET
Dear Participant,

My name is Miriam Geraldi and I am currently studying for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. As part of my doctorate I am researching the experience of clinical supervisors in the context of risk assessment.

From a preliminary search into the available literature, there appears to be an absence of information about the process that supervisors go through when they are called to make clinical judgements about their supervisees' clients and the likelihood of the latter to pose risk for themselves or others. The aim of this study is to attempt to generate information about the experience of supervisors in these contexts. It is hoped that, by drawing on accounts of supervisors, this study will produce detailed accounts for 'best practice' in this domain.

I am interested in interviewing supervisors who have completed professional training within the fields of psychology or psychotherapy and whose professional qualifications are accredited by a professional body (e.g., BPS, or UKCP, BACP). Participants should be providing individual supervision to other professionals who work with out-patient clients.

If you volunteer to take part in this study, you will be asked to participate in a face-to-face interview with me. Throughout the interview we will be focusing on your ideas and experiences of supervision. This will last roughly an hour and will be held at a place and location convenient to you. This interview will be audio-taped for research purposes and later, transcribed. All personal details will be treated with strictest confidence according to the Data Protection Act (1998) and I will thereafter erase the contents of the audio tape. This will be done in order to ensure confidentiality. In case I need to clarify anything further with you I shall contact you again.

If you fulfil the criteria mentioned above and if you feel that you would like to contribute to this research or you would like to learn more about it, please contact me or my supervisor, Dr. Riccardo Draghi-Lorenz. We can be contacted via the address above or via our course secretaries on 01483 689176. Alternatively, you can use my e-mail address: m.geraldi@surrey.co.uk

Kind regards,

Miriam Geraldi
Counselling Psychologist in Training
APPENDIX C – CONSENT FORM
Dear Participant

Thanks a lot for volunteering to participate in this study. Below, I am listing the points we have agreed upon. I would appreciate if you could read them again and sign if you still approve of them:

- You have agreed to participate in this study about your experience as a supervisor with a specific focus on situations which require clinical judgements about risk on the part of your supervisees' clients/patients.
- The interview that you are going to give will be recorded. This will help me to have clearer recollections of your experience and to represent it as accurately as possible. The recording is only intended to help in the analysis of this research and all information will be processed in confidence according to the Data Protection Act (1998). Therefore, names and places mentioned will be withheld. The audio tape of this interview will be erased following transcription.
- If, during the interview, you do not feel comfortable answering any question, you have the right to refuse at any point.
- I am interested in your own personal experience. Therefore, I do not believe that there are any correct answers to these questions.
- It is important to bear in mind that you are free to withdraw from this research at any time without needing to justify my decision and without prejudice.

Please read the following and if you agree, sign or write your initials below:

I understand the purposes of this research and I am satisfied with the explanation given to me. I give my permission to give this interview about my personal experience and for this interview to be recorded and later transcribed for the sole purposes of this study.

Signature / Initials ___________________________ Date ____________

Researcher's Name ___________________________ Date: ____________
APPENDIX D - INTERVIEW SCHEDULE
Interview Schedule

Introducing myself and reminding the participant about research aims

As you may remember from our recent telephone conversation this study is intended to explore the experience of therapists in their role as supervisors. As the interview develops, you will notice that I become more interested about your ideas in relation to risk assessment. My aim is to learn more about what goes on when you become involved in decisions around risk for your supervisees' clients.

- Personal data questionnaire
Here I have a quick questionnaire about demographic data such as your age, sex and ethnic origin which I would like you to fill in. This information is important for me to contextualize better your position. It will not be used to identify you in any way. Do you mind filling it in for me?

Ethical Practice
Before, we start I would like to remind you that taking part in this research is completely voluntary and that you can withdraw your participation at any point should you find it uncomfortable or decide it is not what you would like. You can do this without feeling constrained to give me an explanation.

- Provide Consent form.
Can you please read through this and sign if you agree with the contents.

- Provide Contact details
I am also providing you with my contact details for you to contact me if you would like to withdraw at any point.

I would like to make it clear that if at any point during the interview, you feel uncomfortable with anything we are talking about, we can stop.

- Confidentiality and recording
I am very interested in your experience of supervision. Therefore, in this meeting I would like to ask a few questions about this and I invite you to feel free to express anything that crops up in relation to this. I remind you that this interview is confidential and that the presence of the recording equipment is only for practical purposes, in that, it will allow me to better remember your answers at a later stage. As I explained before, the recordings will be erased after the research has taken place.
Main Interview

Supervision
As I said before, I have a particular interest in supervision and risk assessment. However, before continuing further, I am interested in hearing:
1. What are your thoughts about supervision?
2. Can you describe your experience as a supervisor?
3. Do you believe that being a supervisor has any impact on your professional identity? If yes, how so?
4. Have you received formal training to become a supervisor? How did you come to decide about this?
5. Reflecting on your experience as a supervisee, do you believe that it influences your work as a supervisor in any way? Can you tell me more?
6. How would you describe the characteristics of a good supervisor?

Risk Assessment

Now I would like to turn our conversation to risk assessment if that’s all right...

7. When I mention risk assessment, what comes to mind? (try to find out information of their own definition of risk)
   - How would you describe it?
8. Thinking about your own experience, how do you integrate risk assessment in your role as supervisor?
9. Is there anything that informs your thinking about risk assessment? (Probe – ethical procedures, accrediting organizations’ policies)
10. What about your theoretical orientation?
    - How does it affect your work and conceptualization of risk assessment?
11. Do issues of risk assessment when you are supervising affect you in any way?
12. Are there any particular incidents that come to mind? Would you like to say more about them?
13. Can you tell me about any challenges and/or dilemmas that you have faced? (Probe - client, case responsibility, training, therapeutic framework, ethics, organizational policies)
14. Have you ever thought about the ways in which you come take a decision in these cases? Can you elaborate further?
15. Is there anything that you find helpful/unhelpful? (Probe – skills)

Supervisory Relationship

16. In your opinion, are there any basic requirements for a good supervisory relationship?
17. What impact, if any, do you believe that queries around risk have on the supervisory relationship? How do you deal with these?

**Ending the interview**

18. We are coming to the end of our time together, so now that we have been talking for a while about this topic, I wonder how you feel about participating in this research.

19. During the interview, were there any instances where you felt uncomfortable or that I did not completely understand what you were saying? If yes, when was this? What could I do to make things more helpful?

20. Is there anything on the subject that you would like to talk about which I haven’t covered? Anything that you would like to add?

**Prompts and Probes:**

- Could you tell me more about that?
- How do you make sense of that?
- Is there any example that comes to mind that would help illustrate what you are talking about?
- How do you feel about that?
- Why do you think so? What make you say so?
- How useful/helpful is that?
- In what ways do you relate this to your role as a therapist as well?
APPENDIX E – INTERVIEW TRANSCRIPT
Interview transcript

Labels:

I – Interviewer

P- Participant

…- pause

*Italics* – observations or non-verbal material

I: As you know, the research that I am working on is about the supervisory role and also how management of risk comes into play. So I would like to start with a more general perspective on supervision. So, what comes to mind, what are your thoughts about supervision?

P: Well, I think that supervision is formative and summative. It is formative as in developing the practitioner. Often, if I have got a trainee, I have got a summative, evaluative role… Erm; I think that it is there for the protection of the client and the development of the therapeutic work as an overview, as a safeguard. I think it’s there for the professional development of the practitioner and I think that it is also there as a safeguard for the practitioner, not just the client. And… supervision, I think, requires a good working alliance, a level of honesty, enough trust in order to be honest about your work, and a level of...an adjusted level of support. And, sometimes, there is a teaching component too. It depends on the supervisee. I am also a trainer psychotherapist and I also trained counsellors for a long time... so I am quite familiar with people who are seeing their first clients or are in the early stages of their professional careers, as well as more experienced practitioners who need quite specific and careful thoughts about how they work and how they risk assess. Whereas if I’m working with someone who is an experienced practitioner, clearly that’s different.

I: In what way is it different?

P: Well with an experienced practitioner, I would expect to have less anxiety usually, to have a relationship which will feel more peer even though it’s not, but more that ‘peer feel’ I would expect…
I: With you as a supervisor?

P: With the supervisee. I can take shortcuts...I don't know how to put that, but I don't have to spell things out. I can rely on the level of experience that they have got. It's like being able to dip rather than quite carefully make sure that you arrive at the right place. And often they are more resilient; usually, not always but usually. And they have got the level of background of client work that supports them to know 'I've met something similar to this before' or 'I know this is where I can get blind' or usually, you know, they have a sense of 'here I am again' or 'this isn't unusual for me so I need to pay attention'. Whereas when you are new and you haven't got much client experience, you don't know how you usually are. Does that make sense?

I: Yes...Erm, you basically hint at some of the following questions because what I wanted to ask you next is, can you describe your experience as a supervisor.

P: Well, between 1987 and 1999, so I had about 12 years, I was on two or three counselling training courses and I was supervising 4 groups of trainees a week, as well as other supervision I was also doing. Now, I have much less time because I have a management role and my supervision practice is much, much less. And at the moment, I do individual supervision only, which I am sorry about because I like group supervision too. Mostly, I have supervised integrative counsellors and Gestalt psychotherapy trainees. I also have integrative graduates and psycho-synthesis graduates similar enough to my own orientation.

I: Mhmm...And do you believe that being a supervisor has any bearing on your professional identity?

P: It's a part of my professional identity so I would describe myself as a therapist and as a professional trainer. Besides, I go nearly always to an annual supervision conference and part of my sense of myself is an experienced supervisor so when I am there, it's like we're all supervisors. I have a sense of 'oh yes this is Christine, the experienced supervisor'.

I: Before, we were also talking about formal training and you said that you trained in supervision before actually you became a therapist. So, how did the decision come about of actually going into supervision training?

P: Because in 1987, I was offered two posts as a trainer in two different counselling trainings and as soon as I joined them I had supervision groups and no training in supervision. So it was vast and you needed to do it and there were not so many supervision trainings back then. So I took one.
I: So the experience has almost incited the need to get training.

P: Yes. Yes absolutely.

I: Reflecting on your own experience as a supervisee, how do you think that it impacts the way that you offer supervision nowadays?

Silence...the participant appears to be reflecting.

P: I don't know. It must of course. I have had some very good supervisors and hopefully some of that has rubbed off (laughs) and I have had supervisors who have supervised in different styles to me. I am not saying that I always do it but one of the things I have learnt is the importance of gauging the supervisee's level of self-support and level of shame or robustness, the real importance of a good working alliance with a sense of relational alliance; because this is obviously not therapy. I also learnt about the importance that the supervisee feels free to bring whatever they want to or whatever is troubling them. What often gets missed in supervision is what they did do well, something they feel really good about. As a supervisor I really value supervisees taping their work, particularly, students. It's such an easy way to supervise, I really like it. For years, I would take my own taped work to my own supervision so I learnt from it and I like it as a way of supervising myself. I think I learnt with whom I don't work so well. I don't work with all the people who come to me.

I: Can you explain further on that?

P: I have learnt which trainings I don't particularly rate and I would have much more reservation about taking students. I don't need it. I think I also learnt a bit more about what questions to ask to see whether or not we have a fit. I am also aware of the areas where I have a real lack of expertise. You know, I have never worked in the field of addiction but I have supervised people for a long, long time but there are other fields as well. I have a student at the moment who is working in a mental health setting. She is working with clients with whom I would not be working with. We do well, I think but it's absolutely at the edge of my competence because the clients with whom she's working are very very fragile. So, some of that...

I: So this is how your experience as a supervisee has contributed to your role as a supervisor nowadays?

P: It contributes. Other things contribute too.
I: You have already mentioned some of the good characteristics of a good supervisor. Would you like to describe more?

P: An ability to form their part of a good relationship; an ability to hold boundaries between supervision and therapy; an ability to level and type of support that someone may need; an ability to say 'stop, that's enough'; an ability to support a supervisee developmentally which includes particularly early days, not just swallowing what the supervisor says but think through, disagreeing with me, whatever. You know, not just thinking 'what does my supervisor say? Oh I'll go and do it'. Erm...Intuition, a good enough theoretical base to draw on and a good enough common ground – an understanding of the way someone else works. And, not just understanding but sitting comfortably with somebody else's work. Capacity to risk assess and to support the supervisee to do that too, creative .... Fair, that may sound funny, but I think that it is a good quality; to stay stable under stress; to use my own countertransference in the work. Stability...that sounds a funny word but it is something about being stable, being available if absolutely needed. Humour helps, me at least. I think that's all.

I: Before, when you were mentioning these characteristics, you said also 'the ability to say stop'. Can you clarify what you mean by that?

P: Well part of the ethical responsibility of the supervisor is to gauge whether a supervisee is working ethically including within or in the limits of their competence and to take action if the supervisor believes that the client is seriously at risk or the therapist is seriously at risk; or that there is an ongoing state of very good practice.

I: Now I would like to turn our conversation to risk and risk management. So when I mention risk, what do you describe as risk. What is your personal definition of risk?

P: Client risk is physical: self-harm or harm to others and psychological, mental health risk including all the self-harm; suicide being one obviously. But also 'what is the risk of this client being in therapy?' Because sometimes there are risks involved in being in therapy, such as, if somebody is deeply without support for them. What are the risks if you have a client who is potentially violent for example or obsessive? What are the risks for the therapist? What are the risks for the therapist in undertaking this work with this client psychologically or whatever? And then there are the real basics, such as, what happens if your client suddenly becomes psychotic, you know those kind of risks which are very obvious risks. What are the risks of continuing? What are the risks of stopping with this client? What is the safety of the environment? For instance, some students I have known worked in environments that I don't think that they were safe.
Thinking of your own experience, how do you integrate risk management and assessment in your work as a supervisor?

Silence...the participant appears to be reflecting.

Well...again it will vary but I would expect any new client to have some diagnostic presentation. If not necessarily the first thing to say about a client, then I would expect some sense of client's style. Using Gestalt language, moderations to contact, level of awareness, and level of self-support...You know, any risk factors like medical or mental health background or previous experiences of trauma. I would expect that kind of information either because the client has been assessed by someone else or they fill the form anyway: it is a sort of a front sheet. Certainly all students would complete it and this would include a risk assessment. With experienced practitioners, I'm less...how do I say this, it's a funny word but, I rely more on a sort of gut feeling and that's a tricky one. If you are an experienced practitioner you should come with an assessment of their own...

Is there anything that informs your thinking of risk assessment and risk management?

The fact that I teach it is one thing I think. I am not the person on the team who usually teaches risk assessment. A colleague of mine is very strong on it and usually does the risk assessment module but we all know it. (laughs)...Because we talk about it as a team and sometimes we don't agree about its style...Yeah...So in the team we certainly talk about risk assessment. Often it will come up. And I am also on a management committee where I trained and we talk about risk assessment there more globally because we have a referral service. You know, things like that are talked about at that level too. So those are, sort of, some of the places and then obviously I did learn it in my supervision training even though it was a long time ago and also the field conditions have changed so, you know, not to have a very good sense of risk assessment in this climate is ridiculous.

In this social climate you mean?

Yes and you know the more...Well, twenty years ago I would not have been so alert to risk assessment. I would be more aware of where the client is and working with how they are; and my risk assessment would be there but it would have less priority. Now I think it's important to have a good risk assessment because of all the legal, ethical, professional implications. The field changes.
I: What about your theoretical orientation? How does that inform your ideas about risk?

P: Well, clearly I would do... Whether I would write it or whatever, I would be thinking about a Gestalt assessment so there would be all the things that I would be looking at and some of those will show when somebody is at risk. Yes, if somebody is disassociating all over the place or clearly traumatised the gestalt, well any assessment but certainly in my orientation it is very apparent. But, I would also draw from DSM-IV so, you know, I would look and get the book to look at things and encourage other people to do too. Because I am a Gestalt therapist, another way that I would recognise risk is by my own body reaction and that is true both as a supervisor and as a therapist. It's almost like I can smell it (laughs)... You know, my body is tight and I can't understand why... So I would rely on a bodily process experience as well. Maybe rely on it is too strong but I would use it to clarify what it is, what to explore, what might be going on. Of course reasonably and hopefully I am also aware of how the client is being presented and the level of anxiety or concern or no that the supervisee shows. Sometimes it's when the supervisee is not concerned that I become very concerned. At other times, it's the other way. I think that my Gestalt background will mean that I would talk with a client and that I would encourage the supervisee to talk with the client about this experience. Students would say 'don't go to Christine and say "I didn't ask this" or "I didn't clarify that"'. I would be 'what do you mean you had a psychotic episode and you don't know about it' or 'you didn't ask? What?' (laughs)... So I would say that because students know that when they present in supervision there are certain things that they need to know, including things like level of risk, they know that they need to ask. Some other people use a CORE evaluation and that would give you another indication of risk. Other people obviously use other ones. I suppose I would look at how the client is in relation to themselves, in relation to their worlds and also practically, what support they need. I mean it's quite difficult to work with somebody who has the most basic needs unmet such as a safe environment. I have questions about working with somebody in therapy whose primary need is to be safe... And also, it's about how, and this isn't just Gestalt... We teach and I supervise about calibrating so it's about... Let me explain this. A long time ago, at the end of the year, this group of three supervisees that I was working with told me that they had a competition. This competition was about how many tissues they had in their basket by the end of the week, so how many tears had been shed. Then they would mark down the number. It was very funny but in a way it's like... that is not the criterion for practice. It's what is the support for the level at which you're working? And, that's the risk; such as when somebody is too shamed to continue therapy, too overwhelmed, when they leave in
the state that they are really unable to integrate themselves or unable to return, or when especially beginning student imagine that when a client is ‘outpouring’ that’s helpful. They think that these clients just need to be listened to. No. It’s all these things. The risk of actual therapy continuing is a risk. You know, one of the risk factors is about the potential ruptures in the working alliance and what is contributing to that, how do they work with them so there are the risk factors, all the obvious ones and then there is the risk of the process of the work.

I: Now, do issues of risk assessment when you are supervising affect you in any way?

P: Yes.

I: Can you say more about that?

Silence

P: Where to start? ... If I have a supervisee with a very vulnerable client: fragile self, actively suicidal, I am very aware of actively holding the anxiety and I am very aware again ... Nobody wants a suicidal client and yet, of course, it happens. So I am very aware sometime of really the support that supervisees might need both to hold that and the possibility, and sometimes the reality, that sometimes these things do happen. I find working with somebody whose sense of risk is very different from my own, quite difficult. You know, if I am really worried and somebody else is saying ‘I don’t really see what’s the problem?’ that gives me concern. I think a long way back about a particular supervisee and I became crucially concerned about her psychological well being. I think that she was very empathic with her client but, I think, she was just absorbing and I could really have a sense that she was beginning to come apart. That came really close and was really no good. I had been involved in the selection process of her and the selection to the following year and the sense of what responsibility do I have? I had agreed to somebody joining training and to them seeing clients and then actually changing my mind. Because seeing clients is the very thing that they really want to do but is actually re-traumatising them or create difficulties for them. I can certainly think of those feelings. Then there’s the sort of thing where I would be asking ‘you did what?!’, ‘What do you mean you took her home in your car?’ They’d say something like ‘she was walking down the street all wet’ and then I would ask, ‘did you process that’ and they would say ‘No’... Hmm...Some people do some very funny things. Would you like one example?

I: If you’d like and it’s comfortable for you because anyway, I would have asked you about whether there were any particular incidents that come to mind.
P: Sure. One example ... hmm... you would need to disguise this.

I: OK

(The researcher is making some changes to the following extract to respect the participant's request)

P: It was a long time ago, a counselling training. He was quite a flaky student but still, you know, we were thinking 'we'll see how he is with clients'. I was his group supervisor and he went to eating disorders service. His first client was a woman who ... This supervisor had no idea about transference and countertransference. He had read the book but he had no idea. So each time he came, we were looking at the relationship between the two of them which was causing me concern. Then she started bringing him gifts: a bar of chocolate. We would process it, talk about it and... Bigger box of chocolate, you know... It was a weekly thing and each week we would discuss it in supervision becoming quite worried. A bigger box of chocolates, and I am going 'No give them back', 'No you must not do this'. He was very honest. He comes in every time and the group is 'Oh my God' every time...So I asked him 'What happened this time?' and I asked him 'did she bring you something again?' because we had really been through this gift thing. 'Yes' he said. I asked 'OK, what did she bring you this time?' He said, 'She bought me a Fossil watch because she saw that mine was a little wasted'. So I said 'What did you do then?' keeping my face straight. He said 'I didn't like it very much so I took it back to the shop and exchanged it for a different model'. That was not a good moment... (laughs) That was one of the bad ones. Suffice it to say that he did not complete his training. So there are times where you feel that supervision is falling on quite stony ground: that somebody is really unable, unwilling to hear you. Sometimes, particularly when people have a strong saviour sense, you know 'I must save the world'... I am very unwilling to hear limits of competence. Certainly I have terminated supervisory relationships because I would not supervise a supervisee who would accept some clients who were outside her limits of competence. I am not taking that responsibility. I told her that I would if she would continue and she continued. Then we stopped. It's not good.

I: Again, it seems to be about the amount of risk one is able to take...

P: Yes because risk assessment involves thinking about whether one has the competent skills, experience to work with this level of trauma or whatever and this presenting issue. The level of fragility of the client and this sort of thinking that 'I must save the world' is unethical. Understandable but unethical.
I: Have you ever thought about the way in which you make decisions in these situations. Such as the example you just gave about having to terminate. How do you come to decide?

P: If I'm honest...Well I can give you the right answers about how I do it. I know them but at this stage of my working life, I'm also influenced by 'do I need this'. So partly it's by professional conduct and by professional responsibility such as the level of risk, the degree to which somebody uses supervision, how much they take on board the warnings that I give or the boundaries that I set and that we agree to, the extent to which client or clients are at risk... Well all of those are true. But, over the years, now I have sort of reached the point of asking 'do I need this in my life'. I have a lot of work and I do not need to try to work with somebody who is causing me real anxiety as a supervisee. You know, when they are in training and they are my trainees, I have to because I have a trainer responsibility as well. But apart from that, I have a lot to do in my life; I have enough responsibility and I do not need more.

I: When you are taking these decisions is there anything that you find helpful or unhelpful?

P: Well what is helpful is... You know when I am writing support for someone who is doing BACP accreditation for example. It says 'what would you do about in the event that...' and you need to write it down. Actually it is quite helpful to actually write down 'well this is actually what I would do in the event that somebody would be acting unprofessionally'. It's something about writing it which is actually quite useful to see and supportive in a way. What is helpful is supervision of supervision where I would take my concerns. What is helpful is taking to colleagues and experience. It might not be the answer but it is true. What I find also helpful is to be clear about the areas that one needs to address and the changes that we need to make and check whether we agree about them. Having an understanding of what one needs to do to demonstrate whatever, and if they don't, what are the consequences of that. I really think that it is important for the supervisee to know what my concerns are, what they are or what changes I am looking for and what helps is when the supervisee is collaborative about that. What is unhelpful is when we disagree about we need to change. And I am not saying that I am right. What I am saying is that I am right by my version and I am right in terms of my alliance or lack of it. One of the students was on placement and he had this client who had schizophrenia, was actively suicidal, using drugs. You know that was his third client and I was saying 'No this is not really good for you' and the agency was not assessing clients prior to allocating them to the counsellors. They had an open door policy. So I contacted the agency and said that this was no appropriate for my supervisee. They did not really
like it but it helped for me to be able to intervene in that way...or to say that this is not an appropriate placement. The other thing about risk is, of course, when students are working with underage clients and they need to know a great deal more about rights an working with children. This is something else which I consider to be risk but I forgot to mention it before. What is unhelpful is when I get caught in some transferential of polarised place where I feel like I am a, sort of, safe-guarder of the client and the supervisee becomes the bad one especially if I start feeling like I need to do something and I get caught in that kind of atmosphere. That is not helpful. This sets me thinking that some supervisees work with some really fragile people and what is difficult is working with a supervisee whose client is becoming increasingly fragile rather than supported and certainly that causes a lot of anxiety. I think I am slightly more anxious if the client is young.

I: Because of...

P: Because if things really go badly wrong and they do kill themselves, there is an awful amount of life not lived. Because I think that there is a sense that this person is self harming in a way that is...I'm just aware of the responsibility I take and it's true that there is something about having a 15, 16, 17-year old that are really deteriorating mentally that is really distressing I think.

I: We have tapped on this already but again, I would like to ask you a question. In your opinion are there any basic requirements for a good supervisory relationship?

P: A sense that both the supervisee and supervisee will be accepted as a person even if their work is being critiqued Hopefully they have a safe-enough place and a safe enough relationship, robust, honest and hopefully with not enough strong enough transferential relationship that is going to make supervision difficult. Obviously it happens but it's not my favourite to have to deal with either idealized, demonised or whatever. Because I am a head of department and I supervise, I get a lot of that. A relationship that can contain anxiety both the supervisee's and the supervisor's. A relationship in which I hope that the supervisee knows I am on their side even if sometimes I don't agree with them and a relationship in which I would hope that my supervisees know that if they are really in trouble they could come to me and that I would respond. It does sometimes happen. I don't want to hear about something happening two weeks later that has really gone absolutely pear-shaped or that it has given my supervisee an extremely anxious two weeks if a short phone call would help. You know, just being able to hear and hold their anxiety even for a little while is important. I would want supervisees to know that that is part of the relationship. What I look for is some integrity in the supervisee and some integrity in me. Some
warmth, humour, some willingness to work even when it’s sometimes tough. It helps, I think, if in the relationship the supervisee is able to give me feedback that for example I am not giving enough support or that that was too much or too little or that they need more confirmation so that I will have a sense of where I need to adjust or not depending on what they bring. I know some of my strengths as a supervisor and some of my weaknesses as a supervisor.

I: What impact do you believe that issues around risk assessment or risk management have on the supervisory relationship.

P: I think being able to discuss risk and risk management is part of the cement of the relationship.

I: So it’s strengthening...

P: Yeah. Clearly if we have very different perspectives than it may not be cement as all but I think it’s about ‘yes we have this client here’, ‘what do you need’ and ‘how do you need...’, ‘have you thought about’, ‘who is going to do what’, and ‘what happens if’ is a fundamental part of the support not only of the work. It is about knowing that we can both look at this and try to manage it together. It’s an integral part of the relationship.

I: You seem to be describing almost a positive effect of being able to discuss these issues with the supervisee. Is there any way it can have not such positive effects?

P: Usually not, I don’t think. The negative, if you like, is when the supervisee does not see risk in the same way that I do. Then it doesn’t seem as if it’s collaborative. Either I’m teaching, really informing; this is what we’ve got, this is why I think it’s occurring, let’s go back to it again and see what you can define or see...it’s a teaching exercise really, the teaching part of supervision. Sometimes, it’s unhelpful when my risk management approach is in conflict with the placement approach like I’d say ‘It’s ABC’ and they’d say ‘No it’s XYZ’. That’s not easy for the supervisee at all. Sometimes, if I am prioritizing risk and I am meeting with a supervisee who wants to talk about the process of the work the transferential aspects, you know, whose interest is in something different than risk, I would ask ‘what happened to so and so whom we discussed last week and that I am still concerned about’ and they would say ‘actually I don’t want to talk about that client. I want to talk about this one’. I’d say ‘just satisfy me for a moment and tell me what you did. Did you talk to the GP about this and did you do this?’ Almost like ticking the box. Sometimes that is not helpful. Sometimes it’s about sitting with somebody and accepting that it is tough
and that it is really scary. It's about reminding them that you can do what you can do to minimize that and it will still be scary.

I: We are coming to the end of the interview now. What I would like to ask you is that, since you have quite a long experience in the field but also during this hour thinking about this aspect of supervision. How do you think about participating in the research?

P: I am wondering how, if at all, your research will impact those supervisors who do not prioritise risk and risk assessment. Maybe about training but more about how people use supervision and the multiplicity of risks involved in clinical work when you sit in the therapist's seat and you sit in the supervisor's seat and the risk for the supervisor when something goes wrong. What happens if there is a complaint about my supervisee? And that happens. So I am aware of the risk for the supervisor too both psychologically and professionally. So insurance is good.

I: During the interview were there any instances where you felt uncomfortable or maybe you felt that I was not making myself clear?

P: No you were clear. I hadn't thought enough so you probably didn't get...You know, if I had thought more about things you might say...I feel that I have left gaps all over the place but I'm sure other people will fill them in (laughs)

I: Is there anything about the subject that maybe you felt that I have left out or that you think may have left out in this research?

P: I think I would have liked you to ask about the risks for the supervisor. I will be interested myself, because I did my supervision training so long ago, to know how far current supervision trainings include risk assessment. I'd be interested to know what my supervisees have said (laughs)... I am not sure that this answers your question but one of the things that may be pertinent to risk assessment in training is that people sometimes fail their dissertation because of risk assessment. Not necessarily because they are not good practitioners but also because people sometimes do not write about things that they need to write about. Either, they are really not good practitioners and or they have done the right things and they don't say it. So something else important about risk is being able to communicate it and write it. I am going to ask this question more because it makes me smile and I am not sure it’s part of your research 'as an experienced practitioner, would you take risks that you would not encourage your supervisees to take' and the answer for me would be 'Yes' (laughs). My own supervisor might not agree with me on that but... (laughs)

I: Thank you very much. I have found that really interesting.
APPENDIX F – EVIDENCE OF ETHICAL APPROVAL
31st January 2008

Dear Miriam

Reference: 197-PSY-07
Title of Project: Clinical Supervision: A grounded analysis of the experience of risk assessment for supervisors when their supervisees bring client-related issues

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Mark Cropley
APPENDIX G - TABLE 2

SUMMARY OF THE ANALYSIS OF SUPERVISORS' EXPERIENCES
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APPENDIX H – FIGURE 1

GRAPHICAL REPRESENTATION OF ALL THE INTERLINKING FACTORS
Figure 1. A graphical representation of all the inter-linking factors identified through the participants' observations.